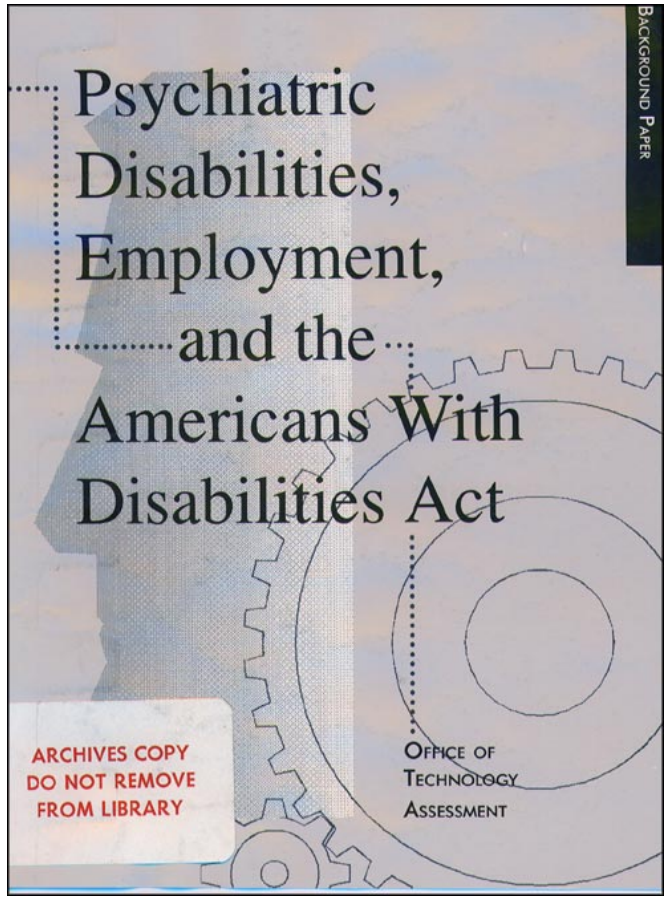
Psychiatric Disabilities, Employment and the Americans With Disabilities Act

March 1994

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Foreword

Few activities are as central to our lives as working. For many of us, employment occupies a large portion of our waking hours and leads to economic independence. Our jobs shape our sense of identity, self-esteem, and social connectedness. The Americans With Disabilities Act (ADA) of 1990 makes it possible for people with disabilities to participate more fully in this key component of modem society.

Employers and people with disabilities must translate this vision of the ADA into a reality. Without question, psychiatric disabilities raise some of the most challenging issues under the ADA's employment provisions. Psychiatric disabilities are not readily apparent. People identified as having one of these conditions often are stigmatized in our society. Moreover, with their impact on behavior and social interactions, psychiatric disabilities sometimes raise difficult issues for employers and coworkers.

Ongoing Congressional] interest in the ADA as well as mental health issues led Senator Edward M. Kennedy (D-Massachusetts), Chairman of the Senate Committee on Labor and Human Resources, to request, and several members of the House Working Group on Mental Illness and Health Issues-Congressman Dave Hobson (R-Ohio), Congresswoman Marcy Kaptur (D-Ohio), Congressman Mike Kopetski (D-Oregon), Congressman Ron Machtley (R-Rhode Island), and Congressman Jim McDermott (D-Washington)-to endorse the request for this OTA background paper. In this background paper, OTA examines current knowledge about psychiatric disabilities and employment in the context of the ADA's requirements and reviews Federal activities directly or indirectly aimed at supporting the ADA's employment provisions.

Many individuals and institutions contributed their time and expertise to this project. People with psychiatric disabilities as well as experts from government, industry, and academia participated in the preparation of this background paper, serving on a workshop panel and reviewing drafts of the chapters. OTA gratefully acknowledges their contributions and assistance. As with all OTA analysis, however, responsibility for the content is OTA's alone.



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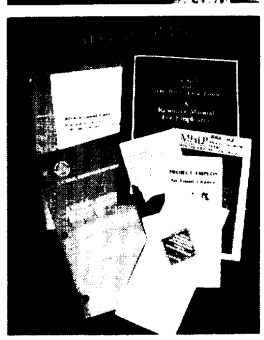
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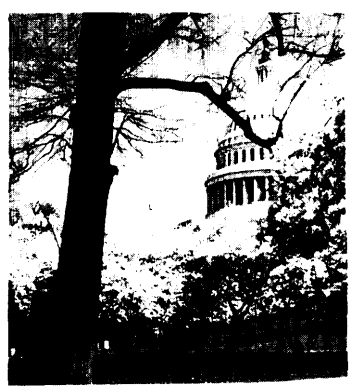
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Executive Summary 1

The Americans with Disabilities Act (ADA) is a watershed in the history of disability rights. It outlaws discrimination against people with disabilities in nearly every domain of public life: employment, transportation, communication, recreational activities, and other accommodations (table 1-1). The ADA enjoyed bipartisan support during its legislative sojourn, winning the President's signature on July 26, 1990. Disability rights advocates celebrated passage of the ADA, hailing it as the single most far-reaching legislation ever enacted against discrimination on the basis of disability. Although the news media had largely ignored previous disability rights legislation, it showered attention on the ADA's passage and its early implementation. Executive branch agencies prepared requisite regulations. Businesses geared up for compliance and voiced concerns about the lack of specific guidance, costs, and the risk of litigation associated with this new law. And a new industry emerged, marketing ADA expertise and technical assistance.

At this early juncture in the law's implementation, it is useful to evaluate current efforts under the ADA in the area of psychiatric disabilities and employment, and to review data that may assist future implementation. This study by the Office of Technology Assessment (OTA) examines these issues, at the request of Senator Edward M. Kennedy (D-Massachusetts), Chairman of the Senate Committee on Labor and Human Resources, and several members of the House Working Group on Mental Illness and Health Issues—Congressman Dave Hobson (R-Ohio), Congresswoman Marcy Kaptur (D-Ohio), Congressman Mike Kopetski (D-Oregon), Congressman Ron Machtley (R-Rhode Island), and Congressman Jim McDermott (D-Washington).



	Brief description	Law's enforcement date	Enforcement jurisdiction
TITLE Employment	Provides that no covered entity shall discriminate against a qualified individual with a disability because of the disability in regard to job application procedures, hiring, advancement, employee compensation, job training, and other privileges of employment.	Effective July 26,1992, for employers with 25 or more employees, and on July 26, 1994, for employers with15 or more employees. Employers with fewer than 15 workers are not covered by ADA	U.S. Equal Employment Opportunity Commission
TITLE H Public Services	Provides that no qualified individual with a disability shall be excluded from participation in or be denied the benefits of the services, programs, or activitives of public entities, including transportation facilities.	As of Aug. 26,1990, all new public buses and light and rapid rail vehicles ordered are to be accessible; one oar per train must be accessible by July 26, 1995; key commuter stations must be retrofitted by July 26, 1993; all existing Amtrak stations must be retrofitted by July 26,2010.	Us. Department of Transportation; U.S. Department of Justice
TITLE III Public Accommodations	Provides that people with disabilities should have access to existing private businesses that serve the public, so long as required accommodations are 'readily achievable." The list includes hotels, restaurants, theaters, laundromats, museums, zoos, private schools, and offices of health-care providers.	Effective Jan. 26, 1992, for businesses with more than 25 employers; on July 26, 1992, for businesses with 25 or fewer employees and annual revenue of $1 million or less; and on Jan. 26, 1993, for companies with 10 or fewer employees and annual revenue not exceeding $500,000.	U.S. Department of Justice
TITLE IV Telecommunications	Amends Title II of the Communications Act of 1934 by adding a section providing that the Federal Communications Commission shall ensure that interstate and intrastate telecommunications relay services are available, to the extent possible, to hearing-impaired and speech-impaired individuals.	By July 26,1993, covered firms should have telecommunications services available 24 hours a day.	Federal Communications Commission

SOURCE: CQ Researcher, The Disabilities Act(Washington, DC: Congressional Quarterly, Inc., 1991).

What does the ADA require, in terms of employment? Title I bars employers from discriminating against qualified individuals with disabilities.

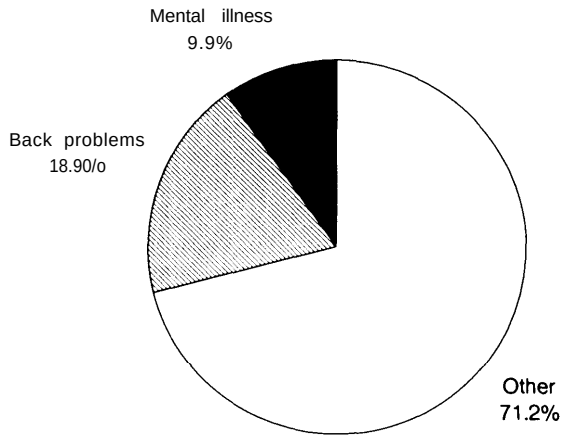
> *No covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment (42* USC *121 12).*

The ADA's construction of discrimination prohibits, among other things, pre-job offer medical examinations or inquiries or the segregation of employees with disabilities. The most important definition of discrimination is an employer's refusal to make a reasonable accommodation. When requested by a qualified applicant or employee with a disability, an employer must provide a reasonable accommodation unless doing so would impose an undue hardship.

In the first 15 months after the ADA went into effect, 17,355 employment discrimination charges were filed with the U.S. Equal Employment Opportunity Commission (EEOC); nearly 10 percent of these charges—1 ,710-related to mental disorders (figure 1-1). That mental disorders accounted for the second largest block of charges, as broken down by type of impairment, hints at the importance of the issue of employment to people with psychiatric disabilities. The numerous charges of discrimination that involve mental disorders also signal that employers will not infrequently face issues around psychiatric disability and the ADA.

This assessment has two major goals. The first is to compare the ADA's employment provisions with what is known about mental disorder-based or psychiatric disabilities.[1] The second goal is to review Federal activities relevant to the ADA, em-

FIGURE 1–1: 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.

ployment, and psychiatric disabilities. This chapter summarizes major findings of the subsequent chapters and underscores areas of needed research, guidance, and technical assistance.

= Chapter 2 provides an overview of the ADA's requirements and the political and legal antecedents.

- Chapter 3 begins with a discussion of the ADA's definition of disability and its potential impact on people with psychiatric disabilities. A description of psychiatric disabilities, their prevalence, common symptoms and treatment, associated functional limitations, and their impact on employment forms the chapter's second section.
- Chapter 4 considers many of the crucial requirements of Title I of the ADA, including dis-

[1] The report focuses on mental disabilities, a broad rubric. However, some conditions are not discussed, including substance abuse disorders, developmental disabilities such as mental retardation, and other cognitive and neurological impairments. While these impairments and resulting disabilities raise important questions under the ADA—some similar and some distinct from the conditions considered in this study—they are beyond the scope of this report.

closure, qualification standards, reasonable accommodations, and the issue of direct threat. The ADA's potential impact on mental health benefits is also discussed.

. Chapter 5 reviews Federal enforcement, technical assistance, and research support related to the ADA, psychiatric disabilities, and employment.

The ADA represents a significant advance in the history of disability rights. The language of the law, the regulations and guidelines offered by the EEOC, experience with the Rehabilitation Act of 1973, the activities of employers and employees implementing the ADA, and technical assistance efforts all guide the ADA's implementation. Nonetheless, employers and people with psychiatric disabilities have concerns about the law and its implementation. Employers fear the costs of implementation and liability under the law and want more specific guidance as to their responsibilities. People with psychiatric disabilities fear that the language of the law and relevant guidelines often do not speak to their needs. Indeed, OTA concludes that inadequate knowledge of relationships between psychiatric disabilities and employment coupled with few efforts to apply available knowledge to the requirements of the ADA are impediments to the law's implementation. In the absence of further research and guidance, employers and people with psychiatric disabilities are handicapped in exercising their rights and responsibilities under the law.

DEFINING DISABILITY

Drawing from the Rehabilitation Act, the ADA offers a three-pronged definition of disability. Disabled individuals are:

- those with a physical or mental impairment that substantially limits one or more major life activities,
- those with a record of such an impairment, or
- those who are regarded as having such an impairment.

The first prong of the definition asserts that a disability reflects impairment and functional result. This definition limits the ADA's protection to those individuals with significant or non-trivial impairments. The second and third prongs are based on the widely held belief that disability is the result of an impairment and the way others perceive an individual with an impairment. Since mental disorders commonly provoke negative reactions and attitudes—stigma—these two prongs of the definition are especially important to people with psychiatric disabilities. Part of the ADA's mandate is to make questions about psychiatric disabilities or mental health history things of the past. Title I of the ADA prohibits employers from asking about disabilities or using any information sources that disclose disability status, including voluntary medical examinations, educational records, prior employment records, billing information from health insurance, and psychological tests, prior to a job offer.

Although the law excludes several specific psychiatric diagnoses,[2] the ADA explicitly includes mental disorders under its protection: "(M)ental impairment mean(s). . . (a)ny mental or psychological disorder, such as. . . emotional or mental illness" (29 CFR 1630.2(h)(2)). While the EEOC does not rely on a specific diagnostic framework to identify such impairments, many experts contend that as a practical matter, a DSM-111-R (the Diagnostic and Statistical Manual, 3d edition, revised) diagnosis will be necessary, if not sufficient, to meet the ADA definition. Beyond the problems involved in diagnosis, mental disorders present problems related to relapsing and remitting symptoms and impairing side-effects of medications. EEOC staff, in review of an earlier draft of this report, indicated to OTA that the upcoming compliance manual will state that episod-

[2] Excluded disorders include transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, other sexual behavior disorders, compulsive gambling, kleptomania, pyromania, or psychoactive substance use disorders resulting from current illegal use of drugs.

ic disorders may be ADA disabilities and that side-effects of medications may also be substantially limiting.

Having an impairment does not equal having a disability. Under the ADA, disability is an impairment that "substantially limit(s) one or more of the major life activities." Of the major life activities listed by the EEOC-caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working—working is the only one that really applies to people with psychiatric disabilities, according to some commentators on the ADA. Thus, people with psychiatric disabilities may find themselves in a Catch-22 situation, having to prove that they are substantially limited in working, and yet are qualified for the job-both requirements of the ADA. Others, including the EEOC, note that the list of major life activities provided by the EEOC was not meant to be exhaustive and that mental disorders can limit many of the life activities listed. Importantly, assessment of functioning in mental disorders is not an easy or validated technique (box l-l). Additional guidance from the EEOC and others on how mental disorders may limit now specified and other major life activities would help clarify this issue, as would research into functional assessment.

The above discussion begs the question: What activities do mental disorders commonly limit? A variety of sources point to three major areas of functional limitations related to mental disorders and especially relevant to work: problems in social functioning, difficulty concentrating long enough to complete tasks, and problems coping with day-to-day stress.

This OTA report unveiled substantial disagreement among mental health experts as to the relationship between mental disorders and employment outcome. Some say nearly no correlation exists. Others point to data that show a significant correlation between psychopathology, treatment status, and work performance. Such disparate conclusions point out that existing data are obviously incomplete. Studies have used different measures of psychiatric symptomatology, work performance, and vocational outcome. Furthermore, treatment status and individual ability are almost always ignored, as are traditional labor predictors, the type or amount of vocational services that an individual may have received, job history, changes in demand for labor, and demoralization caused by stigma and discrimination. Resolution of how impairment, functional limitation, and work disability relate to one another awaits further research.

Nonetheless, some conclusions can be drawn about people with mental disorders and work: Research data support a link between symptoms and work performance. Furthermore, data indicate that treatment may significantly improve work functioning and outcome. Thus, even though treatment may not be mandated by the ADA (see later discussion), access to effective treatment will be paramount for some individuals with mental disorder-based disabilities to maintain employment.

The precise relationships among impairments, functional limitations, and work are obscure and complex. Diagnoses do not predict rehabilitation and employment outcomes except in the broadest terms, and there are wide variations in outcomes within diagnostic groups. Moreover, research data support the contention of many working in this field that treatment itself can sometimes result in other functional impairments. One thing that is clear is that prior work performance remains the best predictor of future work performance.

People with psychiatric disabilities are by no means a homogeneous population. Distinct subgroups exist—ranging from people with the most severe mental disorders and others with less severe conditions—whose members can probably expect different things from the ADA.

People with the most severe mental disorders, clearly covered by the ADA's definition of disability, are unlikely to achieve competitive employment by virtue of the ADA alone. They will require a broad range of educational, psychosocial, and vocational services to prepare them to find and keep jobs; to make them "qualified people with disabilities" as required by the ADA.

BOX 1–1: Assessing Psychiatric Disability

Models of disability and data from research show that identifying a particular diagnosis or symptom is insufficient to determine the severity of disability, required services, or work limitations, In order to qualify for the ADA's protections a person must bean individual with an impairment that "substantially limit(s) one or more of the major life activities. " EEOC investigators, employers, people with mental disorders, and mental health care providers face the challenge of determining who with a mental disorder has a psychiatric disability under the law.

The Status of Functional Assessment

Questionnaires, interviewing techniques, and observational approaches have been developed to assess disability, and disability assessment has become a standard part of vocational and psychosocial rehabilitation services. The goals of assessment maybe very general, aimed at measuring social skills, the ability to maneuver every-day requirements, and work performance; or very specific, aimed at specific disorders and functions. Recent analyses have documented shortcomings of these disability assessment methods, Following a comprehensive review, one researcher concluded that no one instrument was wholly adequate for assessing functional impairments. Recently this same scholar noted that:

> [B]etter methods of assessment would improve both the interpretation of future evaluations and current clinical practice. Most evaluations use relatively idiosyncratic methods of measuring role functioning. What is needed is an easily administered, low-cost assessment tool that not only measures individuals' impairments and role functioning, but provides information that is directly relevant to treatment decisions,

Similarly, expert reviewers of social functioning measures concluded that modest reliability and the lack of evaluation limit the usefulness of available assessment tools, Furthermore, they concluded, none is simple enough for routine clinical use. These conclusions are in the National Institute of Mental Health's plan for services research, which states that:

> Although [disability]. . . assessment seems logical and straightforward enough, the truth is that the mental health field is still without an adequate arsenal of instruments and techniques to fully accomplish the task. . . No aspect of clinical services-or of research designed to improve such services-can prosper without the availability of meaningful and valid techniques for assessing the status of mentally ill patients, not only in purely clinical terms but also in terms of their everyday functioning in the real world and their strength on which rehabilitation can build. Needed are. . ways to assess general health status and physical functioning, the quality of the patient's life, the nature of the family's burden, and the patient's rehabilitation potential and progress.

Disability Assessment at the Social Security Administration

The experience of the Social Security Administration (SSA) illuminates the pitfalls of implementing disability assessment. SSA administers two disability income maintenance programs: the Social Security Disability Insurance (SSDI) program and Supplemental Security Income (SSI) program. Eligibility for these programs hinges on the inability to work. The methods used by SSA to assess severe psychiatric disability in the 1980s was said to be difficult to use, too subjective, out of date, and discriminatory, "The essential problem is that it is not possible to construct a set of medical and vocational standards that will distinguish perfectly between those who are able to work and those who are not able to work." The public outcry that resulted from a disproportionate number of people with severe mental disorders being terminated from the programs led Congress to order a revision of SSA's psychiatric disability assessment methods. The new method includes the consideration of diagnosis as well as limitations in four areas of functioning: activities of daily living; social relations; cognitive functioning such as concentration, persistence, and pace; and decompensation or deterioration in work. Consideration of environmental interventions was also provided as an option in the assessment.

BOX 1–1: Assessing Psychiatric Disability (cont'd.)

SSA's current disability determination is not without its critics: An American Psychiatric Association study of the new guidelines indicates that additional changes may improve the disability determination; the use of this assessment method by psychiatrists and other care providers also warrants improvement; some have criticized the increasing number of people with psychiatric disabilities who now receive SSI or SSDI,

It should be noted that the SSA's disability determination procedure is not appropriate for the ADA, The elaborate hurdle that people with disabilities must vault to receive SSA program benefits would limit unduly the ADA-guaranteed protections against discrimination. In addition, the definition of disability under the ADA obviously is not limited to individuals who cannot work at all.

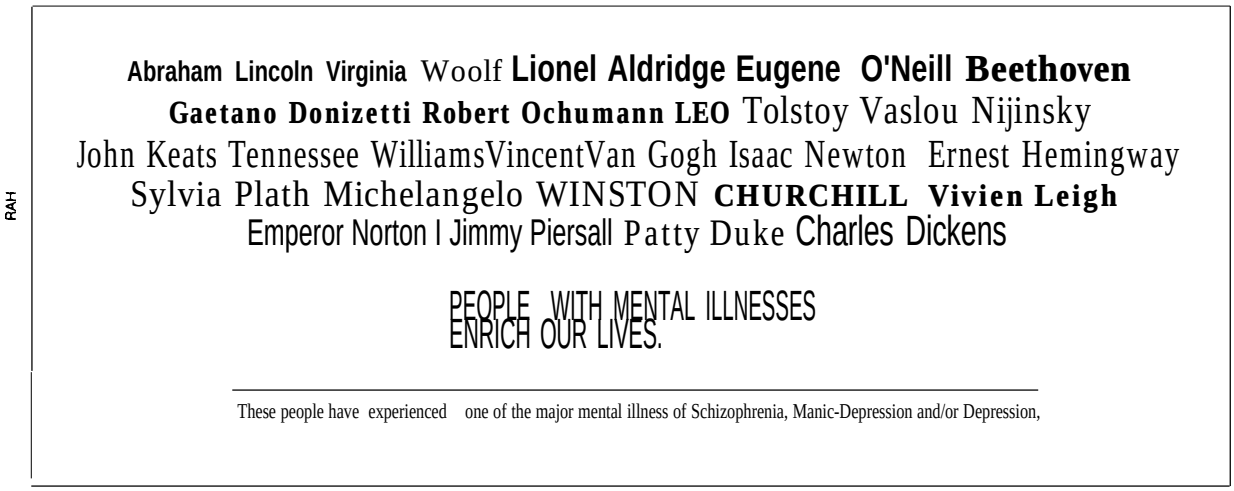
Functional Assessment and the ADA

The ADA defines disability in terms of impairment and functional limitations. In general, an applicant or employee discloses the presence of a disability to an employer or covered entity, often providing very limited information. The employer may require confirmation of a disability that is not readily apparent, such as a psychiatric disability. Also, the EEOC must make a determination as to whether an individual is considered disabled under the ADA in the event that a charge of discrimination is filed. To date, in its computerized charge data system, the EEOC simply lists the marginally informative term "mental illness" as the impairment relevant to psychiatric disability, [1]The EEOC will be implementing a new coding system for disabilities in fiscal year 1994 and it will include a category for "emotional/psychiatric impairment, " under which there will be separate entries for anxiety disorder, depression, manic-depressive disorder, schizophrenia, and other emotional/psychiatric condition where none of the above clearly apply. What doesn't exist are guidelines for determining who with a mental disorder has an impairment that substantially limits a major life activi - ty—is disabled under the ADA's definition. Convening a group of experts and interested parties to help fashion guidance for EEOC investigators and others, concerning diagnoses and other assessment criteria relevant to the ADA and employment would be useful. Continued research and the development of functional assessment tools also represent critical needs.

[1] Mental retardation IS appropriately Iisted separately from mental Illness

SOURCES C Koyanagi and H Goldman, *Inching Forward A Report on Progress Made in Federal Mental Health Policy in the 1980s* (National Mental Health Association, 1991), U.S. Department of Health and Human Services, *Toward a National P/an for the Chronically Menfa//y ///* (Public Health Service, Washington, DC, 1980), H A Pincus, C Kennedy, and S J Simmens, American Psychiatric Association, Washington, DC, "Study of SSA Methods and Standards for Evaluating Dlsability Based on Mental Impairment, " final report to Social Security Administration (SSA-600-84-01 74), November 1987; H A Pincus, C Kennedy, S J Simmens, et al , "Determlnlng Dlsability Due to Mental Impairment, APA's Evaluation of Social Security Administration Guidelines, *"American Journal of Psychiatry* 1481037-1043, 1991, H.H Goldman, A.E, Skodol, and T R Lave, "Revising Axls V for DSM-IV A Review of Measures of Social *Functlonlng, "American Journal of Psychiatry* 1491148-1156, 1992, C J Wallace, 'Functional Assessment in Rehabilitatiion," *Schizophrenla Bulletin 12604-630, 1987*

Some mental health experts and advocates have suggested that the ADA's impact will be most strongly felt by people with less severe mental disorders, who are already working in a competitive setting. Diagnosable mental disorders and symptoms are common among working-age adults. However, much less is known about the functional limitations of the population with less severe mental disorders, their employment characteristics, accommodation needs, or even who among this group would be covered under the first prong of the ADA's definition of disability, which refers to individuals with serious or nontrivial disabilities. While courts have been expansive in defining mental impairment per se under the Rehabilitation Act, substantially limiting psychiatric impair-



As indicated in this poster from the National Alliance for the Mentally Ill, mental health advocates emphasize the talent and productivity of people with psychiatric disabilities.

ments have sometimes been defined more restrictively. Unless questions are answered concerning these less severe conditions—Which ones are covered? How can such determinations be made?—the ADA is open to excessive subjectivity in claims of psychiatric disability.

DISCLOSING A PSYCHIATRIC DISABILITY TO AN EMPLOYER

Before an employer provides an accommodation, indeed before the ADA requires that one be provided, an applicant or employee must disclose his or her need. The obvious gateway to disclosure is employee awareness: A person with a disability must know about the ADA's protections before tapping into them. However, a 1993 Harris poll shows that less than 30 percent of people with any disabilities had ever heard or read about the law.

Ignorance of the ADA's provisions is only the first hurdle to disclosure. A person with a psychiatric disability faces what may be a wrenching decision about divulging his or her mental disorder to a current or would-be employer. Lack of awareness that a mental disorder exists or unwillingness to label oneself disabled prevents such self disclosure. Another obstacle to disclosure is the fear that disclosing a condition invites the stigma attached to mental disorders. While attitudes toward mental disorders may be improving, research data continue to show that ignorance and negative attitudes are attached to these conditions. By disclosing a psychiatric disability, an individual risks discrimination, teasing or harassment, isolation, stigmatizing assumptions about his or her ability, and the labeling of all behavior and emotions as pathological. The most pernicious aspect of stigma maybe the way in which it undermines an individual's self-esteem and social interactions.

Disclosure may gamer benefits for the individual with a disability, however. In addition to invoking the protection of the ADA, in the right circumstances, openly admitting a mental disorder may enhance self-esteem, diminish shame, permit supervisors and coworkers to offer support, and even lengthen job tenure.

After making a decision to disclose a mental disorder, a person also must consider what to disclose, to whom, and when. Legally, an employee need disclose only enough information about his or her disability-related work limitations to support the need for accommodation. There is no legal requirement to disclose prior to the need for an accommodation. However, problems may arise if disclosure occurs only when performance problems have been raised or acted upon by the employer. Little guidance is available to assist people with psychiatric disabilities and their employers

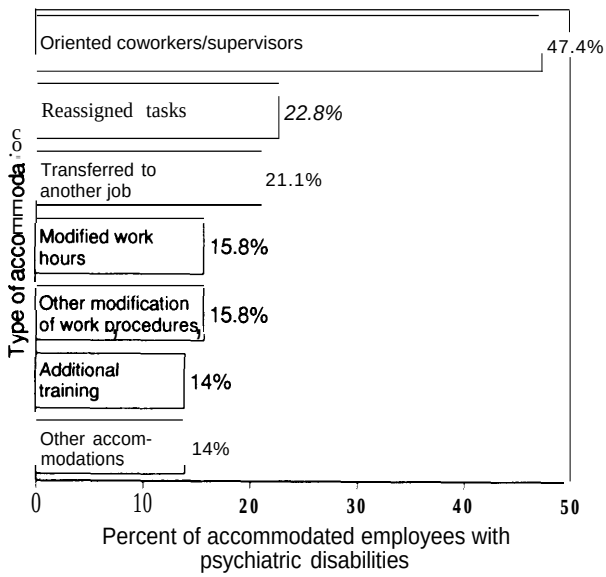
during the disclosure process. With the passage of time and the gaining of experience, the researchers, the EEOC, and other organizations may be able to delineate the methods of disclosure that work well, determine the factors that led to their success, and disseminate this information to employers and people with psychiatric disabilities.

ACCOMMODATING QUALIFIED EMPLOYEES WITH DISABILITIES

Title I of the ADA requires employers to provide reasonable accommodations to qualified individuals with disabilities, unless these accommodations pose an undue hardship. As the linchpin of the ADA's antidiscrimination requirement, the identification of effective accommodations for people with psychiatric disabilities becomes critical. Because 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. Some changes to the physical environment, such as a private office or secluded work space, may be useful to those with psychiatric disabilities along with other measures, such as restructuring job tasks or schedules. OTA found that several mental health experts and consumer groups have compiled lists of accommodations. In addition, at least one study surveyed businesses as to the accommodations provided to employees with disabilities under the Rehabilitation Act (figure 1-2). Many of the identified accommodations address the functional limitations commonly associated with psychiatric disabilities: difficulties in concentrating, dealing with stress, and in managing interpersonal interactions (e.g., table 1-2).

Lists of commonly desired or used accommodations, while informative, do not supplant the need for case-by-case assessment. Work places and jobs vary, as do people with psychiatric disabilities, who have a broad range of talents, abilities, and functional limitations. Furthermore, more information and guidance are needed about the cognitive, behavioral, and social requirements of jobs. Also, questions about applicability, effectiveness, preference, cost, and impact on the work place of various accommodations are largely unaddressed.

FIGURE 1–2: 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 Findmgs (Washington, DC U S Department of Labor, 1982)

Commonly suggested accommodations include those that address treatment needs, such as leave for short-term hospitalization. The need for occasional medical leave raises some difficult issues for employers. Based on experience under the Rehabilitation Act, an employer's duty of reasonable accommodation will almost certainly include the duty to tolerate additional, unpaid absences. However, regular and predictable attendance is commonly viewed as a minimum standard of performance. Differentiating between additional absences as a reasonable accommodation and absences as a performance problem will prove challenging to many employers.

While the EEOC does not require employers to provide treatment to employees as a reasonable

TABLE 1–2: 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
- @@rig-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 supervisor 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/employee assistance programs avaliable for all employees
- Allowing telephone calls during work hours to friends or others for needed support
- Providing substance-abuse recovery support group 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 a 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 preexisting 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 foraging 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 feellngs and to develop strategies to deal 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 reflect 'reasonable accommodations' as defined by the ADA.

SOURCE: Presidents Committee on Employment of People With Disabilities, 1993

accommodation, other complicated, controversial, and often unanswered questions concerning treatment are sure to arise. Can employees be required to take medication to maintain their jobs? Can employers monitor medications as a reasonable accommodation for employees? Full discussion of these issues—by mental health and legal experts, employers, and people with psychiatric disabilities—is clearly needed.

Accommodating aberrant or unusual behavior, which is sometimes associated with mental disorders, also raises some difficult issues for employers. Most lists of accommodations prepared by advocates and mental health experts recognize that increased tolerance of unusual behavior is desirable. It is noteworthy that the EEOC's guidance on undue hardship goes beyond dollars: "Undue hardship" refers to any accommodation that would be unduly costly, extensive, substantial, or disruptive . . ." However, the EEOC provides no specific guidance on disruptive behavior. Case law under the Rehabilitation Act generally limits the employer's responsibility to accommodate disruptive behavior. While work place training may sensitize supervisors and coworkers to some of these issues, and decrease the stigma against mental disorder, EEOC staff, in comments on an earlier draft of this report, indicated to OTA that it is undecided as to whether coworker training could be a reasonable accommodation. Furthermore, effective work place training, whether required or voluntarily instituted by the employer, is likely to require more than the distribution of pamphlets; a clear work place policy and thoughtful and evaluated educational activities will be vital.

THE ADA'S DIRECT THREAT STANDARD AND PSYCHIATRIC DISABILITY

Under the ADA, employers may include as aqualification standard "a requirement that an individual shall not pose a direct threat in the work place." The EEOC regulations and guidelines procedurally narrowed the definition of direct threat to include only significant risk of substantial and imminent harm, individually and expertly assessed, which cannot bee] eliminated or reduced by reasonable accommodation.

Clearly, employers and coworkers have legitimate concerns about their safety at the workplace. Still, the ADA's reference to direct threat touches a raw nerve among people with psychiatric disabilities, their families, and other advocates. If any one stereotype of mental illness is most prevalent and damaging, it is that of the homicidal maniac. To counter this stereotype, anti-stigma campaigns typically assert that people with mental disorders are no more violent than the average person. However, a variety of data show a link, albeit a modest one, between mental disorders and violent behavior. In particular, data suggest that a small subset of mental disorders—psychotic disorders, indeed specific aspects of psychosis, when a person feels personally threatened or the intrusion of thoughts that can override self-control—are linked to violence. Many studies show, however, that substance abuse and a history of violent behavior are more tightly correlated to violence in people whether or not there is evidence of psychiatric disability.

On the basis of relevant case law and concerns about employer liability, the EEOC broadened the direct threat provision to include not only a threat to others, but also to one's self. For example, an employee with narcolepsy could be at risk of harming him or herself if he or she fell asleep while operating apiece of heavy machinery. Many disability rights advocates decried this interpretation, however, claiming that it went well beyond the law's language and intent. Neither the ADA nor the U.S. Department of Justice Title II regulations mention direct threat to self. Experts and advocates on both sides concede that the issue likely will be decided by the courts.

HEALTH INSURANCE FOR PEOPLE WITH PSYCHIATRIC DISABILITIES

The ADA prohibits discrimination against a qualified individual with a disability in regard to the privileges of employment. Among the most valued privileges of employment is health insurance. Health insurance is also among the most impor-

tant issues for people with psychiatric disabilities, as limits are commonly placed on mental health benefits. Employer concerns, however, center around cost. The language of the law, its legislative history, and related regulations and guidelines indicate that the writers of the ADA did not intend a complete revision of insurance industry policy and practice. Thus, while 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 mandate access to mental health benefits.

A key question considered by the EEOC in determining the ADA's influence on mental health benefits 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 a resounding "no" for mental health benefits in general.

> *[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.*

RELEVANT FEDERAL AGENCIES' ACTIVITIES

The ADA requires a variety of Federal activities, including the preparation of implementing regulations and guidelines; the enforcement of the law; the rendering of assistance to those with rights and responsibilities under the law; and the coordination of enforcement and technical assistance among different agencies. Beyond the mandates specified by the ADA itself, the U.S. Congress has required Federal research and service agencies to provide technical assistance and conform services with the ADA's mission. Furthermore, the Federal Government is a principal supporter of disability-related research. OTA surveyed the current efforts of various Federal agencies: the EEOC; the National Institute on Disability and Rehabilitation Research (NIDRR); the Center for Mental Health Services (CMHS); the National Institute of Mental Health (NIMH); and the President's Committee for the Employment of People with Disabilities (President's Committee).

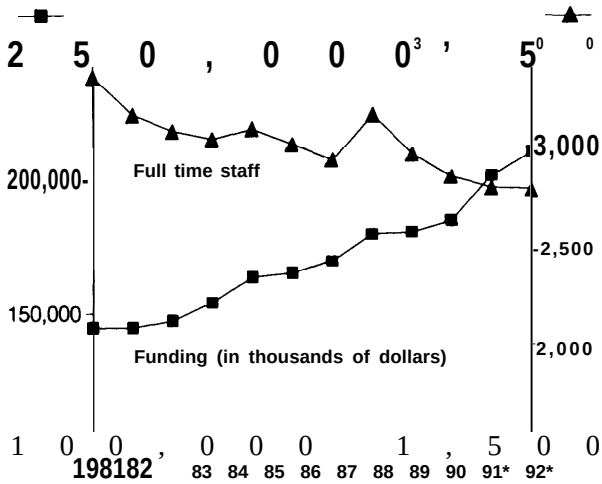
Established by law in 1964, the EEOC enforces Title I of the ADA, as well as Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, section 501 of the Rehabilitation Act, and the equal pay provisions of the Fair Labor Standards Act. Although the EEOC issued ADA regulations as required by the law and provided extensive technical assistance, the regulations, guidance, and technical assistance promulgated by the EEOC provide minimal guidance on many issues specifically relevant to psychiatric disabilities. In fact, OTA's survey of EEOC field offices, where charges of discrimination are received and investigated, found that most personnel lacked any specific training on psychiatric disabilities and employment; indeed they wanted such information. The EEOC traditionally does not focus on any one type of disability. But given the complexity of psychiatric disabilities, the issues sometimes raised in the work place, ignorance of these conditions among the general public, and the relatively high percentage of charges associated with this category of impairment, it appears that specific focus on psychiatric disabilities would be quite useful: People with psychiatric disabilities and employers would better understand their rights and responsibilities under the law. Constraints on resources, especially on trained personnel, however, limit the capacity of

the EEOC to increase guidance and technical assistance for psychiatric disabilities (figure 1-3).

Technical assistance by other Federal agencies—NIDRR, CMHS, the President's Committee, and NIMH—includes distributing brochures, posters, and manuals; sponsoring conferences and training; setting up toll-free help lines and computer bulletin boards; and making public and video presentations. The targets for these efforts are businesses and people with psychiatric disabilities. Although the EEOC's technical assistance efforts have not focused on psychiatric disabilities, the other agencies' efforts have. However, by most estimations, the impact of this technical assistance and education seems inadequate, since data from various surveys reveal considerable ignorance about the ADA and psychiatric disabilities.

OTA's analysis found the Federal Government psychiatric disability research enterprise to be sparse and splintered. The principal supporters of research relevant to psychiatric disabilities and employment include NIDRR, CMHS, and NIMH, who together spend approximately 1.3 percent of their total annual budgets on this topic, less than $15 million (table 1-3). As with disability research in general, psychiatric disability is not a priority with any Federal agency, and mechanisms for interagency communication and cooperation lie moribund (box 1-2).

FIGURE 1-3: EEOC Funding and Staff: Fiscal Years 1981 to 1992



Although total funding to the U.S. Equal Employment Opportunity Commission experienced a real, average annual rate of increase of 8.3°/0 since 1981, full time staff positions declined by approximately 17%.

● includes supplemental for ADA.

SOURCE U S Equal Employment Opportunity Commission, 1993

IMPLICATIONS FOR TECHNICAL ASSISTANCE AND RESEARCH

Despite increasing attention on the part of Federal agencies, OTA's analysis indicates that the current level of guidance, technical assistance, and research activities are unlikely to optimally assist employers and people with psychiatric disabilities in implementing the ADA. The need for gathering and distributing information reflects several factors: Psychiatric disabilities are still poorly understood and greatly stigmatized in our society. These conditions can be complex; they can be difficult to assess in an objective fashion, and, with their impact on behavior and social interactions, they sometimes raise difficult issues for employers. Limited Federal resources and the low priority historically assigned to the topic of employment and mental disorders also have constrained research and technical assistance efforts. From the information drawn together in this report, OTA suggests a technical assistance and research agenda.

People with psychiatric disabilities and employers are the ultimate targets of guidance, technical assistance, and education. How can these audiences be reached? Organizations already providing technical assistance to businesses and people with disabilities—including the EEOC, NIDRR (box 1-3), and the National Council on Disabilities---can better incorporate information on psychiatric disabilities. OTA's research highlights several other specific targets:

ŽMental health advocacy organizations: All mental health advocacy organizations, assert the importance of employment or meaningful activity for people with psychiatric disabilities. Expand-

TABLE 1-3: Key Federal Supporters of Psychiatric Disability Research

institute	Principal mission	Funding mechanisms	Total funds specifically related to psychiatric disability and employment (in millions)	Percent of total budget
National Institute on Disability and Rehabilitation Research	Supports research and technical assistance for all disabilities	Supports training and research centers; field-initiated research projects; and a technical assistance resource center	$3.5[a]	5.6 percent
Center for Mental Health Services	Administers block grants to States for mental health services and supports research	Supports training and research center; demonstration projects; consumer self-help centers	$1.5[a]	0.36 percent
National institute of Mental Health	Supports mental disorders research	Funds investigator-initiated studies and research centers	$9.3[b]	1.5 percent

[a]Fiscal year 1993.
[b]Fiscal year 1992.

SOURCE: Office of Technology Assessment, 1994.

ing on current ties with consumer groups, the Community Support Program funded by the CMHS, the two Rehabilitation Research and Training Centers supported jointly by NIDRR and the CMHS, the two national consumer self-help centers funded by the CMHS, and the DEPRESSION Awareness, Recognition, and Treatment (D/ART) program funded by NIMH could provide information on the ADA in the form of materials and training sessions.

• *Employee assistance programs (EAPs) and other human resources professionals;* Many mid- and large-sized companies have EAPs and/or other human resource offices, whose responsibilities include health education, the provision of or referral for counseling services, disability management, and ADA implementation. These managers and service providers clearly need and are prime targets for information on psychiatric disabilities. NIDRR, with its grant to the Washington Business Group on Health, and NIMH's D/ART program have already begun targeting these groups. Continued and expanded efforts could build on this foundation.

■ *Private– and state -affiliated care providers;* Mental health care providers and advocates, in the private sector and State mental health and protection and advocacy agencies interact with individuals with psychiatric disabilities and they are a potentially useful conduit for information about the ADA. OTA's research reveals a considerable lack of knowledge about the ADA among these care providers and advocates. Federal mental health agencies could develop professional training materials and disseminate them at national and regional meetings sponsored by the Federal Government and professional societies. Also, materials and information could be disseminated in cooperation with State mental health and protection and advocacy agencies through the granting mechanism of the CMHS.

OTA identified another critical target requiring information on psychiatric disabilities: the EEOC field offices. Many lack any information on psychiatric disabilities. Federal mental health agencies, especially the CMHS, could assist the EEOC by providing baseline information and by linking field offices with resources in State and communi-

BOX 1–2: Interagency (Non)Communication About Psychiatric Disability and Employment

Effecting communication among agencies that share responsibilities and interests is a common bureaucratic dilemma. Several Federal agencies, as described in this chapter and report, have authority over research, technical assistance, program administration, and policy enforcement relevant to psychiatric disability and employment. Despite jurisdictional overlap, each agency has a unique culture and functional role. Many observers believe that this heterogeneity is healthy, permitting distinct and potentially useful approaches to flourish. However, redundant or conflicting Federal policies and activities may also flourish in the absence of meaningful communication. While individuals in different agencies informally interact, formal mechanisms of interagency communication lie moribund.

Public Law 102-321 created a new Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Public Health Service, Department of Health and Human Services (DHHS), thus separating this mental health service agency from the principal mental health research agency—the National Institute of Mental Health (NIMH). That law requires cooperation and consultation between the CMHS and the NIMH in a variety of areas. Such communication clearly could help the CMHS move forward with demonstration projects, technical assistance, and services solidly based on research supported by NIMH. Also, NIMH's research expertise could assist in program evaluation at the CMHS Conversely, the CMHS could assist NIMH in promoting research relevant to current practices, policy needs, and real world demands. While NIMH and CMHS indicate that they are working together on a report to the U.S. Congress on effective methods of providing mental health services to individuals in correctional facilities, to date, no general mechanism has been elaborated to animate the congressional mandate for Information exchange between the CMHS and NIMH.

The U.S. Congress established the Interagency Committee on Disability Research to promote communication and funding coordination among the committee's 27 member agencies, which include. the National Institutes of Health (including NIMH), SAMHSA (including CMHS), the National Science Foundation, and offices in the U.S. Departments of Health and Human Services, Education, Labor, and Veterans Affairs, and the National Aeronautics and Space Administration. In existence since 1981, the committee has not met at all during the last year and has never focused directly on psychiatric disability.

(continued)

ty mental health centers and advocacy groups. These local resources could then provide seminars for the field offices in their communities, and perhaps more importantly, form a network of local experts to which EEOC investigators could turn when specific cases arise.

Several topics identified by this OTA report require further guidance from the EEOC as well as experts, representatives of businesses, and people with psychiatric disabilities:

- the impact of and mechanisms for disclosing a psychiatric disability;
- the identification of behavioral and social requirements on the job;
- accommodating difficult or threatening behavior; and
- issues surrounding access to and potential requirement of psychotropic medication or other treatment.

Workshops focused on such topics would be a useful first step. A fair and full exploration of these specific topics would include the perspective and expertise of legal experts and the EEOC, experts in psychiatric disabilities, people with psychiatric disabilities, and employers. The workshop discussions could inform ongoing technical assistance activities as well as official EEOC guidance and research.

BOX 1–2: Interagency (Non)Communication About Psychiatric Disability and Employment (cont'd.)

In April of 1993, the CMHS replaced the NIMH as a cosigner with the Rehabilitation Services Administration (RSA) and NIDRR on a renewed Memorandum of Understanding (MOU). In effect since 1979, the MOU sets out guidelines for interagency collaboration on service delivery, staff training, and evaluation activities related to the rehabilitation and employment of people with psychiatric disabilities, Representatives from each agency serve as members of a liaison group responsible for informing each other about their agency's activities, exploring possible cooperative efforts, recommending cooperative activities to the chief executives of their agency, and developing and implementing a work plan to carry out approved cooperative activities. The MOU specifically mentions as one of its goals the "provision of technical assistance on implementing the Americans with Disabilities Act for persons with psychiatric disabilities, " Also, it helps coordinate the cofunding by CMHS and NIDRR of the National Rehabilitation and Research Centers at Boston University and Thresholds Institute in Chicago, Illinois. While proponents contend that the MOU can and has been an important catalyst for interagency cooperation, several experts and advocates commented to OTA about its current ineffectiveness, And no efforts have focused on the ADA to date,

The National Task Force on Rehabilitation and Employment for People with Psychiatric Disabilities (NTREPPD) has tried to promote collaboration among RSA, NIDRR, NIMH, CMHS, and the Social Security Administration. NTREPPD is composed of representatives of professional organizations, service providers, consumers, family members, research and training organizations, advocacy groups, Federal, State, and local government agencies, and others, Its central function is to advise the RSA and NIDRR on policy and research priorities related to rehabilitation and employment issues for people with psychiatric disabilities, The group originated as the RSA Task Force on Vocational Rehabilitation for Persons with Long-Term Mental Illness. In 1991, it became an independent entity and was chartered as NTREPPD. The members of NTREPPD had been meeting quarterly in Washington, DC to share information and develop recommendations about legislation and regulations, research priorities, training and service delivery issues; many observers considered the group vital. More recently, however, many members have desisted meeting attendance, complaining about NTREPPD's voluntary nature and its limited impact on policies,

SOURCE, Office of Technology Assessment, 1994

Finally, this OTA report identifies many research questions (table 1-4). These questions require different types of research approaches, including:

- descriptive research, aimed at ascertaining current issues and practices (e.g., typical approaches to disclosure; the prevalence of violence and mental disorders in the work place);
- evaluation studies, which would assess the effectiveness and costs of interventions or procedures (e.g., the impact of coworker education or disclosure; the net costs of accommodating psychiatric disabilities; the effectiveness of stress reduction techniques in accommodating people with psychiatric disabilities); and
- hypothesis-driven research aimed at clarifying such issues as the confluence of factors involved in the path from impairment to work disability, and validity of functional assessment techniques.

Clearly, this research agenda falls under the jurisdiction of NIDRR, NIMH, and CMHS. Workable communication among agencies is required to avoid overlap, to assist in collaboration, and to ensure that new information flows among the research agencies as well as to those enforcing the law and providing technical assistance.

BOX 1–3: Disability and Business Technical Assistance Centers

The National Institute on Disability and Rehabilitation Research (NIDRR) has funded 10 regional Disability and Business Technical Assistance Centers—DBTACs—since 1992. The 10 DBTACS represent one of the Federal Government's principle sources of ADA technical assistance. They aim at providing employers, people with disabilities, and others with responsibilities under the ADA with information, training, technical assistance, and referrals to local sources of ADA information and expertise. These centers currently are funded with 5-year grants, but NIDRR's aim is to develop a system whereby the regional centers eventually Will be regarded as State and local resources and affiliated with State and local governments. For this reason, the DBTACs are encouraged to establish relationships with State and local agencies throughout their regions.

To help identify needs and coordinate activities, the DBTACs have organized regional, State, and local advisory committees made up of representatives from small and large businesses, State and local service providers, citizens with all types of disabilities and their family members, and disability support and advocacy groups. To reach as many people with an interest in the ADA as possible, the DBTACs are developing mailing lists of people with disabilities, employers, personnel and recruitment agencies, business groups such as chambers of commerce, small business associations, better business bureaus, minority business associations, and others; State and local government agencies; disability advocacy groups; and service providers. The mailing lists are used for direct-mail campaigns to draw attention to the provisions of the ADA and the DBTACs resources, and to generate information for data bases and reference guides on local sources of ADA information and expertise. Each of the DBTACs provides a toll-free technical assistance hot line for information and referrals. Also, the DBTACs provide training sessions, including regional conferences, and State and local workshops, and presentations.

Several DBTACs have focused to some extent on psychiatric disabilities. Their advisory committees and mailing lists include individuals with psychiatric disabilities and advocacy/consumer groups representing this constituency. One DBTAC in Washington State helped to craft language for the 1993 State Civil Rights Act barring discrimination in employment for people with mental disabilities, and helped to develop training about workplace accommodations for people with psychiatric disabilities. Another DBTAC is working cooperatively with IBM to develop a self-paced software program about Title I of the ADA with situational examples that will include accommodating people with psychiatric disabilities in the work place. The Northeast DBTAC in Trenton, New Jersey is developing a televised panel discussion, "Making the ADA Work: Reasonably Accommodating People with Mental Illness, " which features a successful employee with a psychiatric illness, an employment specialist, and an employer. The Southwest DBTAC is working with the Texas Rehabilitation Commission to develop a model training program on the ADA and people with psychiatric disabilities.

Technical assistance hot-line requests concerning psychiatric disabilities generally form only a small percentage of total requests, however. This suggests that employers and the general public do not yet see the ADA as being related to psychiatric disabilities or they do not see the DBTACs as providing such information. The majority of those requests for information are from individuals with psychiatric disabilities or their employers, followed by mental health agencies, therapists, and rehabilitation counselors. People with psychiatric disabilities typically ask how to approach employers about an accommodation, whether it is necessary to document psychiatric disability, how such documentation is used, and the procedure for deciding an appropriate and reasonable accommodation. Employers usually ask whether they can request documentation of a psychiatric disability, what types of accommodation are appropriate, and how to determine the existence of a direct threat.

SOURCE Off Ice of Technology Assessment, 1994

TABLE 1–4: 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? Coworkers?
- 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 specific and net costs-Including possible redistribution of workload 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 makeaccommodations 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?

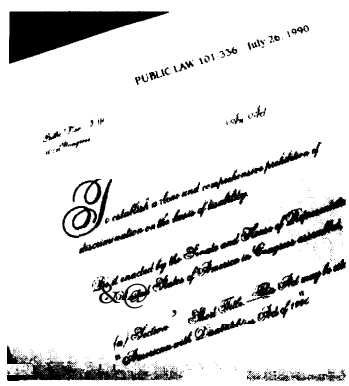
SOURCE: Office of Technology Assessment 1994.

The ADA and People With Disabilities: An Overview

2

The Americans with Disabilities Act (ADA) is a watershed in the history of disability rights. It outlaws discrimination against people with disabilities in nearly every domain of public life: employment, transportation, communication, recreational activities, and other services (table 2-1). The Act's extension of employment provisions to many people with psychiatric disabilities has captured the attention of mental health advocates (24,32,33,35,42,44,47). Jobs are of particular concern to many people with mental disorders: For most people with severe mental disorders employment remains an elusive goal (see ch. 3). Many employees attempt to keep their current or past mental health problems a secret, for fear of stigma and discrimination. Reflecting the misperceptions, fears, and lack of information about mental disorders as well as the difficult issues sometimes raised by these conditions—subjectivity of claims, impact on behavior, and social interactions at work—some employers have expressed concerns about the ADA's provisions for employing people with psychiatric disabilities (27).

This chapter provides an overview of the ADA and some of the factors that led to its passage. First, it summarizes the ADA's provisions, highlighting issues of employment. Second, legal antecedents of the ADA are discussed, illuminating important forebears of the law and their impact on people with psychiatric disabilities. Third, the chapter describes how people with disabilities have influenced disability policy.


PUBLIC LAW 101-336 July 26 1990

THE ADA AND ITS LEGAL ANTECEDENTS

This OTA background paper has proclaimed the ADA "a watershed in the history of disability rights" and "the most far-reach-

TABLE 2–1: Overview of the ADA

	Brief description	Law's enforcement date	Enforcement jurisdiction
TITLE I Employment	Provides that no covered entity shall discriminate against a qualified individual with a disability because of the disability in regard to job application procedures, hiring, advancement, employee compensation, job training, and other privileges of employment.	Effective July 26,1992, for employers with 25 or more employees, and on July 26, 1994, for employers with 15 or more employees. Employers with fewer than 15 workers are not covered by ADA.	U.S. Equal Employment Opportunity Commission
TITLE II Public Services	Provides that no qualified individual with a disability shall be excluded from participation in or be denied the benefits of the services, programs, or activities of public entities, including transportation facilities.	As of Aug. 26, 1990, all new public buses and light and rapid rail vehicles ordered are to be accessible; one car per train must be accessible by July 26, 1995; key commuter stations must be retrofitted by July 26, 1993; all existing Amtrak stations must be retrofitted by July 26,2010.	U.S. Department of Transportation; U.S. Department of Justice
TITLE III Public Accommodations	Provides that people with disabilities should have access to existing private businesses that serve the public, so long as required accommodations are "readily achievable." The list includes hotels, restaurants, theaters, laundromats, museums, zoos, private schools, and offices Of health-care providers.	Effective Jan. 26, 1992, for businesses with more than 25 employers; on July 26, 1992, for businesses with 25 or fewer employees and annual revenue of $1 million or less; and on Jan. 26, 1993, for companies with 10 or fewer employees and annual revenue not exceeding $500,000.	U.S. Department of Justice
TITLE IV Telecommunications	Amends Title II of the Communications Act of 1934 by adding a section providing that the Federal Communications Commisson shall ensure that interstate and intrastate telecommunications relay services are available, to the extent possible, to hearing-impaired and speech-impaired individuals.	By July 26, 1993, covered firms should have telecommunications services available 24 hours a day.	Federal Communications Commission

SOURCE: CQ Researcher, The Disabilities Act(Wa shington, DC: Congressional Quarterly, Inc., 1991).

ing legislation ever enacted against discrimination of people with disabilities." But what exactly is the ADA? What are its specific provisions? Its history? Philosophical roots? This section considers the law and its forerunners. While not exhaustively detailing disability legislation—many other texts do so (e.g., 57)---the section will highlight information that specifically relates to people with psychiatric disabilities.

I Overview of the ADA

The ADA intends sweeping and active antidiscrimination efforts and outcomes. Noting the high and increasing prevalence of disabilities, the lamentable socioeconomic straits of people with these conditions, and the exorbitant costs to society of disabilities, the law sets out:

> *1. to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;*
>
> 2. *to provide clear, strong, consistent enforceable standards addressing discrimination against individuals with disabilities;*
>
> *3. to ensure that the Federal Government plays a central role in enforcing the standards established in this Act on behalf of individuals with disabilities; and*
>
> 4. *to invoke the sweep of congressional authority. . . in order to address the major areas of discrimination faced day-to-day by people with disabilities (42 U.S,C, 12101(b)).*

Drawing from the Rehabilitation Act of 1973, the ADA offers a three-pronged definition of disability:

> *with respect to an individual,*
>
> *(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;*
>
> *(B) a record of such an impairment; or*
>
> *(C) being regarded as having such an impairment (42 U.S.C. 12102(2)).*

While the definition of disability is discussed in detail in the following chapter, a few observations warrant mention here. Although specific conditions are explicitly excluded by the law, including current illegal drug use (box 2-1), the definition is not simply a laundry list of disorders and conditions. Rather, the definition acknowledges the necessity of considering both impairment (e.g., symptoms of a mental disorder; see ch. 3) and functional sequelae. Furthermore, by defining disability in this way, flexibility is maintained, permitting the coverage of disabling conditions that are yet to appear (e.g., a new infectious disease).

The second and third prongs of the definition extend the protection of the law to those who have a history of a substantially limiting impairment or disability, or simply are regarded as such. This language recognizes the discriminatory use of such history or perceptions regardless of an individual's abilities. Because negative attitudes are attached to mental disorders, these prongs of the definition are especially important to them.

Title I of the ADA focuses on employment. It forbids discrimination against qualified people with disabilities in every employment decision, including hiring, advancement, or discharge by employers with 25 or more employees. In July 1994, Title I extends to employers who have 15 or more employees. Key definitions of this section include:

- *Qualified Individual With a Disability.* An employer is not required to hire, promote, or retain any individual with a disability. Rather, the protection of the ADA is afforded to people with disabilities who are qualified for the job. Being qualified for a job often entails relevant training and work experience, factors that may prove problematic for people with psychiatric disabilities that emerged during their education or that disrupted work tenure (see ch. 3). The law defines "qualified individual with a disability" as "an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such person holds or desires." Embedded in this definition are two key terms: 1) '*essential functions of the employ-

BOX 2–1: Substance Abuse, Psychiatric Disabilities, and the ADA

The ADA extends its reach to people with many different types of disabilities. While people with alcoholism and a history of illegal drug use maybe protected by the ADA, the act evidences congressional concern about current illegal drug use. Nearly 25 percent of Title I is devoted to the topic of drugs and alcohol, with the final Title of the act reinforcing much of the discussion. To quote the law itself (42 U. SC. 121 14):

[T]he term "qualified individual with a disability" shall not include any employee or applicant who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use...

[furthermore] A covered entity.

(1) may prohibit the illegal use of drugs and the use of alcohol at the workplace by all *employees;*

(2) *may require that employees shall not be under the influence of alcohol or be engaging in the illegal use of drugs at the workplace,*

(3) *may require that employees behave in conformance with the requirements established under the Drug-Free Workplace Act of 1988,*

(4) may *hold an employee who engages in the illegal use of drugs or who is an alcoholic to the same qualification standards for employment or job performance and behavior that such entity holds other employees, even if any unsatisfactory performance or behavior is related to the drug use or alcoholism of such employee; and*

(5) may, *with respect to Federal regulations regarding alcohol and the illegal use of drugs, require that employees comply with (various) standards established in such regulations of the Department of De fense,.. . Nuclear Regulatory Commission,.. . (and the) Department of Transportation..*

Nothing in this title shall be construed to encourage, prohibit, or authorize the conducting of drug testing for the illegal use of drugs by job applicants or employees or making employment decisions based on such test results.

Thus, Title I of the ADA protects people substantially limited by alcoholism to the same extent that it protects persons with other disabilities Additionally, a person who illegally used drugs in the past may be an individual with a disability under the law. However, regardless of performance, current illegal drug users find no haven in the ADA's protections; they are neither "qualified" nor "disabled" under the law. And use of alcohol or other drugs on the job can be restricted by employers.

The ADA's extensive discussion of substance abuse and the exclusion of current illegal drug users reflects the difficulty of rectifying distinct conceptualizations of drug abuse in making public policy. This difficulty in deciding whether drug abuse is a criminal justice problem, a medical or public health problem, or social issue is nothing new. For example, although the original Rehabilitation Act regulations defined illegal drug abuse as a protected disability, the issue met with considerable controversy. The 1978 Amendments to the Rehabilitation Act qualified the original regulations, protecting current drug and alcohol users only in the absence of poor work performance or threat to the property or safety of others. (The Rehabilitation Act Amendments of 1992 adopted the ADA's approach to coverage of current illegal users of drugs.)

The ADA reveals Congress' hope that employers will give drug abusers opportunities for rehabilitation. The law seeks to prevent the punishment of those who sought treatment in the pastor are continuing to receive treatment, and no longer use drugs. The ADA states that it should not be construed:

to exclude as a qualified individual with a *disability an individual who: 1) has success fully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use, 2) is participating in a supervised rehabilitation program and is no longer engaging in such use, or 3) is erroneously regarded as engaging in such use, but is not.*

BOX 2–1: Substance Abuse, Psychiatric Disabilities, and the ADA (cont'd.)

Unfortunately, this language raises questions even as it attempts to answer them. For example, how long must an iindividual not take a drug to be considered successfully rehabilitated?

OTA has found no discussion of the impact of the ADA's substance abuse provisions on people with psychiatric disabilities Data clearly have demonstrated that people with mental disorders often abuse alcohol and drugs For example, information from a national survey indicated that nearly one-third of those with a diagnosable mental disorder will abuse alcohol or illegal drugs at some time in their lives, More severe diagnoses are associated with higher comorbidity Nearly half of those with schizophrenia will abuse or be dependent on alcohol or other drugs, and over 60 percent of people with manic depression will abuse or become dependent on alcohol, other drugs, or both

The fact that the ADA protects people with mental disorders but excludes those currently abusing illegal drugs also may raise difficulties Analysts with the EEOC hold that distinctions between psychiatric disabilities and substance abuse can be dealt with in a fairly clean fashion

> If an individual IS an alcoholic, then she could be protected under the ADA both for the psychiatric disability and the alcoholism If the individual IS a current illegal user of drugs, then she could be covered by the ADA for the psychiatric disability but not for the current Illegal drug use.. In other words, if an employer refused a reasonable accommodation for the psychiatric disability, the individual has grounds to file an ADA charge.

Gwen the high comorbidity between mental disorders and substance abuse, employer actions—permitted by the ADA—to restrict the use of alcohol or drugs may disparately affect people with psychiatric disabilities Many people with psychiatric disabilities may refrain from seeking the protection of the ADA for fear of revealing a drug abuse problem. Another concern emerges from drug testing in the workplace. Tests for Illegal drugs can register a false positive when an individual is taking some medications for mental disorders (as well as other conditions, such as epilepsy), At best, applicants or employees will be put in the position of disclosing their disability, perhaps against their desire,

SOURCES P R Mastroianni, Assistant Legal Counsel, U S Equal Employment Opportunity Commission, Washington, DC, personal commumcation, Oct. 14, 1993, R K Scotch, *from Good Will to Civil Rights Transforming Federal Disability Policy* (Philadelphia, PA Temple Unversity Press, 1984), R J Henderson, Jr , "Addiction As A Disability The Protection of Alcoholics and Drug Addicts Under the Americans with Disabilities Act of 1990" *Vanderbilt Law Review* 44 *713-740,* 1991; N L Jones, "TheAlcohol and Drug Provisions of the ADA Implications for Employers and Employ ees, " *Consulting Psychology Journal Practice and Research* 4537-45, 1993; L K Haggard, "Reasonable Accommodation of Individuals with Mental Disabilities and Psychoactive Substance Use Disorders Under Title I of the Americans with Disabilities Act, " *Journal of Urban Contemporary Law* 43:343-390, *1993;* W.F Banta, and F Tennant, Jr, *Complete Handbook for Combating Substance Abuse in the Workplace, Medical Facts, Legal Issues, and Practical Solutions, 1989,* U S Congress, Office of Technology Assessment, *TheBlo/ogyofMenta/Disorders, OTA-BA-538* (Washington, DC U S Government Printing Off Ice, September 1992)

ment position," and 2) "reasonable accommodation."

- *Essential Functions of the Employment Position.* The term "essential functions" can be taken at its face value: essential functions of a job are those functions that are not marginal. Employers are vested with considerable, though not unassailable, power by the ADA in determining essential functions of the job. The Act itself says "consideration shall be given to the employer's judgment as to what functions of a job are essential, and if an employer has prepared a written description before advertising or interviewing applicants for the job, this description shall be considered evidence of the essential functions of the job."
- *Reasonable Accommodation.* Providing a reasonable accommodation is the action required of employers by Title I of the ADA. Appropriate accommodation must be determined on an individual basis. However, the law lists some specific possibilities, including job restructur-

ing, part-time or modified work schedules, or reassignment to a vacant position, all of which may prove useful to people with psychiatric disabilities. The ADA indicates that a reasonable accommodation is required unless it poses an "undue hardship" on the employer. Undue hardship "means an action requiring significant difficulty or expense." Factors, specified by the law, that may make an accommodation an undue hardship include "the nature and cost of the accommodation. . . the overall financial resources of the facility. . . [and] the number of persons employed at such facility. . ." (42 U.S.C. 121 11(10)). Undue hardship is not limited to financial difficulty, however, a point especially relevant to psychiatric disabilities; it also refers to any accommodation that would be "unduly. . . extensive, substantial, or disruptive, or that would fundamentally alter the nature or operation of the business."

What constitutes employment discrimination under the ADA? Section 102 of Title I enumerates a variety of practices forbidden by the law—a level of specificity that is uncommon in civil rights law (15). The ADA deems "not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability [42 U.S.C. 121 12(b))" unless the employer can prove the accommodation is an undue hardship. Note that the employer's obligation is to "known" limitations, a critical issue for such "hidden" conditions as psychiatric disabilities. Other expressly prohibited actions include discriminatory:

- limitation, segregation, or classification of job applicants or employees on the basis of disability;
- contractual arrangements, such as with an organization that provides training or facilities for a meeting; and
- use of employment tests or other qualification standards that "screen out" a person with a disability, unless the standard is "job-related and consistent with business necessity."

Another common employment practice that is expressly forbidden by the ADA relates to medical examinations and inquiries. Employers can no longer inquire about the medical or disability status of a job applicant. This provision makes illegal such job application questions as: "Have you had a nervous breakdown?" Employers may require, however, medical exams and inquiries after a conditional job offer is made, provided such exams and inquiries are required of all applicants in the job category, and the information is kept confidential. A job offer may be rescinded only if the exclusionary criteria are job-related, consistent with business necessity and reveal that an applicant could not perform an essential function of the job or could not do the job without posing a direct threat to health or safety, even with a reasonable accommodation. In regards to current employees, employers can only require medical examinations or make medical inquiries if they are "job-related and consistent with business necessity."

One qualification standard specifically permitted by the ADA is "the requirement that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace" (42 U.S.C. 121 13(b)). This standard requires individualized and nonspeculative determinations of direct threat, not generalizations based on stereotypes or myths. Also, the law requires reasonable accommodation that may eliminate or sufficiently reduce a direct threat. Chapter 4 discusses in further detail the direct-threat standard, the regulations and technical guidance proffered by the Federal Government, as well as information on the relationship between mental disorders and violence.

The ADA's potential impact on employer-provided health insurance fuels much speculation, especially in the mental health field, where benefits are generally more limited (see ch. 4). Title I forbids contractual relationships, including those with "an organization providing fringe benefits to an employee" (42 U.S.C. 121 12(b))—that result indiscrimination against employees with disabili-

ties; this provision applies to health benefits (15). In fact, the ADA and its legislative history directly assail discriminatory practices in the area of health care benefits. However, the Act permits "benefit plan(s) that are based on underwriting risks, classifying risks, or administering such risks. . ." (42 U.S.C. 12201 (c)) in accordance with State law (where insured plans are involved), so long as the practice "shall not be used as a subterfuge to evade the purposes of Title L" (See ch. 4 for further discussion of mental health benefits and the ADA.)

In addition to preparing regulations and providing technical guidance, the U.S. Equal Employment Opportunity Commission (EEOC) is responsible for enforcing Title I (see table 2-1). Administrative and judicial remedies are identical to those provided for under Title VII of the Civil Rights Act of 1964, as expanded in 1991 (P.L. 102- 166). After commencing the EEOC's administrative process, an individual may file a private law suit. Upon proving "a discriminatory practice intentionally engaged in with malice or with reckless indifference to the rights of the aggrieved individual," the accusing party may also recover punitive damages. The Civil Rights Act of 1991 limits the maximal compensatory and punitive damages of $50,000 to $300,000. An employer may avoid damages in an ADA reasonable accommodation case if it can show good faith efforts to accommodate the applicant or employee. Chapter 5 provides a detailed discussion of the EEOC's role in implementing and enforcing Title I of the ADA.

Titles II, III, and IV of the ADA prohibit discrimination in public services (e.g., State-run services or programs, public transportation by commuter rail), privately owned public accommodations (e.g., hotels, theaters, restaurants, etc.), and telecommunications, respective] y. These titles leave almost no aspect of public life untouched by the ADA. The ADA charges the U.S. Departments of Justice and Transportation with the enforcement of Title II. The U.S. Department of Justice (DOJ) also has enforcement jurisdiction for Title III. Telecommunications, as covered by Title IV, is in the purview of the Federal Communications Commission. Title II of the ADA also bans employment discrimination on the basis of disability by State and local governments; regulatory and enforcement jurisdiction for this provision lies with the DOJ. [1]

Several Federal authorities are responsible for the sometimes overlapping provisions of the ADA and the Rehabilitation Act. In order to avoid duplication of effort or conflicting standards, the ADA requires executive branch agencies to coordinate their activities. Specifically, the law charges the EEOC, DOJ, and Office of Federal Contract Compliance Programs (in the Department of Labor)* to "establish such coordinating mechanisms. . . in regulations implementing this title and Rehabilitation Act of 1973 not later than 18 months after the date of enactment of this Act" (42 U.S.C. 121 17(b)). Similarly, DOJ, EEOC, and other agencies must coordinate technical assistance efforts. In addition, the Rehabilitation Act was amended in 1992 to provide that the standards of Title I of the ADA shall apply to complaints of nonaffirmative action employment discrimination under the Rehabilitation Act. Acknowledging the importance of technical assistance to the ADA's success, Title V of the law (which includes "miscellaneous" provisions) also requires EEOC to provide technical assistance manuals and other support for implementation. Chapter 5 discusses technical assistance efforts and resources relevant to employment and psychiatric disabilities.

[1] When a State or local government employer meets the jurisdictional requirements of Title I regarding number of employees, the EEOC also has enforcement authority.

[2] The Office of Federal Contract Compliance Programs or OFCCP administers section 503 of the Rehabilitation Act.

Federal Policy Antecedents

Federal disability policy[3] did not begin with the ADA. Many other policies and programs affect people with disabilities. Nor is the ADA the first law to offer protection to people with psychiatric disabilities. In fact, most disability efforts explicitly include this population. A review of the Federal building blocks of the ADA (as well as some disability programs in chapter 3) clarifies the legal precedents for this law and shows how people with psychiatric disabilities have fared under them. The analysis leads to the conclusion that psychiatric disabilities do not always have an easy fit with Federal disability policies that cover them.

Legislation attempting to chip away at discrimination against people with disabilities began with the Architectural Barriers Act of 1968 (46,57) (table 2-2). Title V of the Rehabilitation Act of 1973 formed the most important legal antecedent to the ADA. Sections 501 and 503 of the 1973 Act require affirmative action in the hiring and advancement of people with disabilities by the Federal Government and any of its contractors (and, under section 503, subcontractors) receiving over $10,000. These sections forbid Federal executive agencies and Federal contractors and subcontractors from job discrimination against people with disabilities. Section 504 prohibits discrimination or exclusion because of disability in all programs or services offered by recipients of Federal funds and by executive agencies.

The Rehabilitation Act, however, was implemented slowly. Its regulations were finalized only after several years and a court challenge (49). Many commentators conclude that the impact of the law on people with disabilities was not overwhelming. Studies that evaluated the level of employment of people with disabilities, the frequency of accommodations, and other measures, lead to the often cited conclusion that while the Act "has unlocked the door for handicapped persons to enter the mainstream of society, it has failed in its goal of opening the door wide" (51). Analysis argues that sections 503 and 504 have had even less effect on people with psychiatric disabilities, in terms of favorable employment outcomes and decisions stemming from complaints (2,5,36).

The existing research and analyses implicate several factors in the modest effect of the Rehabilitation Act, including: attitudinal barriers toward people with disabilities; less than vigorous enforcement; the relative obscurity of the law(51); its complexity and limited scope; and the lack of dedicated, Federal leadership (4). Nevertheless, legislative support for the ADA stemmed from its similarity to the Rehabilitation Act. The ADA was seen as an extension of the Rehabilitation Act to the private sector.[4]

What lessons emerge for ADA enforcement and implementation? Attitudes, especially toward people with psychiatric disabilities, are a formidable barrier (see next section). The law itself, as well as the nature of disability+ specially psychiatric disabilities—are complicated and obscure to many. And enforcement activities, at least of Title I by the EEOC, are limited by budgetary constraints (see ch. 5). Finally, ongoing evaluation of the ADA's impact stands as a critical tool in adapting and improving enforcement and implementation efforts. Without attention to these is-

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[3] States have also enacted a variety of policies that affect people with disabilities, including antidiscrimination and workers' compensation laws. The limited scope of this report precludes a review of these policies. Such evaluation would, however, assist the continued implementation of the ADA, by illustrating successes and problems at the State level and distinguishing potential conflicts between laws at the State and Federal levels (45).

[4] While *the language* and experience *with* the Rehabilitation Act of 1973 forma template for the ADA, important distinctions exist (17,22). Most obviously, and as noted in the text, the Rehabilitation Act has a narrower scope, applying only to the Federal Government and those receiving Federal funds. Also, the Rehabilitation Act unambiguously requires affirmative action, not just the reasonable accommodations prescribed by Title I of the ADA. Also, the Rehabilitation Act was broader in its protection of current drug and alcohol users; the Rehabilitation Act Amendments of 1992 (P.L. 102-569) apply the substantive standards of Title I of the ADA to sections 501, 503, and 504 for nonaffirmative action employment discrimination cases.

TABLE 2–2: Federal Legislative Building Blocks to the ADA

Law	Principle action
The Architectural Barriers Act of 1968	Mandated that ail buildings constructed, altered, or financed by the Federal Government after 1969 be accessible and usable by persons with physical disabilities.
Urban Mass Transportion Act of 1970	Required all public transportation services to be accessible to people with disabilities in order to qualify for Federal funding.
Rehabilitation Act of 1973	
• sections 501 and 503	Required affirmative action on plans for the hiring and advancement of persons with disabilities In the Federal Government and any contractors receiving Federal contracts over $10,000 and covered employment discrimination.
• section 504	Prohibited discrimination against otherwise qualified persons with disabilities in any program or activity receiving Federal funds, or any program or activity of the Executive Branch agencies and the Postal Service.
The Education of All Handicapped Children Act of 1975	Now called the Individuals With Disabilities Education Act, this law mandated a free, appropriate public education for all children with disabilities.
The Developmental Disabilities Assistance and Bill of Rights Act, 1975	Included a small, Federal grant program administered by State Developmental Disabilities Councils and is intended to coordinate and fund services for persons with developmental or severe long-term disabilities.
	The Bill of Rights declared that persons with developmental disabilities have a right to appropriate treatment, services, and rehabilitation that maximize the developmental potential of the person and take place in a setting least restrictive to personal liberty.
	The Act also established in every State a system of protection and advocacy organizations that are independent of any service providing organization.
Civil Rights of Institutionalized Persons Act, 1960	Authorized the U.S. Department of Justice to sue States for alleged violations of the rights of institutionalized persons, including persons in mental hospitials.
Voting Accessibility for the Elderly and Handicapped Act of 1984	Required that registration and polling places for Federal elections be accessible to persons with disabilities.
Air Carriers Access Act of 1986	Overturned a Supreme Court decision which held that air carriers operating at federally funded airports were not subject to section 504. The Act prohibits discrimination against persons with disabilities by all air carriers and provides for enforcement under the U.S. Department of Transportation.
Fair Housing Act Amendments of 1986	Added persons with disabilities as a group protected from discrimination in housing. First antidiscrimination mandate for persons with disabilities extended into private sector.
Civil Rights Restoration Act of 1988	Amended section 504 of Rehabilitation Act, as well as other civil rights statutes. Overturned Supreme Court's Grove City College v. Bell decision defining coverage of section 504 as broad rather than narrow when Federal funds were involved.
Civil Rights Restoration Act of 1988	The Humphrey-Harkin provision amended the Rehabilitation Act's definition of an individual with a disability and clarified that an individual with a contagious disease or infection who poses a direct threat to the health or safety of others was not covered by section 504.

SOURCE: Adapted from J. West, "The Social and Policy Context of the Act," *The Americans With Disabilities Ad: From Policy to Practice,* J. West (ad.) (New York, NY: Milbank Memorial Fund, 1991).

sues, the ADA's ultimate effect, like the Rehabilitation Act's, may be limited.

The Fair Housing Act (FHA) Amendments of 1988 form another legislative building block for the ADA. The original FHA, passed in 1968, prohibits discrimination in public and private real estate transactions based on race, color, religion, sex, or national origin. After an abortive attempt in 1980, the U.S. Congress successfully extended FHA's coverage to people with disabilities in 1988 (46). This signaled the first time that an antidiscrimination mandate for people with disabilities was extended into the private sector, an important precedent for the ADA. Indeed, many of the features that appear in the ADA come directly from FHA.

Mental health advocates lauded the FHA amendments, mindful that many people with psychiatric disabilities desperately need housing and suffer considerable discrimination in this arena. However, problems soon arose (52). One resulted from the subsequent influx of young people with psychiatric disabilities into public housing for the elderly that prompted an outcry from public housing agencies (PHAs). Many of the PHAs urged lawmakers to exclude people with mental disabilities from public housing projects for the elderly. In response to their protests, Congress requested that the U.S. Department of Housing and Urban Development (HUD) reexamine the policies that require housing older people and people with mental disabilities together in public housing projects. Although HUD rejected suggestions to exclude people with mental disabilities from the housing projects, subsequent legislation (P.L. 102-550) did authorize separate housing, a reminder that legislative gains are not immutable. To the knowledge of OTA, people with psychiatric disabilities face no current effort to exclude them from the ADA's protection. However, given the stigma and misunderstanding attached to psychiatric disorders and the complex issues they sometimes raise, a backlash is always possible. Efforts aimed at informing people about ADA implementation may be the best means to forestall exclusion of people with psychiatric disabilities.

THE ROLE OF PEOPLE WITH DISABILITIES

The ADA is the culmination of more than two decades of effort to transform Federal disability policy from one fostering dependence and segregation, to one encouraging independence and integration (49,50,57). While not always the initial agents of public policy changes, people with disabilities, abroad coalition of groups, forced policy reforms by their advocacy, sustained attention, and forceful leadership. They can rightly call the ADA their victory. Without a doubt, people with disabilities will continue to play a pivotal role in the ADA's implementation as well as in disability policy in general.

The disability rights movement generally comprises people with physical disabilities. People with mental disabilities, and especially psychiatric disorders, normally stand apart from the larger disability rights community.[5] Given the disability rights movement's profound impact on public policy, the question emerges: What role do people with psychiatric disabilities play in policies, such as the ADA, that affect them? After summarizing the development and role of the disability rights movement, this section considers the alliances of people with psychiatric disabilities and their potential role in implementing the ADA.

The Disability Rights Movement

The disability rights movement evolved slowly over the twentieth century (12,49,50,57). While some groups organized around a shared occupation-related illness (e.g., miners with black lung disease), specific disability (e.g., the National Federation of the Blind), or other common ties (e.g., war veteran status), the social isolation of in-

[5] This, of course, is not always the case, and may be changing. For example, commentators have noted the importance of the disability rights movement representatives standing with advocates for people with mental disorders to ensure their inclusion in the ADA (47) and major Federal financing programs (24).

dividuals with disabilities and their low socioeconomic status essentially barred them from organizing.

Social changes that began the 1960s inspired the vigorous growth of the disability rights movement. The disability rights movement embraced the values of equal opportunity and social integration advocated by people of color and women, and appropriated the political activism of the civil rights, womens, and consumer movements. The concepts of self-determination and freedom of choice also nurtured the concept of independent living (57). This model of coping with disability, in contrast to the medical dependence model, provided a framework for *living with* long-term disabilities. It emphasized the role of individuals with a disability in making decisions.

Changes in the populations of peoples with disabilities in America also helped foster the nascent disability rights movement. Many adolescents and young adults joined the ranks of people with disabilities after the epidemic of polio in the early 1950s and the Vietnam war in the 1960s and 1970s (49). More recently, an aging population (26) and the relative increase in chronic medical illness have added to the number of people with disabilities. Medical and technological advances lengthened life span and resulted in the survival of people with previously fatal diseases or congenital conditions. People with disabilities were no longer being instilled with a life-long experience of dependency and segregation. Thus discrimination, as opposed to physical impairment or personal attitude, assumed more importance in the lives of individuals with disabilities.

A leader of the disability rights movement, Patricia Wright, has noted that "(a)]] disabled people share one common experience-discrimination" (12). The recognition of discrimination as a key problem for people with disabilities had an important result: Individuals with disabilities gained a common identity (18) which fostered their work together in the public policy arena, Advocates documented discrimination and developed an arsenal of information that fueled their advocacy efforts (1 8,41). The publicizing of problems that people with disabilities face in society as a result of myths, stereotypes, and exclusionary practices was a driving force behind the ADA and is reflected in the language of the law itself:

• *The Congress finds that. . . individuals with disabilities. . . have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the ability of such individuals to participate in, and contribute to, society. . . (42 U.S. C. 12101(a)).*

Disability language also changed, moving away from "patronizing and stigmatizing descriptors to empowering and respectful terminology" (57). While differences exist in the disability community over appropriate language and its relative importance, in general "people first" language prevails: the phrase "people with disabilities" is used as opposed to "disabled people." The term "handicap" is generally rejected because of its negative connotations; it does not reflect how the environment contributes to producing disabilities.

Clearly, people with disabilities have made significant strides in the last 30 years. While still disproportionately poor and unemployed (21), they have formed a strong coalition, effectively and passionately advocating changes in public policy. They are increasingly at the helm of disability organizations, other interest groups, and Federal disability programs. The disability rights movement continues pressing for policy reform-in health insurance, home health care, and personal assistants—and ADA implementation (37,38).

People With Psychiatric Disabilities and Their Family Members

The growing coalitions of people with psychiatric disabilities and their family members share some features with the broader disability rights movement, including social influences, an evolving sense of shared identity, and increasing involvement in public policy. People disabled by mental disorders often suffer lower socioeconomic status and unemployment. Medical advances contributed to social and public policy trends, such as

deinstitutionalization (23). The civil rights and consumer movements of the 1960s and 1970s motivated some individuals with psychiatric disabilities as they did the disability rights movement in general. Beginning in the early 1970s, small groups of former patients railed against institutionalization and mental hospital abuses, as well as the perceptions of mental illness held by mental health professionals and the public (6,7). These former patients and other advocates fought for and often won policy changes concerning involuntary commitment standards, patient civil rights, independent and community living, and treatment issues.

Changes in language were also a part of the movement of people with psychiatric disabilities. While all of the movement's members agree on the importance of destigmatizing, "people first" language, preferred designations for people with psychiatric disabilities include clients, consumers, ex-patients, patients, and psychiatric survivors (11). In this OTA report, people-first language will be used. Unless referring to a particular body of research in which there is a distinct and more specific designation (e.g., people with a particular diagnosis), the report will refer to *people with mental disorders or psychiatric or mental disorder-based disabilities.*[6,7]

Coalitions of people with psychiatric disabilities and their families, primary and secondary consumers,[8] are neither singular nor unified. Rather, various groups of people with psychiatric disabilities and mental health problems and their family members have joined together on the basis of need, treatment experience, types of disorders, and ideology (13,55). It is important to note that while some leaders in the various groups have eloquently described the evolution and beliefs associated with their respective coalitions, little empirically based information (e.g., from surveys, ethnographic studies, etc.) documents these movements, or the experiences and beliefs of people involved in them (1 3,20,55).

Nevertheless, hundreds, perhaps thousands of local consumer groups have formed across the nation (13,55). At the national level, several groups figure prominently, including (in alphabetical order): Anxiety Disorders Association of America; National Association of Psychiatric Survivors; National Depressive and Manic-Depressive Association; and the National Mental Health Consumers' Association (20). An organization of family members as well as some primary consumers—the National Alliance for the Mentally Ill—also has a strong national voice. A brief description of each organization is provided below (and see table 2-3):

- Anxiety Disorders Association of America (ADAA): Between 2,000 and 4,000 professionals, consumers, and other interested parties form the membership of the ADAA (1,20). Founded in 1980, the ADAA has an annual budget of more than $500,000 derived from membership fees, as well as individual and corporate contributions. Activities of the ADAA include: self-help/support groups, lobbying and public education efforts, and professional training seminars. When asked to describe its driving philosophy, the ADAA responded that "anxiety disorders are to be viewed on a par with physical illnesses which are currently

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6 The report focuses on mental disabilities, a broad rubric. However, some conditions are not discussed, including substance abuse disorders, developmental disabilities such as mental retardation, and other cognitive and neurological impairments. While these impairments and resulting disabilities raise important questions under the ADA—some similar and some distinct from the conditions considered in this study—they are beyond the scope of this report.

7 The term psychiatric disabilities, as opposed to mental disabilities, is used because it is generally understood to refer to a narrower set of disabilities—those associated with mental disorders or mental health problems—that are the subject of this report. Also, the term psychiatric disabilities is commonly used in the rehabilitation community *(32,40).* Use of the term "psychiatric" is not intended to endorse a particular profession's role in treating or providing services for these conditions.

8 Primary consumers refers to individuals with psychiatric disabilities themselves; secondary consumers indicate family members or others who care for people with disabilities.

TABLE 2–3: Coalitions of People With Psychiatric Disabilities and Their Families

Organization name	Year founded	Total number of members	Composition of membership	Total budget (1992)	Source of funds
Anxiety Disorders Association of America (ADAA)	1980	2,0004,000	People with anxiety disorders, their families, and professionals.	$500,000+	Membership fees, individual and Corprate contributions.
National Association of Psychiatric Survivors (NAPS)	1985	2,000	Current and former psychiatric patients, their families, friends, and others.	$20,000	Membership dues and contributions.
National Depressive and Manic Depressive Association (NDMDA)	197a	30,000+	People with depressive and *manic*-depressive disorders and their families and friends.	*$780,000*	Membership fees, private and public grants, fund-raisers.
National Mental Health Consumers' Association (NMHCA)	1985	1,000	Current and former consumers of mental health care services, professionals, and others.	*$2,000*	*Membership* dues.
National Alliance for the Mentally Ill (NAMI)	1979	140,000+	Principally parents and other family members of people with severe mental disorders.	$2,000,000+	Membership fees, individual and corporate contributions.

SOURCE: Office of Technology Assessment, 1994.

most responsive to both medication and cognitive/behavioral therapy. No preference is expressed for either medication or therapy" (l).

- National Association of Psychiatric Survivors (NAPS): NAPS, which began as the National Alliance of Mental Patients in 1985, emerged as a national coalition of local groups (7,8,20). Individuals angry at their treatment by the mental health care system, including many of whom have experienced involuntary treatment and hospitalization, constitute the 2,000 active members of NAPS. The group shares some goals with other primary consumer organizations, such as the promotion of mutual support and self-help (see later discussion). But NAPS principles and tactics make it the most radical of consumer organizations. Members categorically oppose involuntary or forced treatment as well as the medical model of mental illness and treatment. They frequently adopt a confrontational approach in policy discussions and public forums.
- National Depressive and Manic-Depressive Association (NDMDA): The NDMDA, formed in 1978, identifies as its primary objectives self-help and support for people with serious mood disorders and their families, and education (20). With more than 30,000 members and an annual budget approaching **$800,000,** NDMDA sponsors more than 200 local groups; forums and lectures for professionals, a semiannual national conference, several regional conferences, and publishes a quarterly newsletter, books, and other material. NDMDA views major depression and manic-depression as biological illnesses that can be treated with medication and therapy (39).
- National Mental Health Consumers' Association (NMHCA): Most of the estimated 1,000 members of the NMHCA have serious psychiatric conditions, with many having experienced hospitalizations, involuntary treatment, and reliance on the public sector (7,10,28). Formed in 1985 as a network of local consumer groups, NMHCA engages in a variety of advocacy, technical assistance, and self-help activities. While sharing a strong commitment to civil rights for people with mental disorders, self-representation, and self-help, the organization is less doctrinaire about the issue of forced treatment, and has worked for access to appropriate treatment, including medical interventions.
- National Alliance for the Mentally Ill (NAMI): NAMI was founded in 1979, as a national alliance of parents and family members of people with severe mental disorders. Most of the approximately 140,000 members are secondary consumers, with the "typical member (being). . . a mother in her sixties with a son in his twenties who has schizophrenia" (19). Increasingly, primary consumers are active although not dominant in NAMI. They are members of the Client Council and Board of Directors at the national level and leaders of some local groups. NAMI is the most influential of national mental health consumer groups, as reflected in its annual budget of more than $2 million, large membership, and influence on public policy (20). The organization focuses on individuals with the most severe mental disorders and strongly advocates biomedical research and treatment.

Differences among these groups are real, and sometimes acrimonious. However, as they coalesce around shared goals, they also have much in common, including the experience and repudiation of stigma and discrimination, their insistence on the importance of empowerment and advocacy, and, notable for this report, the availability of jobs or meaningful activity (7).

While stigma and discrimination affect the lives of all people with disabilities, people with psychiatric disabilities suffer some of the harshest and cruelest attitudes (box 2-2). Although attitudes toward mental disorders may be improving (9), a recent national survey of public attitudes toward people with disabilities shows that, from the public's perspective, mental illness is the most disturbing of all disabling conditions (41) (figure 2-1). This is not surprising given the exceedingly negative images of people with mental disorders—as incompetent, ineffectual, or violent—

BOX 2–2: The Politics of Stigma

The public perception of an individual's stability, competence, and stamina is perhaps most important in the political arena Indeed, the slightest hint of mental health problems can be the political kiss of death Recent history shows that the stigma associated with mental illness is a formidable weapon when used to cast doubts on a candidate's fitness for political office. Although it was acknowledged among his peers that President Lincoln was plagued by "melancholy" throughout his life and his presidency, it wasn't until 1964 that a "mental Illness" was first raised as a campaign issue. Since that attack on Republican presidential candidate Barry Goldwater's mental health, several other national candidates have had their mental stability attacked A closer look at some of these political races corroborates the stigma of mental illness while hinting at an evolution in public attitudes

The Political Kiss of Death

In October 1964, in an effort to discredit presidential nominee Barry Goldwater, the publisher of the now defunct "Fact" magazine published the results of a survey he had commissioned in which more than 1,189 of the 2,417 psychiatrists answered "no" to the question, "IS Barry Goldwater psychologically fit to be President of the United States?" The American Psychiatric Association (APA) and the American Medical Association assailed the survey as "yellow journalism , " with the APA noting that

> By attaching the stigma of extreme political partisanship to the psychiatric profession as a whole in the heated climate of the current political campaign, *Fact* has in effect administered a low blow to all who would advance the treatment and care of the mentally ill of America.

Subsequently, the APA adopted what it called '{the Goldwater Rule" which forbids doctors from offering a psychiatric opinion on a public figure unless the psychiatrist has personally treated the off icial and has authorization to break patient-doctor confidentiality. Although it is difficult to know with any certainty the effect of any one factor on a political campaign, it appears that the incident contributed to Mr. Goldwater's defeat in the presidential election He did, however, successfully sue the magazine's publisher, becoming one of the few public figures to win such a libel suit

Several days after Democratic presidential candidate George McGovern selected Senator Thomas Eagleton as his running mate, the national press revealed that Mr. Eagleton had withheld the fact that he had been hospitalized on three occasions for "nervous exhaustion and fatigue" and that he had undergone electroconvulsive therapy for depression on two of the three occasions In this instance, the information was true Mr. Eagleton had withheld the information from Mr. McGovern and his staff when asked if he had "any skeletons in the closet "

Perhaps Mr. Eagleton did not regard his medical history of depression as a "skeleton " It became clear, however, that the press and much of the public did. While some people praised Mr. Eagleton for his candor, most people criticized his judgment for failing to make the facts known before his nomination Moreover, while some people found it reassuring that Mr. Eagleton recognized the need and sought treatment for depression and expressed confidence in his ability to be Vice President, others viewed him an unfit candidate for the office and urged him to withdraw from the race. After a painful and public debate, Mr. Eagleton was dropped from the ticket.

Sixteen years after Mr. Eagleton was forced to withdraw, rumors of mental illness were used against Michael Dukakis' bid for the presidency During the 1988 presidential campaign, supporters of Lyndon LaRouche circulated the rumor that Michael Dukakis had been treated by a psychiatrist for depression Initially, Mr. Dukakis dismissed the allegations with an assertion that there was no evidence to support the rumor and he refused to release his personal medical records. But then, President Reagan brought national attention to the rumor when he joked at a press conference that,"1 am not going to pick on an invalid, " when asked

(continued)

BOX 2–2: The Politics of Stigma (cont'd.)

his opinion about Mr. Dukakis' refusal to release his medical records. Eventually, Mr. Dukakis' personal physician issued a statement assuring the public that the presidential candidate was in excellent health and had had no psychological symptoms, complaints, or treatment. While the ultimate outcome of the presidential race may not have hinged on this issue, it nonetheless underscores the potency of such allegations.

A New Age?

More recent experience suggests that voters' attitudes about mental illness may be changing. In 1990, former United States Senator Lawton Chiles had to deal with the mental health issue during his gubernatorial campaign in Florida. Mr. Chiles acknowledged that he was taking the widely prescribed drug Prozac for treatment of depression, which he had suffered since leaving the U.S. Senate, complaining of "burnout." During the gubernatorial primary campaign, his opponent's running mate suggested that Mr. Chiles could be suicidal. His allegation was based on newspaper accounts that the makers of Prozac were being sued because the drug induced suicidal tendencies.

Mr. Chiles was obliged to release medical records that said he did not contemplate suicide during his bouts with depression. The voters did not seem to consider Mr. Chiles' taking of Prozac to be a significant issue. Mr. Chiles said he thought the health issue was much more of a concern to the press and politicians than to average people. "1 didn't realize how many people knew something about depression, had somebody in their family with it or whatever," he said. "People are always coming up to me, just kinda squeezing my arm and saying something. " Mr. Chiles won the election.

Most recently, in 1992, Congresswoman Nydia Velazquez, former U.S. Secretary of the Department of Puerto Rican Community Affairs, won her bid to represent New York City's 12th Congressional District despite reports that she had attempted suicide in 1991. After hospital records revealing a bout with depression, pills, alcohol, and attempted suicide were anonymously leaked to news organizations, Ms. Velazquez held a news conference to assure voters that she had been receiving professional counseling that gave her "a whole new outlook on life. " Apparently voters were convinced; she won the election with **77 percent of** the votes.

The experience of candidates for public office reflects what people in all walks of life know: Mental disorders trigger stigmatizing perceptions of incompetence, personal turpitude and weakness, endangering job prospects. Thus, even with the suggestion of diminishing negative attitudes, people with psychiatric disabilities clearly need protection from discrimination offered by the ADA.

SOURCES "Risks of Prying Into Mental Health Problems," *CQ* Researcher 2:346, 1992; J. Fuller, "Editorials Are Mixed on Eagleton, " *Washington Post*, July 28, 1972, p. A13; J. LeMoyne, "Polls Show Chiles Leading in Florida," New York *Times,* Sept. 2,1990, p. A24, "IS Barry Goldwater Psychologically Fit to be President of the United States?" advertisement in New *York Times,* Sept. 12, 1964, p. L26; "Doctors Deplore Goldwater Poll," New *York Times,* Oct. 2, 1964; New *York Times,* "The 1992 Election: New York Stat*U.S. House Races: Green and Downey Lose as New York State Delegation Changes Dramatically," New *York Times, Nov.* 4, 1992, p.B11; C. Sandburg, Abraham *Lincoln: The Prairie Years and The War Years* (New York, NY: Harcourt, Brace, 1954); R. Toner, "Florida Governor Warily Fights Chiles Mystique, " New *York Times,* Sept. 14, 1990, p. A14; "Ex-Senator Chiles Issues Health Data, " *Washington Post, Aug. 22, 1990,* p A3; "After Suicide Try, Candidate is 'Truly' Living, " *Washington Post*, Oct. 9, 1992.

routinely projected by the news and entertainment media, the public primary source of information about mental illness (16,28,31,48,53) (see ch. 4 for discussion of mental disorders and violence).

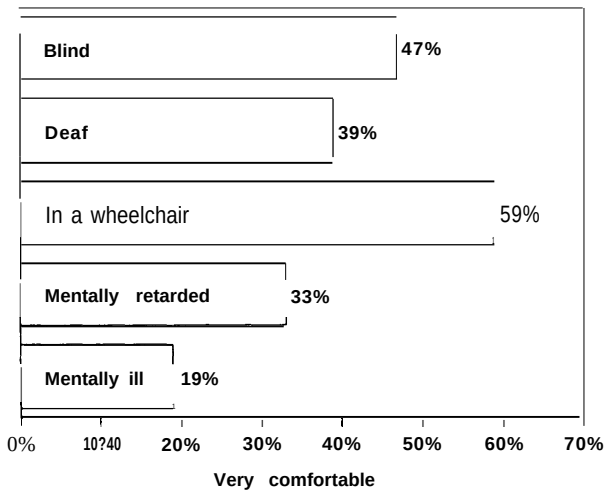
The negative attitudes attached to mental disorders have profound implications for the implementation of the ADA. Fear, ignorance, and misperceptions about psychiatric disability undoubtedly contribute to employment discrimination (40,56). Furthermore, the education of employers and coworkers about mental disorders as well as employee willingness to disclose a psy -

chiatric disability will be critical (see ch. 4). Stigma and discrimination also inspire the adoption of a principle that seems to be universally held by consumer groups: empowerment.

Before defining empowerment, it is important to explicate one of the most insidious results of stigma and discrimination. People with psychiatric disabilities often internalize the attitudes and practices of people who victimize them (7,28,40,43,56). Research findings support the observation that stigma and discrimination attached to mental illness undermine an individual's self-esteem and social interactions (31,56). For example, one study (30) correlated the expectation of rejection with demoralization and unemployment among people with mental disorders.

To counter these crippling effects, many people with psychiatric disabilities and their family members hold empowerment as a fundamental goal (5,34,55). While the term may suffer from overuse and some ambiguity (34), empowerment connotes a sense of personal and social potency. "Empowerment means acquiring the ability to make decisions that affect an individual's life" (55). Government officials at the Federal and State level increasingly endorse the principle of empowerment and have legislated consumer involvement in policy making and the delivery of mental health care (55). For example, the statement from the Federal consensus conference on "Strategies to Secure and Maintain Employment for Persons with Long-Term Mental Illness" prominently highlights consumer involvement (40): "It is important to promote the active participation of people with psychiatric disabilities at all levels of research development, implementation, and evaluation." Similarly, the National Association of State Mental Health Program Directors asserts in a position paper that "former mental patients/mental health consumers have a unique contribution to make to the improvement of the quality of mental health services in many arenas of the service delivery system. . . Their contribution should be valued and sought in areas of program development, policy formation, program evaluation, quality assurance, system designs, education of mental health service providers, and the provision of direct services" (43). Federal legislation also has required the involvement of people with psychiatric disabilities and their family members in mental health services and policy. The Mental Health Planning Act (P.L. 99-660) and the Protection and Advocacy for Mentally Ill Individuals Act (P.L. 99-319) require the formal involvement of consumers on State advisory bodies. A more recent development is the establishment of the Consumer/Survivor Mental Health Research Policy Work Group by the Center for Mental Health Services[9] (CMHS). The group, which includes several people with psychiatric

FIGURE 2–1: Public Attitudes Attached to Mental Disorders



A survey conducted by Louis Harris and Associates, Inc., for the National Organization on Disability indicated that of all the disabilities asked about, people felt least comfortable with people with mental illness,

SOURCE Adapted from National Organization on Disability, "Public Attitudes Toward People With Disabilities," survey conducted by Louis Harris and Associates, Inc , 1991

[9] The Center for Mental Health Services is part of a newly organized Federal agency, Substance Abuse and Mental Health Services Administration (SAMHSA), in the U.S. Department of Health and Human Services (P. L. 102-321). See chapter 5 for complete description.

disabilities, identifies roles for consumers in mental health policy and research (3).

The Community Support Program (CSP) in CMHS is among the most prominent governmental supports for groups of people with psychiatric disabilities and their families (8; see ch. **5).** Since its inception in 1977 as the first national program to promote consumer involvement in mental health care, CSP has funded several national conferences, two national technical assistance centers, a self-help clearinghouse, a national monthly teleconference, and various model programs for self-help and consumer service involvement (see ch. 5). In fiscal year 1993, CSP provided $4.4 million (about 35 percent of the CSP budget) in grants to31 States to support family and consumer initiatives. In addition, the CSP funds research into the consumer movement (55).[10]

Two activities commonly performed by consumer groups could effect better ADA implementation. First, these groups may offer technical assistance to businesses. Because people with psychiatric disabilities and their family members have a long involvement in rehabilitation, job clubs, and consumer-run businesses, they have first-hand knowledge of the issues that arise in employment (55). For example, Fountain House, founded in 1957 in New York, pioneered "club houses," an approach to psychosocial rehabilitation that provides for transitional employment services. The club houses place individuals in temporary jobs with on-site support and training. Second, many groups have considerable experience educating outside groups about mental disorders, a service that many employers may find helpful. Thus, many consumer organizations can help employers devise accommodations and sensitize them to the issues associated with psychiatric disabilities. As mentioned, the CSP supports two consumer-run national technical assistance centers—Project Share in Philadelphia, Pennsylvania, and the National Empowerment Center in Lawrence, Massachusetts—as well as the National Mental Health Consumer Self-Help Clearinghouse. These centers can assist employees and employers in finding local groups and employment/ADA related information.

Consumer self-help groups form another potential resource during ADA implementation. Such groups, in operation since the late 1970s, offer empowerment, inspiration, education, and support (7,8, 14,34,55). Self-help group functions range from support services to advocacy (25,55). Recently published data detail the nature of these services and provide evidence that many people with psychiatric disabilities and their family members utilize them (55). While empirical proof of performance is yet to come, new and ongoing studies suggest that self-help groups can provide effective services (25,55). Given their apparent wide use and the support that they provide, self-help groups may be useful in helping people with psychiatric disabilities address ADA employment issues.

The above discussion asserts that consumer groups may advance ADA implementation by serving as a source of information and support to employers and employees. Three caveats warrant notice, however: First, in general, employers have not tapped into the experience and expertise of people with disabilities; people with psychiatric disabilities and their family members may be even more underutilized. Second, characterization and evaluation of consumer-provided services to identify the groups that are most effective are at a very early stage (25,29,34,55). Third, to be effective agents of information and support for the ADA, people with psychiatric disabilities and their family members need to understand the law.

SUMMARY AND CONCLUSIONS

This chapter summarizes the ADA's provisions, highlighting issues of employment. While not an

10 According to an informal survey by the U.S. Department of Health and Human Services Inspector General, while CSP is rightly credited with fostering the mental health consumer movement, it "has become overidentified with. . . certain consumers over others." (54).

in-depth analysis of the ADA's legislative history or requirements, the overview points out the importance of this legislative mandate for people with psychiatric disabilities. The overview also points out some potential problems. Chapters 3 and 4 consider these areas in greater detail.

The ADA stems from a 25-year history of antidiscrimination laws. Review of the policy antecedents of the ADA in this chapter and in the next led OTA to the conclusion that psychiatric disabilities do not always have an easy fit with Federal disability policies. This reflects the stigma attached to mental disorders and the complexity of psychiatric disability. This history has important implications for the ADA: Federal leadership, public education about the law's goals, and understanding of psychiatric disabilities will be critical for fair and effective implementation.

This chapter also outlines the history of people with disabilities in making public policy. Individuals with physical disabilities organized over the last three decades; they worked to invest disability policy with values of self-determination, equal opportunity, and full participation in society. United against discrimination, the disability rights movement passionately worked to win the ADA's passage. In addition, people with physical disabilities have achieved important policy goals, political clout, and leadership.

Although not yet at the same level of leadership and political influence as those with physical disabilities, people with psychiatric disabilities and their families have founded several national organizations and have gained a voice in public policy over the last 10 to 20 years. While often divided over priorities and ideologies, these groups express common concerns over the need for employment and the problems of discrimination. Their experience with employment, technical assistance, support groups, and public education has the potential to inform and promote ADA implementation.

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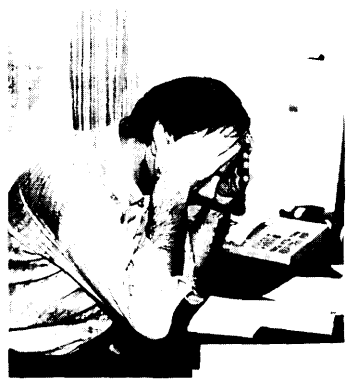
How the ADA and Research Define Psychiatric Disabilities

3

What is a disability? Being in a wheelchair? Not being able to see or hear? At first blush, the term may seem self-evident, conjuring up familiar images. But, in fact, disability is complex and much misunderstood. Various models and definitions of disability can be confusing (box 3-1). Stigmatizing stereotypes and misperceptions attached to disability further obscure its meaning. Finally, a disability is not simply what a person has, but reflects an individual's functional limitations and abilities, as well as the supports and demands of the environment in which that person lives and works.

Defining the disabilities that result from mental disorders may be even more difficult. Dubbed "invisible," psychiatric disabilities often are not obvious. Mental disorders engender such difficulties as problems in concentration or social interactions, which are usually not readily apparent. And public perceptions are even more fallacious and cruel: People with psychiatric disabilities often are considered dangerous, morally corrupt, inept, weak, or even fakes.

Clearly, the first order of business with the Americans With Disabilities Act (ADA) is the task of ensuring that all people who are affected by the law understand its definition of disability. Furthermore, implementing the ADA requires a nexus between the legal definitions and regulations and the true nature of these conditions. This chapter describes the ADA's definition of disability, along with relevant regulations and guidelines from the U.S. Equal Employment Opportunity Commission (EEOC), and how research characterizes these conditions.



BOX 3-1: Tower of Disability Babel

The endeavor to define disability in the ADA is not unprecedented. As noted in chapter 2, the ADA's specifications stem from a series of disability laws, regulations, and court decisions. Definitions of disability have evolved over the course of the 20th century, reflecting program, policy, and research needs. This box describes various models and definitions of disability as well as inconsistencies that flag the potential for conflict among disability programs and policies.

A recent study by the Institute of Medicine (IOM) described two major models for defining disability: the functional limitation model, developed by Nagi, and the World Health Organization (WHO) model. Both acknowledge three critical factors in disability: underlying impairment, functional result, and environmental influences. But they differ in their terminology and application.

The functional limitation model includes four stages on the path toward disability: pathology, impairment, functional limitation, and disability (figure 3-1). The concept of pathology refers to an abnormal change in a normal bodily process or structure that results from such factors as infection, trauma, or developmental process. *Impairment* reflects functional restrictions at the organ level, stemming from either pathologies or other mental, emotional, physiological, or anatomical losses or abnormalities. For example, symptoms such as hallucinations in schizophrenia represent an impairment in this framework. Restrictions on an individual's actions or activities—such as lifting a heavy weight or carrying on a coherent conversation—form *functional /imitations. Disability* refers to impaired performance of a socially defined role, reflecting an impairment or functional limitation and environmental supports and demands. This model notes that a variety of factors, such as treatment, financial resources, or personal expectations, can impinge on any stage. The model also asserts that disability is not the inevitable result of a pathological condition, impairment, or even functional limitation.

The WHO model for defining disability—WHO's 1980 International Classification of Impairments, Disabilities, and Handicaps (ICIDH)—is a taxonomy or classification system. Currently under revision, it is the most widely used system for classification in the world. Like the functional limitation model, the WHO model builds on four concepts: disease, impairment, disability, and handicap. The concept of *disease* stems directly from the medical model, referring to pathology in an individual. *Impairment is* any loss or abnormality of physiological, psychological, or anatomical structure or function. *Disability* results from impairment, referring to the inability or restricted ability to perform activities considered within the range normal for humans, Finally, a person is said to have a *handicap* when an impairment or disability limits or prevents role performance for that individual in society. Note that IOM's concept of disability is equivalent to handicap in WHO's model. Some, including the IOM, have criticized the ICIDH because of internal inconsistencies and the use of the term handicap, which generally is rejected as stigmatizing in the United States.

Public health entities are not the only ones to define disability In fact, the first definitions of disability came from rehabilitation, compensation, and insurance programs. Three programs, with differing definitions of disability, may be particularly relevant to the ADA's implementation:

Social Security Disability Programs: The U.S. Social Security Administration (SSA) operates two disability income maintenance programs. The Social Security Disability Insurance (SSDI) program is an insurance program for those who have become disabled. The Supplemental Security Income (SSI) program is a social welfare program for people who are blind, aged, or disabled. In both SSDI and SSI, people with psychiatric disabilities form the largest portion of beneficiaries. In 1991,24 percent of SSDI beneficiaries received financial support on the basis of mental disorders. In that same year, **27.4** percent of SSI beneficiaries with disabilities received financial support on the basis of mental disorders. Eligibility for these income-support programs hinges on the strictest of all definitions of vocational disability. As detailed in the Federal Social Security Act, disability is "the inability to engage in any substantial gainful

BOX 3-1: Tower of Disability Babel (cont'd.)

activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. "Guided by the statutory language, SSA developed an administrative procedure to determine disability status, based on medical and nonmedical evidence,

Vocational Rehabilitation The Rehabilitation Services Administration (RSA) administers vocational rehabilitation (VR) services, including employment potential assessment, vocational training, job placement, and followup support, under a Federal-State program. The Rehabilitation Act originally authorized the VR program in 1920 to help injured workers return to their jobs. Since 1975, amendments to the Rehabilitation Act gives priority of services to people with severe disabilities—'' persons who need multiple services over an extended period of time''—but who had demonstrable employment potential. The 1992 reauthorization reconciles the language and ideals of the VR program with those of the ADA. The law also specifies that people with the most severe disabilities should be served, asserting that any individual is employable given the proper support services and technology. Today, people with psychiatric disabilities are the second-largest group of applicants for VR services-17 percent of the client population served. However, experts and advocates claim that these individuals are underserved by this program and that vocational services remain a major need for this population. Data from the RSA indicate that people with psychiatric disabilities have the lowest rate of successful rehabilitation under this program.

Workers' Compensation Lost wages or earning capacity due to an employment-related injury or illness provides evidence of disability in workers' compensation programs. While varying somewhat among jurisdictions, eligibility determinations generally rest on medical documentation and resulting inability to work Rather than relying on an either/or proposition- disabled or not—information on the relative degree of disability (Is the disability temporary or permanent ? partial or complete?) is sought. Benefits in workers' compensation may cover medical care, wage replacement and compensation, and rehabilitation services. In the last 10 years, as wages and medical costs have increased, workers' compensation costs have risen significantly. The changing nature of work and evolving definitions of work-related disorders also have spawned new categories of disabilities, Stress-related disorders represent one example In California, they account for a 700 percent increase in claims between 1979 and 1988. Much debate surrounds the issue of fraudulent claims, the subjectivity of claims, as well as the difficulty such disorders present in separating job-related causes from aggravating personal factors.

As this review of the programs and academic models reveals, all consider impairment and its functional results as key concepts of disability but their definitions differ, Impairments can mean any impairment, or only those that result from injury on the job. Functional results can mean the inability to work over a long period of time, or refer to a temporary hiatus. Such distinctions are unavoidable with different program goals, and the ADA adds yet another set of definitions.

Confusion, conflict, and inefficiency evolve from this "tower of disability Babel, " however While a common nomenclature may not be possible, given the different policy and program goals, guidance on the jurisdictional overlaps would greatly assist employers, care providers, and those who enforce disability policy.

For example, some experts claim that compliance with the ADA in providing an accommodation for an injured worker can save employers money in workers' compensation, by putting the employee back to work. On the other hand, injured workers with no desire to return to work may use the ADA to increase workers' compensation settlements. Or, employers trying to limit the spiraling costs of workers' compensation, may medically screen out workers who may pose an increased risk of benefit utilization; this practice is forbidden by the ADA. The interplay of these different policies and programs warrants attention, both monitoring and guidance.

(continued)

BOX 3-1: Tower of Disability Babel (cont'd.)

So does determining disability. Many different experts—medical, psychological and rehabilitative—have considerable skill in this area. However, experience has shown that clinicians usually equate disability with a medical diagnosis, a determination that is not necessarily applicable under ADA. The development and dissemination of disability assessment methodologies that apply to different policies and programs may assist clinicians. It would also be helpful if academic models and classification systems better reflected program and policy language to provide a cross-walk between research and public policies, and if disability research reflected the policy definitions in use.

It is also notable that psychiatric disability has not always had an easy fit with disability models and programs. In each program discussed in this section—Workers' Compensation, SSDI and SSI, and VR—psychiatric disabilities have led, at one time or another, to controversy, fraudulent claims and abuse ,and/or people being undeserved. The debate surrounding workers' compensation and stress-related conditions was mentioned above. SSI and especially SSDI still pose work disincentives for people with psychiatric disabilities, although there have been some recent improvements. Also, experiences with SSI and SSDI in the early 1980s, and continuing in the VR program, show significant gaps in the service provided people with psychiatric disabilities. Not only are people with psychiatric disabilities among the largest constituencies in these programs, they are also among the most vulnerable because of stigma, the nature of their impairments, and service and support needs. These conditions also raise complex questions because of their behavioral manifestations and subjectivity of claims. This suggests that effective implementation of the ADA will hinge on accurate information on psychiatric disabilities and consideration of the special issues raised by this population. Advance attention to problems that occurred in other programs could prevent them in the ADA,

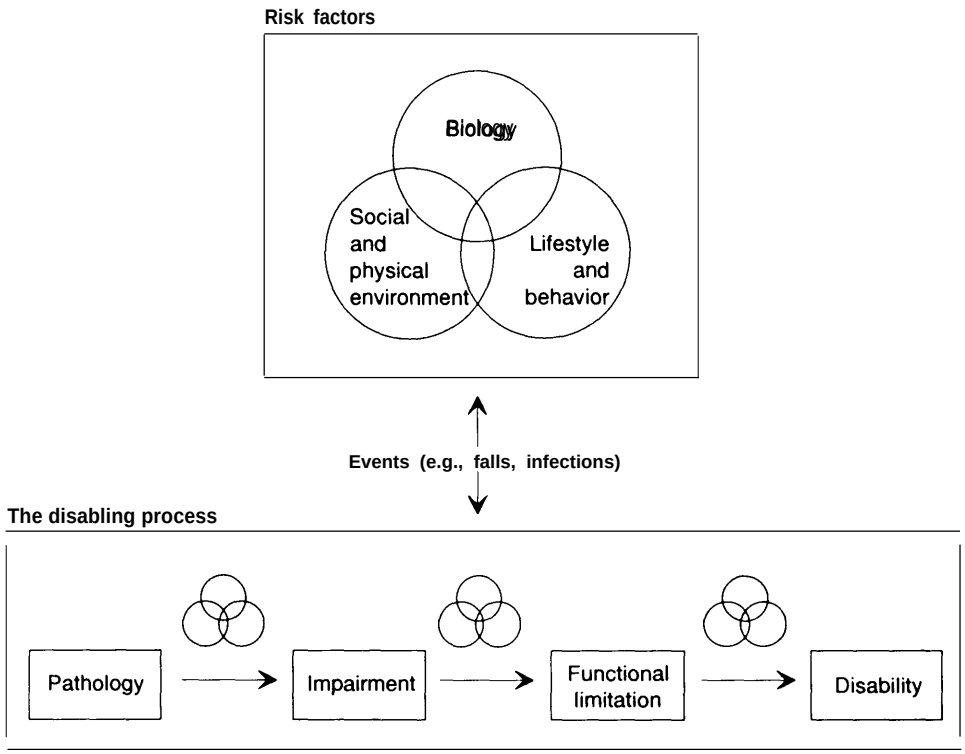
SOURCES. H. Andrews, J. Barker, J. Pittman et al., "National Trends in Vocational Rehabilitation: A Comparison of Individuals With Physical Disabilities and Individuals With Psychiatric Disabilities," *Journal of Rehabilitation* January-March 7-16, 1992, California Workers' Compensation Institute, *Mental Stress Claims in California Workers' Compensation—Incidence* (San Francisco, CA California Workers' Compensation Institute, 1990); Institute of Medicine, *Disability in America" Toward A National Agenda for Prevention,* AM, Pope and A R Tarlov (eds) (Washington, DC: National Academy Press, 1991); C Kennedy, and E.M Gruenberg, "A Lexicology for the Consequences of Mental Disorders," *Psychiatric Disability: Clinical, Legal and Administrative Dimensions,* A T Myerson and T Fine (eds) (Washington, DC: American Psychiatric Press, 1987), C Kennedy and R.W Manderscheid, "SSDI and SSI Disability Beneficiaries With Mental Disorders," *Mental Health, United States, 7992,* R.W Manderscheid and M A. Sonnenschein (eds), DHHS Pub No.(SMA) 92-1942 (Washington, DC. Superintendent of Documents, Government Printing Off Ice, 1992), J G Kilgour, "Workers' Compensation Problems and Solutions. The California Experience, " *Labor Law Journal* February :84-96, 1992, J C McElveen, Jr, "RecentTrends in Workers' Compensation, "Employee *Relations Law Journal* 18 255-271,1992, M D Tashjian, B J Hayward, S Stoddard et al , *Best Practice Study of Vocational Rehabilitation Services to Severely Mentally Ill Persons, Volume I Study Findings* (Washington, DC: Policy Study Associates, 1989); World Health Organization, International *Classification* of /impairments, *Disabilities, and Handicaps* (Geneva, Switzerland, World Health Organization, 1980)

THE ADA'S DEFINITION OF DISABILITY

Chapter 2 of this report introduces the ADA's three-pronged definition of disability: individuals with a current impairment that substantially limits a major life activity, those with a history of such impairment, or those perceived as having such an impairment. Regulations and interpretive guidelines from the EEOC[1] expound on this approach to disability, and draw from the ADA's legislative

[1]The EEOC **published regulations and interpretive guidelines for Title I of the ADA on** July 26, 1991. The guidelines reflect the EEOC's interpretation of the ADA; it will serve as the EEOC's guide when resolving charges of employment discrimination.

FIGURE 3-1: The Path to Disability



This model of disability endorsed by the Institute of Medicine in 1991, includes a progression from pathology and impairment to functional limitation and ultimately disability a state in which socially defined role performance is hampered. A variety of risk factors may affect various stages in the process.

SOURCE Adapted from Institute of Medicine, *Disability in America Toward a National Agenda for Prevention* (Washington, DC. National Academy Press, 1991).

history and regulations, and case law from section 504 of the Rehabilitation Act.

After repeating the ADA's disability definition, the EEOC expands on the first prong to include explicitly mental disorders: "Physical or mental impairment mean(s). . . [a]ny mental or psychological disorder, such as. . . emotional or mental illness. . . (56 FR 35735)." Note that the EEOC does not equate mental impairments with a particular diagnostic framework (e.g., the Diagnostic and Statistical Manual, third edition, revised--or DSM-III-R) (2).[2] However, many experts contend that as a practical matter, a DSM-III-R diagnosis will be necessary if not sufficient to cross the impairment threshold in the first prong of the ADA

2 The DSM-III-R, published by the American Psychiatric Association, is the most widely used mental health diagnostic manual in the world (2). The classification of mental disorders in the DSM-III-R is mostly based on symptoms, such as expressed mood or thought processes or on observed behaviors. in most cases, a DSM-diagnosable disorder is required for third-party reimbursement of treatment costs.

definition (12).[3] The EEOC further delimits the notion of impairment and specifies that an impairment exists even when the condition is completely controlled by medications or other devices (56 FR 35741). Distinguishing between "impairments and physical, psychological, environmental, cultural and economic characteristics that are not impairments" is, however, considered paramount. For example, normal traits, such as poor judgment or a quick temper, are deemed distinct from impairments (56 FR 35741).

ADA and EEOC regulations do not explicitly protect people genetically predisposed to a disease under this prong of the definition. Indeed, the EEOC's guidelines explicitly exclude "predisposition to illness or disease" in defining impairment.[4] Because some mental disorders have a genetic component and genetic tests for predisposition may become possible, this distinction could have future ramifications for people with psychiatric disabilities (19,46). Given concerns about employment and insurance discrimination against people with genetic diseases, some experts and advocates have urged the EEOC to delineate such coverage (51). However, others concerned about simplistic and discriminatory perceptions of genetic predisposition to illness maintain that it is critical to distinguish between such predisposition and the illness itself (10,37).

Two recent analyses note that courts rarely disputed whether an individual had a mental impairment under the Rehabilitation Act (19,40). According to Haggard, "the impairments to qualify for protection under the Rehabilitation Act [have included]: paranoid schizophrenia, manic-depression, depression, post-traumatic stress disorder, borderline personality disorder, schizoid personality disorder, passive aggressive personality disorder, kleptomania, apraxia, transsexual disorder, and mental retardation" (19). The ADA excludes some of these and other disorders—specifically, transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, other sexual behavior disorders, compulsive gambling, kleptomania, pyromania, or psychoactive substance use disorders resulting from current illegal use of drugs—as noted in chapter 2. While these restrictions are decried as stigmatizing (40), or at least detrimental to treatment (23), they reflect the contentious issues surrounding substance abuse and various DSM-III-R diagnoses (46).

Simply having an impairment—any impairment-does not equal having a disability under the first prong of the definition. The ADA further circumscribes the concept of disability by adding that the impairment must "substantially limit one or more of the major life activities (42 USC 12102 .3(2)(A))." The EEOC's spelling out of "substantially limits" and "major life activities" upholds the basic principle that a disability reflects impairment and functional result, although the interpretation of those terms will be difficult. In line with the spirit of the law and the opinion of many advocates, the EEOC's interpretation also asserts that the ADA's protection is for those with "significant" or nontrivial impairments. The EEOC's regulations state:

> *The term substantially limits means:*
>
> *(i) Unable to perform a major life activity* that the average *person in the general population can perform; or*
>
> *(ii) Significantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity as compared to the condition, manner or duration under which the average person in the*

[3] Not all conditions identified by some as psycho] ogical disorders are identifiable under the DSM-III-R, such as conditions in the occupational health arena and commonly investigated under the general rubric of "job stress." Some data suggest that these conditions, such as mood or anxiety disturbances, may limit functioning. However, staff at the EEOC has indicated to OTA that they "do not now, and do not currently plan to categorize 'stress' as a category of disability" (48).

[4] However, some interpret the ADA as providing protection for those predisposed to illness under the third prong of the definition (36).

general population can perform that same major life activity. . .

The following factors should be considered in determining whether an individual is substantially limited in a major life activity:

(i) The nature and severity of the impairment;

(ii) The duration or expected duration of the impairment; and

(iii) The permanent or long term impact, or the expected permanent or long term impact of or resulting from the impairment (56 FR 35735).

As noted above, this explanation connotes significant impairment. Certain mental disorders, by their very nature, possibly could be considered a disability under the ADA. The EEOC guidelines state:

The determination of whether an individual has a disability is not necessarily based on the name or diagnosis of the impairment the person has, but rather on the effect of that impairment on the life of the individual. Some impairments may be disabling for particular individuals but not for others, depending on the stage of the disease or disorder, the presence of other impairments that combine to make the impairment disabling or any number of other factors. Other impairments, however, . . are inherently substantially limiting (56 FR 35741).

Certain mental disorders are, by their nature and definition, chronic and quite disabling. For example, the DSM-III-R diagnostic criteria for schizophrenia include severe symptoms (e.g., hallucinations and catatonic behavior), marked functional impairment, and a duration of at least 6 months (2). People with schizophrenia often suffer a lifelong, degenerating course. Certainly the determination of a work accommodation normally requires more information than a diagnosis, for mental disorders or other conditions. And some advocates and experts note that classifying a particular disorder as "severe" or "chronic" can be stigmatizing. Nonetheless, it is clear that the diagnostic criteria for certain mental disorders make them, by definition, "inherently substantially limiting." Advice to the EEOC on this point from experts and advocates could assist in delineating diagnoses that fall in this category.

Another point to consider, in regard to the definition of "substantially limiting," is the duration of an impairment. The EEOC, in its regulations and guidelines, asserts that the duration of an impairment is an important consideration in determining whether it is substantially limiting. The guidelines elaborate: "[T]emporary, non-chronic impairments of short duration, with little or no long term or permanent impact, are usually not disabilities" (56 FR 35741). Department of Justice regulations for Title II also indicate, in slightly different language, that "short-term or transitory illnesses are not disabilities if they do not place a substantial limitation on a person major life activities." Some mental health advocates and experts object to defining "substantial limitation" in terms of duration or temporal limits (24). While the guidelines do not list a psychiatric impairment as an example ("[S]uch impairments may include, but are not limited to, broken limbs, sprained joints, concussions, appendicitis, and influenza."), conditions such as short-term depression following the loss of a spouse, which is a temporally delimited mental disorder included in the DSM-III-R, may not be considered disabilities under this rationale.

Mental health experts and advocates have expressed concern over how impairments that episodically remit then intensify fit into the ADA's definition of disability (40). While many major mental disorders are chronic conditions, like some physical impairments (e.g., multiple sclerosis), symptoms may wax and wane over time. EEOC staff indicated to OTA that a new chapter for the compliance manual on the topic of "Disability" will expressly address this issue. "Episodic disorders, which remit and then intensify, may be ADA disabilities. They may be substantially limiting when active or may have a high likelihood of reoccurrence in substantially limiting forms. In addition, such conditions may require a substantial limitation of a major life activity to prevent or to lessen the likelihood or severity of recurrence. Fi-

nally, side effects of medications may be substantially limiting in themselves" (48).

"Major life activities" is the other defining term discussed by the EEOC: an impairment rises to the level of disability if it limits a major life activity. The EEOC defines major life activities in its regulations as "functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." The interpretive guidelines provide further details: "Major life activities are those basic activities that the average person in the general population can perform with little or no difficulty. Major life activities include caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working" (56 FR 35741).

Even though the list of major life activities provided by the EEOC is not meant to be exhaustive, many mental health advocates and experts have criticized it, asserting that none of the examples is especially relevant to psychiatric disabilities (19,40). To quote the American Psychological Association's comment on the regulations:

> In the listing of "major life activities," the only activity listed which is likely to pertain to people with mental disabilities is "working." "Working" is a very general term and so persons with mental disabilities will be put in the difficult and possibly untenable position of having to prove they are qualified to work at the same time that they have to demonstrate that they are substantially limited in their ability to work in order to be covered by the ADA (3).

It is important to note that neither the EEOC nor all mental health experts concur with this viewpoint (29). As noted by analysts with the EEOC, "In our view, the major life activities of learning, caring for oneself, and performing manual tasks all may be substantially limited by psychiatric disorders or by the side effects of psychotropic medications" (48). Advocates' concerns reflect, in part, the fact that people do not generally appreciate how mental disorders can impair function.

Various mental health advocates have suggested that the following life functions be added to EEOC technical assistance materials or guidelines: remembering, concentrating, thinking, information processing, communicating, perceiving, reasoning, and maintaining social relationships (3,40). Although the list of major life activities in the EEOC's guidelines is not meant to be exhaustive, more explicit guidance in terms of mental disorders and related disabilities would undoubtedly be very useful to employers and employees attempting to implement the ADA. The next section summarizes information on the functions and activities that are limited in psychiatric conditions.

It is also relevant to note how the EEOC defines a substantial limitation in the major life activity of working. First, the EEOC states that this consideration is one of last resort. "If an individual is substantially limited in any other major life activity, no determination should be made as to whether the individual is substantially limited in working" (56 FR 35741). In the absence of a limitation in other major life activities, the EEOC advises an individualized evaluation of work limitation. Consideration should be given, in the view of the EEOC, to the geographic area to which an individual has reasonable access, as well as the number and types of jobs—with similar or distinct qualification demands—affected by the work limitation. The EEOC is careful to note that "an individual does not have to be totally unable to work in order to be considered substantially limited in the major life activity of working.

While the guidelines do not provide a description, they do refer to a case relevant to psychiatric disabilities brought under the Rehabilitation *Act—Forrisi v. Bowen, 794* F. 2d 931, 934 (4th Cir. 1986). This case shows that while courts have been expansive in defining mental impairment per se, substantially limiting psychiatric impairments have sometimes been defined more restrictively. In this particular case, the court held that acrophobia—fear of heights-did not substantially limit a utility systems repairman from jobs that do not require climbing and exposure to heights; he did not have a disability under the law.

The last two prongs of the ADA's disability definition add a record of past impairment and the perception of such an impairment in the law's definition of disability:

> *Has a record of such impairment means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.*
>
> *Is regarded as having such an impairment means :*
>
> *(1) Has a physical or mental impairment that does not substantially limit major life activities but is treated. . . as constituting such limitation;*
>
> *(2) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or*
>
> *(3) Has none of the impairments defined (above). . . but is treated by a covered entity as having a substantially limiting impairment (56 FR 35735).*

The law itself, these regulations, and guidelines from the EEOC reflect an attitude of zero-tolerance for employment decisions based on stereotypes or discriminatory beliefs. The often-cited decision of the U.S. Supreme Court in *School Board of Nassau County v. Arline (1987)* underscores the point that the attitudes of others are important contributors to disability:

> *. . . [S]ociety's accumulated myths and fears about ability and diseases are as handicapping as are the physical limitations that flow from the actual impairment (480 U.S. 273 (1987)).*

As noted in chapter 2, the stigma attached to psychiatric disabilities epitomizes this U.S. Supreme Court finding. Indeed, the negative attitudes surrounding mental disorders are so strong that job application forms commonly asked: "Have you had a nervous breakdown?"" Have you ever been hospitalized in a mental institution?" or "Have you ever received treatment for a nervous or emotionaI condition?" These questions evince the firmly entrenched belief in our society that mental illness, present or past, is incompatible with work. Research and experience reflected in the second part of this chapter show that this simplistic belief is false.

The ADA should make such questions a thing of the past.[5] Title I of the ADA prohibits employers from asking applicants about their disabilities, an important protection for such "invisible" conditions as psychiatric disabilities. Under the ADA, employers are barred from using any source of information about disability status—voluntary medical examinations, educational records, prior employment records, billing information from health insurance, psychological tests, and others. In addition to prohibiting pre-job-offer medical exams and prescribing a specific mechanism for conducting post-offer exams, the burden of proof placed on employers serves to protect applicants and employees with disabilities. While the burden of proving that one is disabled under the ADA's definition lies with the individual alleging discrimination, the EEOC's guidelines indicate that the second prong "of the definition is satisfied if a record relied on by an employer indicates that the individual has or has had a substantially limiting impairment." In terms of the third prong of the ADA's definition of disability, the EEOC guidelines require employers to "articulate a non-discriminatory reason for the employment action. . . (or else) an inference that the employer is acting on the basis of 'myth, fear or stereotype' can be drawn" (56 FR 35743).

RESEARCH CHARACTERIZATIONS OF PSYCHIATRIC DISABILITIES

The above discussion reveals several questions about psychiatric disability that are relevant under the ADA. How do mental disorders affect life activities? Which impairments are most limiting? How long do the symptoms and functional limitations of various mental disorders last, and do they

[5] It is interesting to note that questions on applications for Federal jobs persisted for as long as a decade after becoming illegal under the Rehabilitation Act (45). To the knowledge of OTA, no data address whether this is the case for the ADA.

TABLE 3-1: Some Serious Mental Disorders

Disorder	Some common symptoms	Common treatment approaches
Schizophrenia	Delusions, hallucinations; impaired ability to integrate information, to reason, to concentrate, or to focus attention; usually marked by incoherence, bizarre behavior, suspicion, paranoia (psyohotic or "positive" symptoms); dulling of emotions or inappropriateness of emotional response (e.g., a "wooden" personality), apathy, social withdrawal (nonpsychotic or "negative" symptoms). Symptoms vary widely among patients, combine In different ways, and may change over time.	Treatment usually integrates antipsychotic medications to manage psychosis and supportive psychotherapy aimed at helping individuals understand illness reduce stress, and enhance coping skills; may involve hospitalization.
Major depression	Complete loss of interest or pleasure in activities; weight gain or loss; insomnia or hypersomnia; slowed or agitated movement; fatigue; intense feelings of guilt or worthlessness; diminished ability to think or concentrate; recurrent thoughts of death or suicide.	Treatment often consists of antidepressant medications and/or various forms of psychotherapy; short term hospitalization and/or electroconvulsivetherapy (ECT) may be required in severe oases.
Bipolar disorder (manic-depression)	Symptoms of depression are described above. Mania is characterized by an extremely elevated, expansive, or irritable mood; inflated self-esteem or grandiosity; decreased need for sleep; extremely talkative and distractible; agitated motion; excessive Involvement In pleasurable activities (e.g., buying sprees, sexual indiscretions); psyohotic symptoms (delusions and hallucinations) may also occur.	Depressive episodes are treated as above. Manic episodes are usually treated with lithlum carbonate. Psychosis maybe treated with antipsychotic drugs; hospitalization may be required.
Obsessive-com pulsive disorder	Obsessions are recurrent and persistent ideas, thoughts, impulses, or images (e.g., the feeling of being dirty, the desire for symmetry) that although irrational and unwanted, cannot be resisted. Compulsions are repetitive, purposeful, and intentional behaviors (e.g., hand-washing, checking if stove Is on or door is looked). The obsessions or compulsions cause marked distress, are time-consuming, or significantly interfere with the person's normal routine.	Treatment currently conslsts of medication and/or behavioral therapy.
Panic disorder	Hallmark symptom includes sudden, inexplicable attacks of intense fear that is associated with powerful physical symptoms, including shortness of breath, dizziness or faintness, trembling, sweating, choking, nausea numbness, flushes, chest pain, fear of dying, fear of going crazy, or of doing something uncontrolled. May be associated with agoraphobia--fear of being in public places.	Treatment may Include mediation (antidepressant tier antianxiety drugs) or psychotherapy (especially behavioral and cognitive therapies as well as relaxation techniques), or both.

SOURCE: U.S. Congress, Office of Technology Assessment, *The Biology of Mental Disorders*, OTA-BA-538 (Washington, DC: U.S. Government Printing office, September 1992).

recur? Many of the legal issues concerned with these questions await further governmental guidance and adjudication. However, knowledge from research on and past experience with mental disorders can assist ADA implementation. This section describes current models of and provides information on psychiatric disabilities.

Mental disorders and their functional sequelae are prevalent and costly to society at large and in the workplace:

- People with mental disorders account for approximately 10 percent of the charges filed by individuals with the EEOC between July 26,

1992 and October 31, 1993; they represent the second largest population of disabilities (48).[6]

- Decreased productivity and lost work days are the largest cost imposed by mental disorders on society. Of the total estimated cost of $136.1 billion in 1991, $60.0 billion or nearly 50 percent accrued from lost output, exceeding the cost of hospitalization, care provider consultation, and medication combined (38,43).
- Data from a recent survey of white collar workers confirm the high toll of depression on business: 9 percent of the men and 17 percent of the women surveyed experienced an episode of major depression during the previous year. More than 50 percent of employees with depressive symptoms reported work impairments (14).
- Data from several studies link depression to disability at work (13,22,50): Individuals with depression were shown to experience four times as many disability days when compared to asymptomatic individuals. In fact, depressive symptoms lead to levels of disability comparable to major heart conditions and exceed other major medical disorders such as diabetes. Furthermore, simply the presence of depressive symptoms—far below the threshold for a diagnosis of major depression—significantly impairs functioning.

What are mental disorders? As noted in an earlier OTA report, *The Biology of Mental Disorders (46),* mental disorders encompass abroad range of conditions, classified on the basis of expressed thought processes or emotions, observed behaviors, physical symptoms, and functional impairments. Some of the most common and serious conditions afflicting American adults, their symptoms and common treatments are listed in table 3-1. As in physical conditions, mental disorders can range from temporary, relatively minor conditions to chronic and severely incapacitating disorders. The more common and serious conditions listed in table 3-1 typically have a chronic course, with symptoms remitting and relapsing. While the causes of many mental disorders have not been determined, ongoing research is providing more clues about the biological and psychological substrates and contributors. Furthermore, in many cases effective treatment approaches, including medication and psychotherapy, are available (47).

TABLE 3–2: One-Year Prevalence of Some Mental Disorders Among American Adults

Type of disorder	One year prevalence rate (percent + standard error)	Estimated number of persons
Schizophrenic disorders	1.1 + 0.1	1,749,000
Mood disorders	9.5 + 0.3	15,143,000
. Bipolar disorder	1.2 + 0.1	1,908,000
• Major depression	5.0 + 0.2	7,950,000
. Dysthymia	5.4 + 0.2	8,586,000
Anxiety disorders	12.6 + 0.3	20,034,000
. Phobic disorders	10.9 + 0.3	17,331,000
• Panic disorders	1.3 + 0.1	2,067,000
. Obsessive-compulsive disorder	2.1 + 0.1	3,339,000
Antisocial personality disorder	1.5 + 0.1	2,385,000
Any mental disorder	22.1 + 0.4	35,139,000
Any mental/substance abuse disorder	28.1 + 0.5	44,679,000

SOURCE: D.A. Regier, W.E. Narrow, D.S. Rae et al., The de Facto U.S. Mental and Addictive Disorders Service System: Epidemiologic Catchment Area Prospective l-Year Prevalence Rates of Disorders and Services," *Archives of General* Psychiatry 50:85-94, 1993.

Just how prevalent are mental disorders? The most recently reported findings from the National Institute of Mental Health's (NIMH's) Epidemiologic Catchment Area (ECA) program[7] show that more than one in five American adults has a diagnosable mental disorder in a given year (42) (table 3-2). Conditions range from the less common dis-

6 Chapter 5 provides a complete description of the EEOC's process for handling charges under the ADA.

7 The Epidemiologic Catchment Area (ECA) program involved face-to-face interviews of more than 20,000 adults living in communities and institutions. Data on the prevalence of mental and addictive disorders were collected between 1980 and 1985 in five regions of the United States. A complete description of the ECA program is available (44).

TABLE 3–3: Use of Mental or Addictive Disorder Services in One Year

Service setting	Percent of population	Estimated number of persons
Specialty mental health/addictive	5.9	9,361,000
General medical	6.4	10,043,000
Other human services	12.5	19,734,000
Voluntary supports	4.1	6,535,000
Total*	14.7	23,107,000

Total is lees than sum of service in each setting since individuals often access more than one type of provider.

SOURCE: D.A. Regier, W.W. Narrow, D.S. Rae et al., "The de Facto U.S. Mental and Addictive Disorders Service System: Epidemiologic Catchment Area Prospective l-Year Prevalence Rates of Disorders and Services," Archives *of General Psychiatry 50:35-94, 1993.*

orders of schizophrenia and bipolar disorder, with a 1-year prevalence rate of 1.1 ± 0.1 percent and 1.2 ± 0.1 percent, respectively, to the exceedingly prevalent mood disorders of major depression (5.0 ± 0.2 percent), and dysthymia (5.4 ± 0.2 percent). The ECA data also reveal that 14.7 percent of American adults—more than 23 million people—sought treatment for mental or addictive disorders from mental health specialists, primary care providers, other human service personnel (such as pastoral counselors), and/or peers, families, and friends (table 3-3).[8]

The ECA data underline the broad spectrum of diagnoses and service needs that typify mental health problems in the United States. Although it is clear that all of these conditions would not equal disabilities under the ADA, this diversity will undoubtedly surface in the workplace, as indicated by requests received by the Job Accommodation Network (JAN),[9] which is funded by the President's Committee on the Employment of People with Disabilities. While 47 percent of the inquiries received by JAN related to mood disorders, calls sought information on a wide variety of mental disorders (table 3-4). What these data on diagnoses, symptoms, and service use do not reveal is the nature of associated disabilities.

Current models of psychiatric disability began with the need to apportion resources and to deliver useful services. Psychiatric or psychosocial rehabilitation comprises a broad range of services that "assist persons with long-term psychiatric disabilities increase their functioning so that they are successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention" (5,7). The psychosocial reha-

TABLE 3–4: Inquiries Received by the JAN on Specific Mental Disorders

Specific disorder*	Percent (%) of total inquiries on mental disorders
Bipolar disorder (manic depression)	30
Depression	17
Schizophrenia.	15
Stress/anxiety	11
Phobias	7
Other (personality disorder, post traumatic stress disorder, obsessive-compulsive disorder)	20

● As specified by caller.

SOURCE: Job Accommodation Network, 1993.

[8] ECA data reveal two issues worthy of comment. First, most people with diagnosable mental or addictive disorders-71.5 percent-receive no treatment or service. Even people with the most serious diagnoses—schizophrenia, major depression, obsessive-compulsive disorder, and panic disorder-receive treatment only 45 to 65 percent of the time. The gap between diagnosis and treatment may reflect transient symptoms for which treatment was not sought, inadequate access to mental health care, lack of recognition on the part of a care provider, or other factors.

The second issue concerning service use and prevalence involves the many individuals without a diagnosable disorder who receive treatment: 46 percent of those receiving treatment fail under this category. The ECA data offer some clues about this apparent discrepancy. The vast majority of those receiving care without a current diagnosis have a history of a serious mental disorder (schizophrenia, bipolar disorder, major depression, and panic disorder) or significant, if diagnostically subthreshold, symptoms.

[9] The Job Accommodation Network or JAN is a government-funded technical assistance program aimed at offering employers and employees practical advice on how to accommodate disabilities in the workplace. A complete description of JAN appears in chapter 5.

TABLE 3–5: Psychosocial Rehabilitation Model of Psychiatric Disability

Stages:	1. Impairment	II. Disability	III. Handicap
Definitions:	Any loss or abnormality of psychological, physiological, or anatomical structure or function.	Any restriction or lack of ability, resulting from an impairment, to perform an activity in the manner or within the range considered normal for a human being.	A disadvantage, resulting from an impairment and/or a disability, for a given individual that limits or prevents the fulfillment of a role that is normal (depending on age, sex, social, cultural factors) for that individual.
Exam pies:	Hallucinations, delusions, depression.	Lack of work adjustment skills or social skills.	Unemployment.

SOURCE: W. Anthony, H. Cohen, and M. Farkas, *Psychiatric Rehabilitation(Boston,* MA: Center for Psychiatric Rehabilitation, 1990).

bilitation model, based on the WHO's model for disability (5,21 ,27) (table 3-5), specifies that an impairment, which entails the symptoms of a mental disorder, may restrict certain skills or functions including various social skills. Psychiatric disabilities may impede an individuals' ability to fulfill certain roles, such as holding a job. This model has clear implications for service delivery: While treatment to alleviate a psychiatric impairment remains important, interventions geared toward improving skills, functional performance and environmental supports are also critical.

What data exist concerning the prevalence and nature of psychiatric disabilities (box 3-2)? No data specify how many people with psychiatric disabilities are covered by the ADA. However, recent information from a random survey of adults living in communities detail the prevalence of psychiatric disabilities and associated serious limitations in activity (8). The results of the 1989 supplement to the National Health Interview Survey indicate that approximately 5 million adults with 3.3 million currently in communities—1.8 percent of the total population—have a serious mental illness: a mental disorder during the past year that seriously interfered with daily life. Nearly 80 percent of individuals with a psychiatric impairment were limited in: taking care of personal needs such as eating, dressing, and bathing (activities of daily living); managing money, doing everyday household chores, and getting around outside the home (instrumental activities of daily living); and, cognitive and social functioning. Impaired functioning translated into employment problems for many: Nearly 50 percent of the people with serious mental illnesses between the ages of 18 and 69 were either completely unable to work (28.9 percent) or limited in work (18.4 percent). Unsurprisingly, a significant fraction of these individual s—23.2 percent—receive disability payments from the government, because of their mental conditions.

This study also defines functional limitations that stem from mental disorders and are especially relevant to employment. More than 90 percent of those restricted in work: 1) experience problems in social functioning; 2) have problems coping with day-to-day stress; and 3) find it difficult to concentrate long enough to complete tasks (table 3-6). These data mirror guidelines for assessing disability (e.g., SSA disability determinations), experience in service delivery, and a large body of research (17). Preliminary data and analysis related to the ADA also echo these findings. Telephone requests handled by JAN since the ADA's implementation identify stress intolerance as an important functional limitation in mental illness (25). Other limitations related by callers include behavior that may contribute to problems in interpersonal relationships, and the reduced ability to concentrate. Similarly, in a report on 12 employed individuals with serious mental disorders, common functional limitations included difficulty concentrating, handling stress, initiating personal contact, and responding to negative feedback (31).

While the conceptual model of psychiatric disabilities embrace the notion of impairment and

BOX 3-2: Federal Measures of Disabilities

Measures of disability can be quite useful to policymakers, Information on prevalence, longitudinal course, and associated socioeconomic status can aid in service planning, resource distribution, and the assessment of enacted policies The Federal Government collects some relevant information on disability in general, and psychiatric disabilities specifically. Several analyses have concluded, however, that these efforts contribute to a shallow and irregularly updated database.

The National Health Interview Survey (NHIS) is the Federal Government's most regular collection of information on disabilities. Conducted by the National Center for Health Statistics every 2 years, the NHIS collects data concerning existing impairments and activity limitations in noninstitutionalized individuals Another source of information on disabilities is the Survey of Income and Program Participation (SIPP), conducted by the U.S. Census Bureau since 1983. SIPP is an ongoing study of the economic well-being of U.S. households. As part of the third round of interviews, data were collected on functional limitations, work limitations, and the receipt of Social Security or Veterans disability benefits, Finally, the Current Population Survey (CPS), in which the U. S. Department of Labor collects data on the work status of the population each month, solicits information on disability status in each March supplement

NH IS, SIPP, and CPS provide limited information on disabilities in general; The data they provide on psychiatric disabilities are even more scant. To augment the Nation's database on disabilities in general and psychiatric disabilities specifically, a special survey to supplement the NHIS is underway. The survey was planned to provide a depth of data heretofore unknown in the field of disability statistics, In addition to information on health status, health care utilization, and activity limitation, the survey includes a variety of questions on impairments (e.g , severity, nature, onset, and duration), receipt of benefits, employment status, work accommodations, earnings, use of vocational rehabilitation services, social interactions, and self-perceptions of disability. The survey also provides an opportunity for longitudinal study. Furthermore, a group of experts developed a new section on psychiatric and cognitive impairments,

To improve the Nation's database on psychiatric disabilities, the Center for Mental Health Services (CMHS) has developed the Uniform Client Data Instrument (UCDI) to assess psychiatric disability, The UCDI incorporates questions on psychiatric symptomatology, daily activities, social functioning, behavioral

functional limitation, the relative role of each factor in work is unclear and controversial. On the one hand, many people in the psychosocial rehabilitation community disavow a high correlation between symptoms or diagnosis and employment outcome (4,5,35).

> A number of studies illustrate the lack of relationship between a variety of assessments of psychiatric symptomatology and future ability to live and work independently. . . Although occasional studies do report a relationship between a type of symptom and rehabilitative outcome . . . the evidence is overwhelming that little or no relationship exists (5).

On the other hand, some researchers offer evidence of significant correlation between psychopathology and work performance. For example, data from a recently completed study of nearly 500 individuals with various mental and addictive disorders implicate a close correlation between the type and severity of symptoms and work performance and employment (28,30,32).

> [A]ssessments of psychiatric symptoms and vocational performance . . . documented that severity of psychiatric symptoms was significantly related to the functional capacity for work in a wide variety of mental disorders. Persons with psychotic disorders performed much more poorly on work performance than those with nonpsychotic disorders (30).

These seemingly antithetical results reflect differing measures of psychiatric symptomatology,

BOX 3-2: Federal Measures of Disabilities (cont'd.)

problems at home and/or work, and substance abuse, The UCDI was incorporated into the National Medical Expenditures Survey (conducted in 1986, data not yet available). More recently, the UCDI was incorporated into a supplement to the NH IS; the data are described in table 3-6. While much of the regular CMHS' data collection focuses on service providers and use, a current project—the Longitudinal Client Sample Survey of Outpatient Mental Health Programs—will include information on client functioning. But, Federal support for the collection, analyses, and reporting of national statistics on mental health services and client characteristics has been precarious over the last several years, in that it has not had an official budget of its own Prior to fiscal year 1989, the program received funds from program management and support accounts at NIMH. Since that time, $5.1 million in fiscal year 1992 and $8,8 million in fiscal year 1993 came from a mental health block grant set-aside.

Information relating to the impact of the ADA on employment is not addressed by any of the ongoing or planned Federal surveys. Data are lacking on the hiring of people with psychiatric disabilities, discrimination and other problems in the workplace, or the attitudes of employers and employees about the ADA and psychiatric disabilities Indeed, which people with mental disorders are covered by the ADA is not clear. Some analysts have suggested that the EEOC, which now collects information from large employers on the hiring of women and minorities, could monitor such trends among people with disabilities as well, to establish a statistical basis for discrimination. Also, surveys by Federal granting agencies, including the CMHS, NIMH, or the National Institute on Disability and Rehabilitation Research, could incorporate the ADA's definition of disability and ask questions about employment experiences.

SOURCES Institute of Medicine, *Disability in America Toward a National Agenda for Prevention* (Washington, DC: NationalAcademy of Sciences, 1991), E HYelin "The Recent History and Immediate Future of Employment Among Persons With Disabilities, "*The Americans With Disabilities Act From Policy to Practice*, J West (ed) (New York, NY Milbank Memorial Fund, 1991), R. Manderscheid, Director, Division of State and Community Systems Development, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Rockville, MD, personal communication, February 1993, M Adler, Office of the Assistant Secretary for Planning and Evaluation, U S Department of Health and Human Services, Washington, DC, personal communication, January 1993

measures of work performance, and vocational outcomes. Furthermore, treatment status and individual ability are almost always ignored in these studies as are traditional labor force predictors (e.g., age, gender, ethnicity, and social class), the type or amount of any vocational services that the individual may have received, and prior job history (15).[10] Complete resolution of how impairment, functional limitation, and work disability relate to one another awaits further research (box 3-3). That is not to say that some conclusions cannot be drawn. Data and experience permit the following assertions.

Psychiatric symptomatology has practical relevance for employment. Some research data suggest an important link between certain psychiatric impairments and ability to work. Indeed, several scholars, upon review of the research literature, acknowledge data supporting the link between symptoms and functioning, and point out the association between severe and chronic conditions, psychotic features, and subsets of symp-

10 Other factors to be considered are changes i, the demand for labor, the changing roles of men and women in work, and changing industrial structure. Preliminary data suggest that people with psychiatric disabilities fared more poorly than people with other types of disabilities during the 1980s, with a general increase in the unemployment rate (52).

TABLE 3–6: Serious Mental Illness, Functional Limitatior

Work limitation status among people 18-69 years of age	Total with serious mental illness (in 1,000's)	Limited in personal care activities such as eating, dressing, and bathing (% of total)	Limited in instrumental activities of daily living such as managing money, household chores (% of total)	Limited In social functioning (% of total)	Limited in coping with day-to-day stress (% of total)	Limited in concentrating long enough to complete tasks (% of total)
Unable to work	829	7.7	48.8	70.4	86.5	72.9
Limited in work	529	2.6	30.2	61.2	80.1	67.2
No current work limitation	1,032		4.6	26.8	52.6	21.4
Does not work for other reasons or work limitation status unknown	485		9.8	30.7	54.3	32.0
Total	2,874	2.7	22.9	46.3	67.7	46.5

SOURCE: P.R. Barker, R.W. Manderscheid, G.E. Hendershot et al., "Serious Mental Illness and Disability in the Adult Household Population: United States, 1989," *Advance Data Frum VW/and Health Statistics of the Center for Disease Control/National Center for Health Statistics, Sept. 16, 1992.*

BOX 3-3: Assessing Psychiatric Disability

Models of disability and data from research show that identifying a particular diagnosis or symptom is insufficient to determine the severity of disability, required services, or work limitations In order to qualify for the ADA's protections a person must be an individual with an impairment that "substantially limit(s) one or more of the major life activities " EEOC investigators, employers, people with mental disorders, and mental health care providers face the challenge of determining who with a mental disorder has a psychiatric disability under the law

The Status of Functional Assessment

Questionnaires, interviewing techniques, and observational approaches have been developed to assess disability, and disability assessment has become a standard part of vocational and psychosocial rehabilitation services. The goals of assessment maybe very general, aimed at measuring social skills, the ability to maneuver every-day requirements, and work performance; or very specific, aimed at specific disorders and functions Recent analyses have documented shortcomings of these disability assessment methods Following a comprehensive review, one researcher concluded that no one instrument was wholly adequate for assessing functional impairments Recently this same scholar noted that:

> [B]etter methods of assessment would Improve both the interpretation of future evaluations and current clinical practice Most evaluations use relatively idiosyncratic methods of measuring role functioning What is needed is an easily administered, low-cost assessment tool that not only measures individuals' impairments and role functioning, but provides information that is directly relevant to treatment decisions.

Similarly, expert reviewers of social functioning measures concluded that modest reliability and the lack of evaluation limit the usefulness of available assessment tools Furthermore, they concluded, none is simple enough for routine clinical use These conclusions are in the National Institute of Mental Health's plan for services research, which states that

> [a]lthough [dlsability] assessment seems logical and straightforward enough, the truth is that the mental health field is still without an adequate arsenal of Instruments and techniques to fully accomplish the task No aspect of clinical services-or of research designed to improve such services-can prosper without the availability of meaningful and valid techniques for assessing the status of mentally ill patients, not only in purely clinical terms but also in terms of their everyday functioning in the real world and their strength on which rehabilitation can build Needed are ways to assess general health status and physical functioning, the quality of the patient's life, the nature of the family's burden, and the patient's rehabilitation potential and progress.

Disability Assessment at the Social Security Administration

The experience of the Social Security Administration (SSA) illuminates the pitfalls of implementing disability assessment SSA administers two disability income maintenance programs the Social Security Disability Insurance (SSDI) program and Supplemental Security Income (SSI) program Eligibility for these programs hinges on the inability to work. The methods used by SSA to assess severe psychiatric disability in the 1980s was said to be difficult to use, too subjective, out of date, and discriminatory. "The essential problem is. that it is not possible to construct a set of medical and vocational standards that will distinguish perfectly between those who are able to work and those who are not able to work " The public outcry that resulted from a disproportionate number of people with severe mental disorders being terminated from the programs led Congress to order a revision of SSA's psychiatric disability assessment methods The new method includes the consideration of diagnosis as well as limitations in four areas of functioning: activities of daily living, social relations: cognitive functioning such as concentration, persistence, and pace; and decompensation or deterioration in work Consideration of environmental interventions was also provided as an option in the assessment

(continued)

BOX 3-3: Assessing Psychiatric Disability (cont'd.)

SSA's current disability determination is not without its critics: An American Psychiatric Association study of the new guidelines indicates that additional changes may improve the disability determination; the use of this assessment method by psychiatrists and other care providers also warrants improvement; some have criticized the increasing number of people with psychiatric disabilities who now receive SSI or SSDI.

It should be noted that the SSA's disability determination procedure is not appropriate for the ADA. The elaborate hurdle that people with disabilities must vault to receive SSA program benefits would limit unduly the ADA-guaranteed protections against discrimination. In addition, the definition of disability under the ADA obviously is not limited to individuals who cannot work at all.

Functional Assessment and the ADA

The ADA defines disability in terms of impairment and functional limitations. In general, an applicant or employee discloses the presence of a disability to an employer or covered entity, often providing very limited information. The employer may require confirmation of a disability that is not readily apparent, such as a psychiatric disability. Also, the EEOC must make a determination as to whether an individual is considered disabled under the ADA in the event that a charge of discrimination is filed. To date, in its computerized charge data system, the EEOC simply lists the marginally informative term "mental illness" as the impairment relevant to psychiatric disability.[1] The EEOC will be implementing anew coding system for disabilities in fiscal year 1994 and it will include a category for "emotional/psychiatric impairment, " under which there will be separate entries for anxiety disorder, depression, manic-depressive disorder, schizophrenia, and other emotional/psychiatric condition where none of the above clearly apply. What doesn't exist are guidelines for determining who with a mental disorder has an impairment that substantially limits a major life activity—is disabled under the ADA's definition. Convening a group of experts and interested parties to help fashion guidance for EEOC investigators and others, concerning diagnoses and other assessment criteria relevant to the ADA and employment would be useful. Continued research and the development of functional assessment tools also represent critical needs.

[1] Mental retardation is appropriately listed separately from mental illness

SOURCES. C Koyanagi and H. Goldman, *Inching Forward. A Report on Progress Made in Federal Mental Health Policy in the 1980s* (National Mental Health Association, 1991), U.S. Department of Health and Human Services, *Toward a National Plan for the Chronically Mentally Ill* (Public Health Service, Washington, DC, 1980); H.A Pincus, C. Kennedy, and S J Simmens, American Psychiatric Association, Washington, DC, "Study of SSA Methods and Standards for Evaluating Disability Based on Mental Impairment, " final report to Social Security Administration (SSA-600-84-0174), November 1987; H.A Pincus, C. Kennedy, S.J. Simmens, et al , "Determining Disability Due to Mental Impairment: APA's Evaluation of Social Security Administration Guidelines," *American Journal of Psychiatry* 148:1037-1043, 1991; H.H. Goldman, A E. Skodol, and T.R Lave, "Revising Axis V for DSM-IV A Review of Measures of Social Functioning," *American Journal of Psychiatry* 149.1148-1156, 1992; C.J. Wallace, "Functional Assessment in Rehabilitation, " *Schizophrenia Bulletin* 12604-630, 1987

toms and work (5,16,49). What does this mean now, in practical terms? People with psychiatric disabilities as well as care providers, advocates, and other experts note that exacerbation of symptoms may require brief time away from work for treatment (see discussion of reasonable accommodations in ch. 4). In fact, access to treatment may become paramount.

Many people with psychiatric disabilities will find access to appropriate treatment necessary for maintaining employment. Even experts who highlight the importance of functional and environmental interventions admit that medication, psychotherapy and/or other clinical interventions are a necessary component of care. "Psychiatric treatment and psychiatric rehabilitation

procedures ideally occur in close sequence or simultaneously" (5). Results from a recent study of depression reinforce this point. Data from 10 major studies of depression treatment revealed that symptom relief significantly improved work function and outcome (33). The authors of the study concluded that "behavioral impairments, including missed time, decreased performance, and significant interpersonal problems are common features of depression that appear to be highly responsive to symptomatically effective treatment given adequate time" (33).

Although many effective medications, psychotherapeutic interventions, and other approaches are available (1,47), access to effective treatment is far from universal. Research and policy analyses point to several barriers to treatment, including: Limitations on insurance coverage, underrecognition of symptoms by care providers, and inadequate or inappropriate treatment offered by some care providers (46). Without access to treatment, the protections and requirements of the ADA become a moot point for many people with psychiatric disabilities.

While important, the relevance of psychiatric symptoms and treatment to employment remains limited and not clearly understood. The precise relationship among impairments, functional limitations, and work is obscure and complex. For example, the course of symptoms over time does not parallel that of functional limitations. An author of one recent review of the data concluded that "diagnoses do not predict rehabilitation outcomes except in the broadest terms, and there are wide variations in outcomes within diagnostic groups" (49). Also, while research data increasingly characterize the nature of cognitive impairments in schizophrenia—including problems with attention, memory, information processing, and other aspects of learning-very little is known about how these specific deficits relate to job performance (18,20,34,39,41 ,49). Certainly the presence of even unusual symptoms does not necessarily hamper work performance. An example, shared by a rehabilitation specialist, conveys this last point: A computer programmer, who suffered hallucinations that could be distracting, found that audibly responding to the voices allowed him to continue successfully with his work (9). No doubt, the young man's talking to himself appeared unusual to his coworkers, but his work did not suffer.

Clinical treatment can have a paradoxical impact on disability and employment. While, as noted above, effective treatments are available for many mental disorders, they are not a panacea. Medications are not effective for everyone, and some of the most disabling symptoms of mental disorders may resist their effects. In fact, medication has little direct impact that has been measured on such functional issues as interpersonal relationships (6,49). Furthermore, the side effects of psychotropic medications can prove quite annoying if not outright disabling. Some common side effects of psychoactive medications include: Dry mouth, constipation, blurred vision, memory difficulties, restlessness, tremor, and sedation. Data from a recent survey of employed individuals with psychiatric disabilities confirm this observation: Medication side effects commonly led to functional difficulties on the job (31). Similarly, a reviewer of the research literature concluded that while standard or minimal medication dose in schizophrenia was associated with positive work outcomes, a "surprising number of studies [suggested] that higher dose or more consistent neuroleptic treatment might be associated with poorer work outcomes" (32).

This research on impairments and their treatments notwithstanding, one of the most reliable indicator of future work performance is prior work (1 1,16):

> Notably, every study that investigated the link between prior work history and future vocational performance has found a significant, positive relationship between these two variables (16).

Some of the most severe mental disorders interrupt key aspects of developing a work history, however, For most people, late adolescence and early adulthood are critical times for building vocational skills and gaining knowledge, through education or early work experience. This is just

the time that symptoms of disorders such as schizophrenia first erupt. ECA data reveals theresulting disruption of educational achievement. While the educational achievement of people with schizophrenia is comparable to others at the beginning of college, achievement diverges by the end of college: Only 4.8 percent of individuals with schizophrenia obtain a degree compared to 17 percent in the total population (26).

What do these data imply for the ADA? Quite bluntly, people with the most severe mental disorders, and often with less education and a checkered work history, are unlikely to achieve competitive employment by virtue of the ADA's passage alone. Individuals with severe psychiatric disabilities will require a broad range of educational, psychosocial, and vocational services to prepare them to find and keep a job. While the ADA is an important tool for fighting the discrimination commonly attached to psychiatric disabilities, it is only one piece of the puzzle for people with the most severe conditions.

Several experts have commented that the ADA's impact will be most strongly felt by people with less severe mental disorders (12, 45):

> There are many people, probably a much larger number, in the workforce with less severe conditions or less pronounced functional limitations, who have much to gain from the ADA. It is particularly for their vocational needs that the provisions of the ADA provide a good fit (1 2).

Indeed, data described throughout this section demonstrate the prevalence of diagnosable mental disorders and symptoms among working-age adults. However, much less is known about this population's functional limitations, their employment characteristics, accommodation needs, or even who among this group would be covered under the first prong of the ADA's definition of disability. As noted above, the first prong of the ADA's definition refers to individuals with serious or nontrivial disabilities. While courts have been expansive in defining mental impairment per se under the Rehabilitation Act, substantially limiting psychiatric impairments have sometimes been defined more restrictively. Unless questions are answered concerning these less severe conditions—Which ones are covered? How can such determinations be made?—the ADA is open to excessive subjectivity in claims of psychiatric disability.

SUMMARY AND CONCLUSIONS

The ADA's definition of disability explicitly includes people with psychiatric disabilities, as does Title V of the Rehabilitation Act. Furthermore, the law addresses some specific concerns of this population, such as discrimination on the basis of past impairment. More recently, the EEOC has been developing guidelines especially relevant to psychiatric disabilities, including a discussion of issues surrounding episodic disorders and the potentially impairing effects of treatment. The charge coding system used by the EEOC is also being updated to reflect more specific diagnostic terminology. Further guidance from the EEOC concerning psychiatric disabilities would still be useful. Specifically, questions remain on whether any mental disorders are, by definition, "substantially limiting impairments" and how to determine the functional implications of psychiatric impairments. A useful first step on these questions would be to convene groups of experts to help fashion guidance.

OTA's review of the literature reveals some general characteristics of psychiatric disabilities:

- Mental disorders range from relatively short-lived, minor conditions to extremely debilitating, chronic ones with remitting and relapsing symptoms.
- Data do not divulge the number of people with psychiatric disabilities covered by the ADA. We know that mental disorders are common, with more than one in five American adults having a diagnosable mental disorder in a given year. Five million adults in the U.S. have a serious mental illness: A mental disorder during the past year that seriously interfered with daily life.
- Studies document a few, specific functional limitations associated with mental disorders

and relevant to employment: Problems in social functioning; difficulty in concentrating; and problems coping with stress.

- The relative role of symptoms and functional limitations in employment for people with psychiatric disabilities has been a contentious topic. Data do permit some conclusions, however. Psychiatric symptoms have been linked to work performance and employment outcome. Thus, access to effective treatment and time off during symptom exacerbation, or other accommodation of symptoms, will be important for many people with psychiatric disabilities. Symptomatology is not the whole picture, however. Functional limitations and environmental supports (or lack thereof) are critical issues for people with psychiatric disabilities.
- It is unlikely that people with the most severe psychiatric disabilities will gain competitive employment—the underlying value of the ADA—in the absence of treatment, access, and vocational and other psychosocial supports.
- Many more people with less severe conditions may be covered by the ADA. However, much less is known about this population's functional limitations, their employment characteristics, accommodation needs, or even who among this group would be covered under the first prong of the ADA's definition of disability. Unless questions are answered concerning these less severe conditions—Which ones are covered? How can such determinations be made?—the ADA is open to excessive subjectivity in claims of psychiatric disability.

OTA recommends research into the following issues to close the psychiatric disability data gap:

- The relationship between mental disorder symptom and treatment to work disability.
- The number of people with mental disorders covered by the ADA.
- The development of functional assessment measures of psychiatric disabilities for clinical and public policy arenas.
- The impact of the ADA on the relationship between mental disorders and employment status.

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The ADA's Tools for Effecting Employment

4

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).*

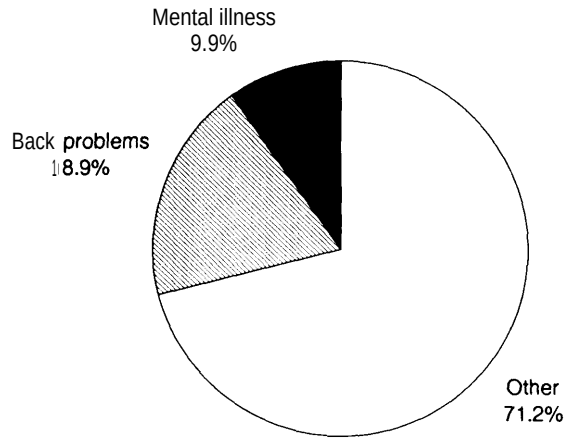
For many individuals, revealing the presence of a disability is not a voluntary decision. Although the specific impairment and needed accommodations may not be apparent, a person in a wheelchair visibly discloses the presence of a disability. This is not the case for many people with psychiatric disabilities 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.)

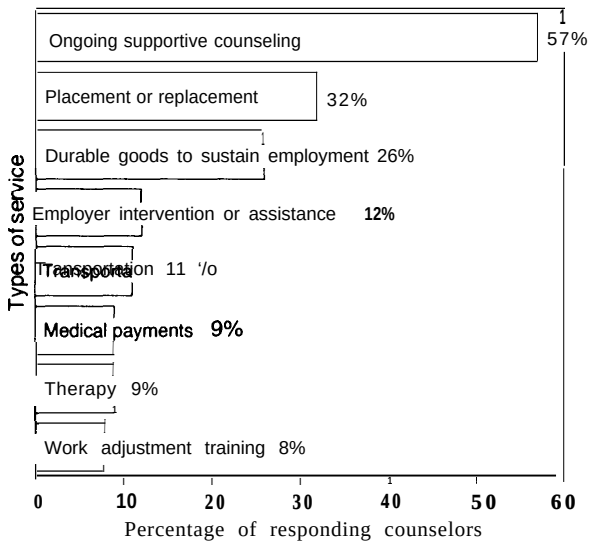
Wages and benefits
- Providing adequate wages and benefits
- Providing health insurance coverage that does not exclude pre-existing conditions, including psychiatric disabilities, HIV, cancer, etc.
- Permitting sick leave for emotional well-being, in addition to physical well-being
- Providing assistance 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)

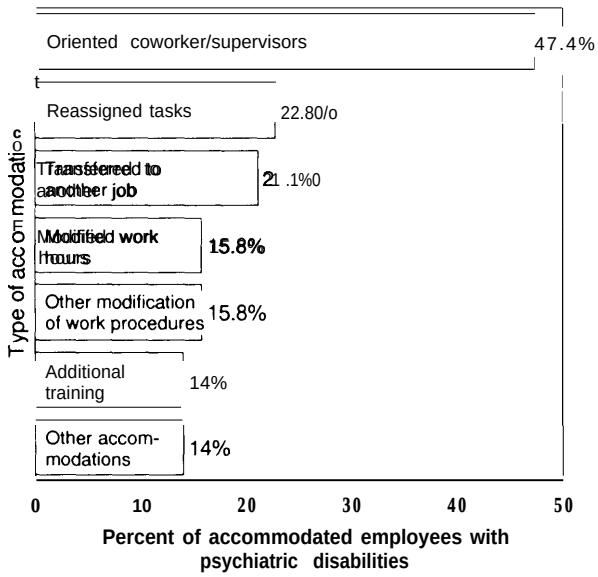
ignorance and harmful myths attached to mental disorders or providing information on how best to manage an employee with a psychiatric disability. But, focusing a training course around an individual employee identified as having a psychiatric disability may be exceedingly stigmatizing and illegal. Experience 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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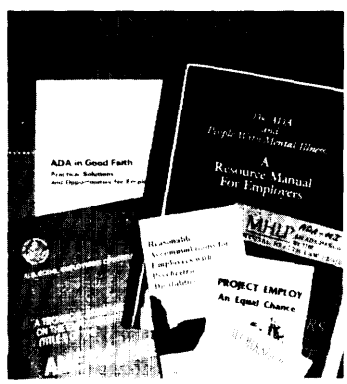
Relevant Federal Agencies' Activities 5

The Americans With Disabilities Act's (ADA's) success depends on many individuals and organizations. Employers and people with disabilities who educate themselves about the law and comply voluntarily will be most important. Consumer, advocacy, and business organizations can assist employers and people with disabilities by providing materials and other forms of educational outreach. State and local governments, who must also meet ADA requirements, will further extend knowledge of and compliance with the ADA by dove tailing their disability programs and business support activities with the law.

The Federal Government must also play a role in translating the law's vision into reality. The ADA requires the Federal Government to prepare regulations and guidelines to implement the law; to enforce the law; to assist those with rights and responsibilities under the law; and to coordinate their enforcement and technical assistance efforts. In addition to these requirements, specified by the ADA itself, the U.S. Congress has ordered Federal research and service agencies to provide technical assistance and to conform their activities with the ADA's mission. Furthermore, the Federal Government is a key source of monetary support for ADA and employment research.

This chapter describes Federal activities relevant to Title I of the ADA and psychiatric disabilities. The agencies and offices discussed in this review are as follows:

- U.S. Equal Employment Opportunity Commission (EEOC);
- National Institute on Disability and Rehabilitation Research (NIDRR);
- Center for Mental Health Services (CMHS);



- National Institute of Mental Health (NIMH); and
- President's Committee for the Employment of People with Disabilities (President's Committee).

The chapter also briefly discusses the research efforts of the National Institute for Occupational Safety and Health (NIOSH). Of course, not every ADA activity supported by the Federal Government is reviewed. Federal programs that collect disability statistics were discussed in chapter three; and although the National Council on Disability (NCOD) is among the Federal Government's most prominent ADA actors, the agency does not devote any special attention to psychiatric disabilities and Title I of the ADA. The U.S. Department of Justice—another key player under the ADA—also is not discussed, as its efforts do not focus on employment.

While the ADA clearly assigns to the EEOC the enforcement of Title I, technical assistance and research responsibilities do not neatly disperse among the various agencies listed above. Before commencing an agency by agency review, this section takes a closer look at technical assistance and research activities.

"Technical assistance" includes just about any form of information dissemination: brochures, public and video presentations, conferences, training programs, toll-free help lines, computer bulletin boards, clearing house activities, posters, or manuals. Compliance with the requirements of a new statute like the ADA depends on awareness and understanding by people whom the law affects. The minimal impact of the Rehabilitation Act's antidiscrimination provisions reflects, in part, the general lack of awareness of this law (21) (see ch. 2). The congressional sponsors of the ADA were well aware of the importance of technical assistance, mandating such activities in the language of the law and in other legislation.

Executive branch agencies have responded to the call for technical assistance with a veritable blizzard of materials and activities (16,30). But surveys of businesses and individuals indicate that the campaign has been inadequate (2,5,8). For example, results from a survey of businesses employing 25 or more individuals revealed that nearly 40 percent of the respondents had little awareness of the ADA (5). Also, a recent Harris poll found that only 30 percent of people with disabilities had heard or read about the ADA (6). Corroborating these observations, a recent report that assessed Federal ADA activities concluded: "The need for information and technical assistance continues to grow, outstripping Federal and State resources" (16). The report highlighted the need for information aimed at small businesses and minorities with disabilities, as well as the requirement for more sophisticated information that focused on specific kinds of disabilities' and complex provisions of the ADA (e.g., health insurance, workers' compensation, and collective bargaining agreements).

Information on psychiatric disabilities and the ADA rank among the most critical of technical assistance needs (10). As noted in previous chapters, mental disorders and psychiatric disabilities are poorly understood and greatly stigmatized in our society (see ch. 2). With their impact on behavior and social interactions, they raise difficult and somewhat unique employment issues (see chs. 3 and 4) that cry out for technical assistance. Although fairly primitive and generally not critical in its analysis, the response has begun (19). For example, in 1992 the Bazelon Center for Mental Health Law* published *Mental Health Consumers in the Workplace: How the Americans With Disabilities Act Protects You Against Employment Discrimination* for consumers (1 3). In 1993, The American Bar Association and National Mental Health Association published *The ADA and*

[1] Although providing some examples of specific disabilities needing technical assistance attention, the report did not specifically indicate that psychiatric disabilities require such attention, a conclusion of this OTA report.

[2] The Bazelon Center for Mental Health Law was formerly The Mental Health Law Project.

People With Mental Illness: A Resource Manual for Employers (33). And NIDRR funded a technical assistance center with the Washington Business Group on Health (see later discussion).

It is important to keep in mind that the type of technical assistance needed varies, depending on the target audiences' expertise, available resources, and role in implementing the ADA. For example, what will help businesses with fewer than 100 employees differs from that which will assist larger firms. Smaller firms are much more limited in the time, staff, or money that they can devote to learning about a new law and complex area of disability.

In considering the Federal Government's psychiatric disability research efforts, estimates of total Federal expenditures on disability-related research provide a useful perspective.[3] Comprehensive estimates, however, are not easy to derive, given the diverse range of conditions, methods, and sponsors that constitute the disability research enterprise. OTA, citing a survey by the National Institute of Handicapped Research (NIHR, now NIDRR), proffered one of the most comprehensive estimates of Federal disability research dollars more than 10 years ago (22). According to the NIHR survey, 16 agencies and offices devoted nearly $66 million to disability- related research in fiscal year 1979. Nearly half of that amount —$31.7 million—was provided by NIHR. A 1991 Institute of Medicine (IOM) report provides a more recent (if less complete) tally of disability research expenditures (7): NIDRR spent $60 million in fiscal year 1990, which reflects a IO-percent increase from 1979, when adjusted for inflation.[4] The U.S. Veterans Administration devoted $22 million to disability-related research in that same year. In addition, the National Institutes of Health estimated that $78 million was spent over several years on rehabilitation research projects beginning in 1984.

Analysts repeatedly have concluded that the Federal Government's disability research expenditures are much less than the amounts spent on health care research in general or the economic toll of these conditions. For example, the 1982 OTA study estimated that Federal funds spent on disability-related research equaled less than 1 percent of all health-care research dollars, and more recent computations show that the cost of disabilities to the nation each year is 1,000 times higher than the public funds spent on disability research (7,22). Specifically, disability research receives no more than $200 million annually from the Federal Government, while disabilities cost our society an estimated $200 billion each year, including health care expenditures, lost or diminished productivity, and income maintenance (7). Given these expenses and other factors, OTA's conclusion from the 1982 study holds true today:

> The amount of funds devoted to research and development in the disability area is quite small in comparison to the number of people affected, the complexity of the research problems involved, and the total health-care research and development budget.

Many of the characteristics of disability research in general hold true for the psychiatric disability research enterprise: A diverse range of approaches is involved, as described later in the chapter. And despite the costs imposed by mental disorders—an estimated $136.1 billion in 1991, with the largest part, $60 billion, stemming from lost or diminished productivity-only $14.3 million are available for research (17,1 8,23). Those funds total approximately 1.3 percent of the combined total annual budgets of NIDRR, CMHS, and NIMH—the key Federal funders of research (and technical assistance) related to mental disorders and disability-devoted to issues directly relevant to psychiatric disability and employment (table 5-l). Moreover, research on employment and mental disorders is fragmented within the Federal Government, with little interagency coor-

[3] Research devoted to disability as a civil rights issue —as opposed to health, rehabilitative, or socioeconomic issues—is not included in the OTA's estimate of research funding.

[4] Adjusted for inflation using the 1987 implicit price deflator for the Gross Domestic Product (4).

TABLE 5-1 : Key Federal Supporters of Psychiatric Disability Research

Institute	Principal mission	Funding mechanisms	Total funds Specifically related to psychiatric disability and employment (in $ millions)	Percent of total budget
National Institute on Disability and Rehabilitation Research	Supports research and technical assistance for all disabilities	Supports training and research centers; field-initiated research projects; and a technioal assistance resource center	$3.5[a]	5.6 percent
Center for Mental Health Services	Administers block grants to States for mental health services and supports research	Supports training and research centers; demonstration projects; consumer self-help centers	$1.5[a]	0.36 percent (1 .4% of non-block grant budget)
National *Institute* of Mental Health	Supports mental disorders research	Funds investigator-initiated studies and research centers	$9.3[b]	1.5 percent

[a]Fiscal year 1993.
[b]Fiscal year 1992.

SOURCE: Office of Technology Assessment, 1994.

dination and no agency or office currently offering leadership or making this issue a priority (box 5-l).

U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

Established by law in 1964, the EEOC, or Commission, enforces Title I of the ADA, as well as Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, section 501 of the Rehabilitation Act, and the equal pay provisions of the Fair Labor Standards Act. The EEOC is composed of five individuals (no more than three from one political party) (figure 5-l),with the chair and vice-chair designated by the U.S. President. As of this writing, no new Chair of the EEOC has been appointed. In addition to national headquarters staff, the Commission has field offices in all 50 States.

The Commission's enforcement of Title I of the ADA, as spelled out by the statute, involves issuing regulations, providing technical assistance to covered entities and people protected by the law, and coordinating activities with the U.S. Departments of Justice and Labor. As noted in the 1993 NCOD report, the EEOC's regulations were issued in the time frame required by the law, and technical assistance activities have been extensive. However, and as documented throughout this OTA report, the regulations, guidance, and technical assistance promulgated by the EEOC provide minimal guidance on many issues specifically relevant to psychiatric disabilities. As reiterated throughout this report, the complexity of psychiatric disabilities and the general lack of knowledge about these conditions engenders the need for further information and guidance, an observation shared by the EEOC itself. "Cases involving individuals with alleged mental disabilities are frequently more complicated than those involving physical disabilities. Investigators may require more time to determine whether a mental impairment exists, whether a disability exists, and whether an individual with a mental disability is qualified (which may involve consideration of whether a reasonable accommodation is needed, and if so, what would be an effective accommodation)" (24,3 1). This concern is magnified by the

BOX 5-1: Interagency (Non)Communication About Psychiatric Disability and Employment

Effecting communication among agencies that share responsibilities and interests is a common bureaucratic dilemma, Several Federal agencies, as described in this chapter and report, have authority over research, technical assistance, program administration, and policy enforcement relevant to psychiatric disability and employment, Despite jurisdictional overlap, each agency has a unique culture and functional role Many observers believe that this heterogeneity is healthy, permitting distinct and potentially useful approaches to flourish. However, redundant or conflicting Federal policies and activities may also flourish in the absence of meaningful communication, While individuals in different agencies informally interact, formal mechanisms of interagency communication lie moribund,

Public Law 102-321 created a new Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Public Health Service, Department of Health and Human Services, thus separating this mental health service agency from the principal mental health research agency—the National Institute of Mental Health (NIMH), That law requires cooperation and consultation between the CMHS and the NIMH in a variety of areas Such communication clearly could help the CMHS move forward with demonstration projects, technical assistance, and services solidly based on research supported by NIMH Also, NIMH's research expertise could assist in program evaluation at the CMHS. Conversely, the CMHS could assist NIMH in promoting research relevant to current practices, policy needs, and real world demands While NIMH and CMHS indicate that they are working together on a report to the U.S. Congress on effective methods of providing mental health services to individuals in correctional facilities, to date, no general mechanism has been elaborated to animate the congressional mandate for information exchange between the CMHS and NIMH,

The U S Congress established the Interagency Committee on Disability Research to promote communication and funding coordination among the committee's 27 member agencies, which include: the National Institutes of Health (including NIMH), SAMHSA (including CMHS); the National Science Foundation; and offices in the U S Departments of Health and Human Services, Education, Labor, and Veterans Affairs, and the National Aeronautics and Space Administration. In existence since 1981, the committee has not met at all during the last year and has never focused directly on psychiatric disability.

In April of 1993, the CMHS replaced the NIMH as a cosigner with the Rehabilitation Services Administration (RSA) and NIDRR on a renewed Memorandum of Understanding (MOU) In effect since 1979, the MOU sets out guidelines for interagency collaboration on service delivery, staff training, and evaluation activities related to the rehabilitation and employment of people with psychiatric disabilities. Representatives from each agency serve as members of a liaison group responsible for informing each other about their agency's activities, exploring possible cooperative efforts, recommending cooperative activities to the chief executives of their agency, and developing and implementing a work plan to carry out approved cooperative activities The MOU specifically mentions as one of its goals the "provision of technical assistance on implementing the Americans with Disabilities Act for persons with psychiatric disabilities " Also, it helps coordinate the cofunding by CMHS and NIDRR of the National Rehabilitation and Research Centers at Boston University and Thresholds Institute in Chicago, Illinois. While proponents contend that the MOU can and has been an important catalyst for interagency cooperation, several experts and advocates commented to OTA about its current ineffectiveness And no efforts have focused on the ADA to date,

(continued)

BOX 5-1 Interagency (Non)Communication About Psychiatric Disability and Employment (cont'd.)

The National Task Force on Rehabilitation and Employment for People with Psychiatric Disabilities (NTREPPD) has tried to promote collaboration among RSA, NIDRR, NIMH, CMHS, and the Social Security Administration. NTREPPD is composed of representatives of professional organizations, service providers, consumers, family members, research and training organizations, advocacy groups, Federal, State, and local government agencies, and others. Its central function is to advise the RSA and NIDRR on policy and research priorities related to rehabilitation and employment issues for people with psychiatric disabilities. The group originated as the RSA Task Force on Vocational Rehabilitation for Persons with Long-Term Mental Illness. In 1991, it became an independent entity and was chartered as NTREPPD, The members of NTREPPD had been meeting quarterly in Washington, DC to share information and develop recommendations about legislation and regulations, research priorities, training and service delivery issues; many observers considered the group vital. More recently, however, many members have desisted meeting attendance, complaining about NTREPPD's voluntary nature and its limited impact on policies.

SOURCE. Office of Technology Assessment, 1994.

fact that charges related to psychiatric disabilities account for approximately 10 percent of all charges, second only to back problems (see chs. 3 and 4).

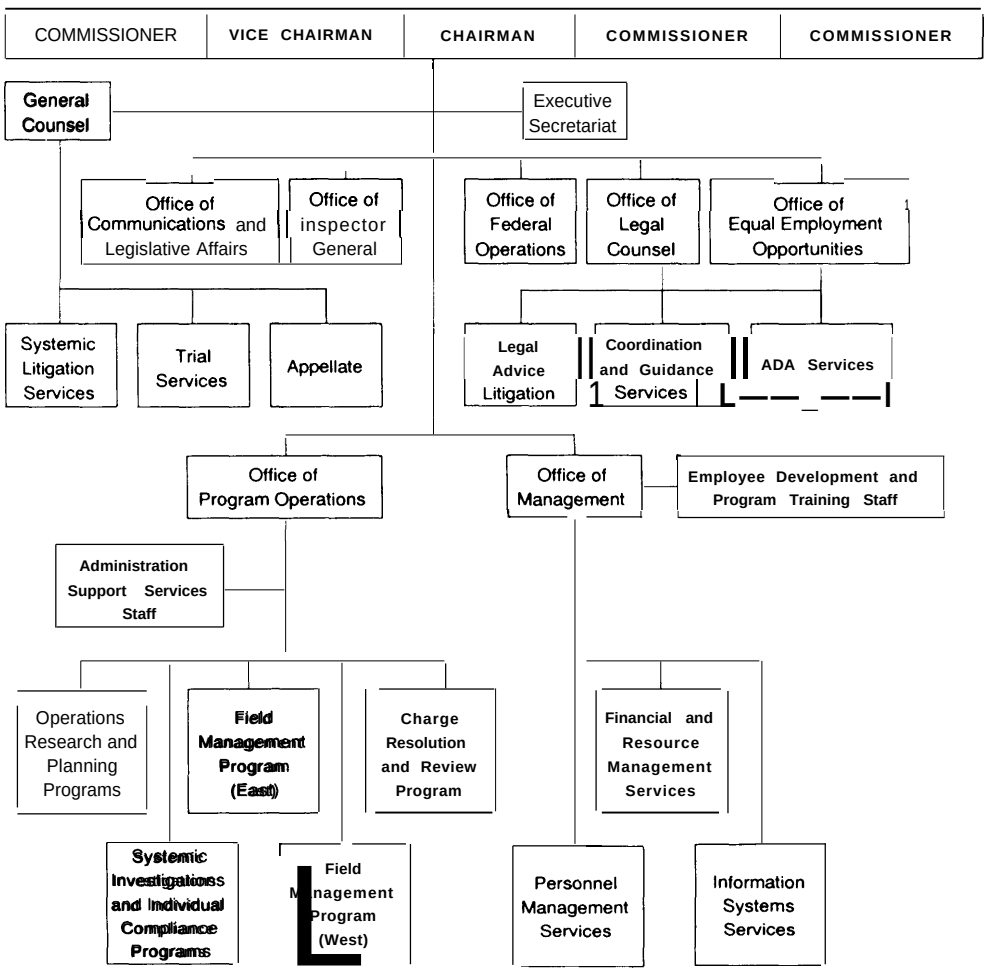
The EEOC's budget, in fiscal year 1991, was approximately $200 million, with $1 million provided to begin the required preparations for implementing the ADA. In addition, in fiscal year 1991, Congress provided EEOC $3.6 million in supplemental funding. In fiscal year 1992, Congress appropriated a total of $211 million, with $4 million for ADA implementation. The EEOC also received a supplemental appropriation providing $1 million available through fiscal year 1993. A total of $222 million was appropriated to the EEOC for fiscal year 1993.

Many analysts have concluded that despite these appropriation increases, the EEOC is under considerable fiscal and staffing strain (e.g., 1,19,20). Between fiscal year 1981 and 1992, while the average annual real rate of the total EEOC budget increased 8.13 percent,[5] staff were being significantly reduced (figure 5-2). Between fiscal year 1980 and fiscal year 1991, staff was reduced by 594 full-time equivalents—a 17.5 percent decrease. Although the U.S. Congress provialed for 32 additional staff positions for ADA implementation in fiscal year 1992, total staff fell from 2,853 in 1990 to 2,791 in 1992. The overall decreases in staff-which with rent, communications, and utilities consume approximately 90 percent of the total budget—were mirrored in the number of investigators. In the field offices, assigned enforcement investigators dropped from 949 in fiscal year 1988 to 782 in 1992, a 17.6 percent decrease. At the same time its staff was being reduced, the EEOC was given more responsibilities-enforcement of the ADA and the Civil Rights Act of 1991. Overall charges of discrimination received by the EEOC increased by 13 percent between fiscal year 1991 and 1992 and continue to rise (31).

These staff and budget figures have significant implications for ADA enforcement and technical assistance activities of the EEOC. For example, the staffing constraints curtail the time available for investigation of charges and conciliation efforts (20,3 1). These constraints are likely to have a particularly acute impact on the investigation of complaints relating to psychiatric disabilities, which raise complex issues and require more time for investigation than other disabilities. Addition-

[5] Adjusted for inflation using the 1987 implicit price deflator for the Gross Domestic Product (4).

FIGURE 5-1: Organization of the U.S. Equal Employment Opportunity Commission

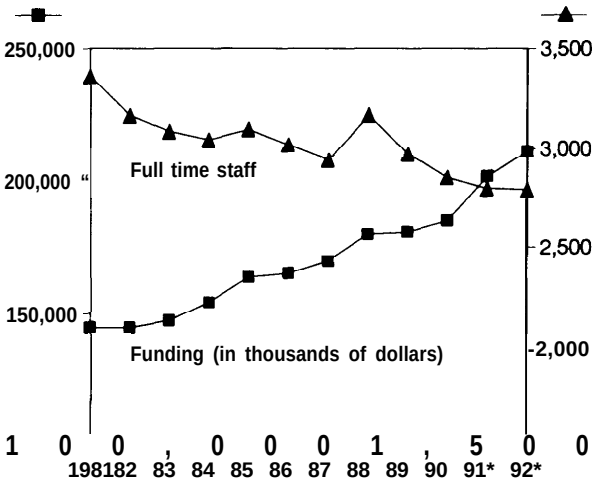


DISTRICT, AREA" AND LOCAL OFFICES

Field Management Programs (East)				Field Management Programs (West)			
Atlanta Savannah	Charlotte Greensboro"' Greenville"' Ralelgh	Memphis Little Rock" Nashville	New York Boston* Buffalo"*	Chicago	Houston	Milwaukee Minneapolis	San Francisco Fresno Honolulu Oakland SanJose
Baltimore Norfolk* Richmond*	Cleveland Cincinnati*	Miami Tampa"	Philadelphia Newark" Pittsburgh	Dallas Oklahoma City"	Indianapolis Louisville"	Phoenix Albuquerque"	Seattle
Birmingham Jackson" ,	New Orleans	St. Louis Kansas City"	Washington, DC Field Office	Denver	Los Angeles San Diego	San Antonio El Paso"	
				Detroit			

SOURCE U S Equal Employment Opportunity Commission, 1993

FIGURE 5-2: EEOC Funding and Staff: Fiscal Years 1981 to 1992



Although total funding to the U.S. Equal Employment Opportunity Commission experienced a real, average annual rate of increase of 8.3°/0 since 1981, full time staff positions declined by approximately 17%.

***includes supplemental for ADA.**

SOURCE: US. Equal Employment Opportunity Commission, 1993.

al technical assistance and monitoring or other research efforts are also likely to be restricted.

Title I of the ADA orders the EEOC to use the same enforcement procedures as used for Title VII of the Civil Rights Act of 1964. In general, charges are received and investigated by the field and headquarters offices. The EEOC's 1992 Technical Assistance Manual provides a detailed description of the enforcement process, which is summarized below (30).

The process begins when an applicant or employee files a charge of discrimination with the EEOC. A group or organization may also file a charge on behalf of an individual. Commissioners also may file charges when they have evidence of discrimination but no charging party. It is incumbent upon the charging party to file with the EEOC within 180 days of an alleged discriminatory act.[6] Charges, including basic identifying information, the nature of the alleged discrimination, and the disability involved, can be filed in person, by telephone, or by mail.

Investigating officers in the field offices investigate each claim: They review the written charge and interview the charging party, witnesses, and the employer or alleged discriminator (the respondent). In approximately 95 percent of charges, the investigator finds no cause to believe discrimination occurred under the statutory definition. The charging party still maintains the right to sue privately, however.

In approximately 5 percent of cases in which the investigator finds reasonable cause to believe discrimination has occurred, the EEOC attempts to resolve the issue and to avoid litigation. If conciliation fails, the EEOC may file a lawsuit on behalf of the charging party, or it may issue a right-to-sue letter to the charging party. Most charges are conciliated or settled before a court trial begins, and EEOC-initiated lawsuits account for less than 5 percent of all cases that reach court.

Investigators in EEOC field offices are critical for the enforcement of Title I of the ADA. They are the engine of charge investigation. Each investigator's high case load can obviously diminish the quality of each investigation. Knowledge of the ADA and psychiatric disabilities is another critical factor. To ascertain field office investigators' resources on psychiatric disabilities and the ADA, OTA contacted each of the 50 field offices asking questions about training received on the ADA in general, psychiatric disabilities, other available resources, and the perceived need for further assistance (see ch. 5 appendix).[7]

EEOC headquarters provided general training to all field offices on Title I of the ADA in two sessions: The first session was in 2 days to provide a legal analysis of ADA principles. A second week-

[6] Up to 300 days may be available for filing a charge in the event that other State or local laws are involved.

[7] Forty field offices provided information to OTA. The appendix to this chapter describes the request for information from the EEOC field offices.

long session focused on how to investigate and process complaints related to the ADA. The EEOC headquarters also provided an investigation manual, the "Desk Book," and the "Technical Assistance Resource Directory "-a comprehensive list of agencies and services available, by locale.

How well did these information resources cover psychiatric disabilities? Given the general focus of these training sessions and materials, it is not surprising that the answer to this question is "sparsely." The week-long training on investigatory procedures used hypothetical cases for discussion purposes; only one of the cases dealt with an employee with a mental disability who required time off from work for periodic treatment or diagnostic services.

While investigators have received little formal information on psychiatric disabilities from headquarters, some field offices have tapped into additional resources. Twelve of the 40 respondents have sponsored seminars by local experts, and 15 have connected with a local network of experts to call for assistance on a case-by-case basis. Most field offices indicated that additional training on psychiatric disabilities would be very helpful. One of the most suggested needs was training or assistance for the initial stage of the investigation, including guidance on the types of information that are important. For example, 28 of the 40 responding field offices said information on the nature of mental illness, impact on employment functioning, and useful accommodations would be very useful. EEOC headquarters could address this resource need with additional guidance in technical assistance manuals and policy papers. Other Federal agencies, including NIDRR, CMHS, and NIMH, could also develop resource information in consultation with the EEOC. Nearly all of the field offices indicated that seminars would be useful. However, individuals associated with the Washington, DC and Chicago IL field offices indicate that intensive training sessions or seminars do not suffice. Since people with disabilities, the workplace issues that arise, and the philosophy of the ADA require case-by-case assessment, outside experts, who can be consulted as needed, are among the most useful resources. The issue thus becomes identifying local, knowledgeable experts. The Federal Government may be able to help by bringing together EEOC field offices with federally-funded service providers, including those funded by mental health block grants, vocational rehabilitation funds, and the community support program supported by the CMHS.

NATIONAL INSTITUTE ON DISABILITY AND REHABILITATION RESEARCH

NIDRR is the lead Federal agency supporting disability research. Located within the Department of Education's Office of Special Education and Rehabilitative Services (OSERS), NIDRR develops and implements long-range plans for rehabilitation research, coordinates the work of all Federal agencies supporting or conducting such research, and disseminates research results to businesses, professionals, and people with disabilities.

With an annual budget of $62 million in fiscal year 1992, NIDRR's research portfolio emphasizes clinical and applied studies in conjunction with service provision. Psychiatric disabilities are not the prime focus of NIDRR's program; rather its research portfolio spans all disabilities. Of the $62 million spent in fiscal year 1992, 5.6 percent—$3.5 million—went to psychiatric disabilities (25). NIDRR, along with CMHS, funds two Rehabilitation Research and Training Centers that focus on people with severe and chronic mental disorders: Boston University's Center for Psychiatric Rehabilitation, and Thresholds National Research and Training Center located in Chicago, Illinois. Both of these centers receive additional funds from NIDRR for field-initiated research projects. The Boston University's Center receives funds to explore the long-term outcomes of a specific rehabilitation program, and the possibilities of including consumers in the conduct and definition of research regarding services. Thresholds National Research and Training Center received a

field-initiated research grant supporting research on the effectiveness of educating State rehabilitation counselors about the ADA and psychiatric disabilities.

NIDRR has recently increased its commitment to psychiatric disabilities. In September 1992, NIDRR sponsored a consensus validation conference on "Strategies to Secure and Maintain Employment for Persons with Long-Term Mental Illness." A panel of experts commissioned papers summarizing research in the field and heard one day of testimony from consumers, providers, family members, and researchers. NIDRR also awarded the Matrix Research Institute a $400,000 per-year grant, for 4 years, for support of a Rehabilitation Research and Training Center on Long Term Mental Illness.

The U.S. Congress has assigned NIDRR with considerable responsibilities under the ADA. Specifically, 15 grantees receive approximately $5 million in funds from NIDRR to provide information, training, and technical assistance to businesses and agencies with duties and responsibilities under the ADA. In addition to 10 regional Disability and Business Technical Assistance Centers, two National Peer Training Projects provide education about the ADA: One project targets staff, associates, and volunteers at independent living centers, and the other targets individuals with disabilities and their family members. Three materials development projects develop and test technical assistance, training materials, and programs for use by the Technical Assistance Centers and the Peer Training Projects. While these ADA-technical assistance activities include information on psychiatric disabilities, in general, they have had but little impact on consumers and employers (box 5-2). Recognizing that more technical assistance is still needed, NIDRR recently provided $120,000 for each of 3 years for a resource center on psychiatric disabilities organized and coordinated by the Washington Business Group on Health (WBGH), a nonprofit membership organization of employers. The purpose of the center is to provide information and technical assistance to employers, advocates, service providers, unions, and others to assist in achieving voluntary compliance with Title I of the ADA. Among the project goals are: The creation of widespread awareness among employers about their responsibilities under the ADA; the establishment of a WBGH/ADA Resource Center consisting of a database of effective employer policies, "best practices" and resource individuals and materials; the provision of information and technical assistance; the production and wide dissemination of a series of ADA mental health information briefs; and the production of an employer's guide to accommodating individuals with mental disabilities in the workplace.

CENTER FOR MENTAL HEALTH SERVICES

Public Law 102-321 created a new Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Public Health Service, Department of Health and Human Services (DHHS).[8] The CMHS is the Federal Government's leading administrator of funds devoted specifically to mental health services. The largest portion of its budget—$278 million of a total of $385 million in fiscal year 1993—funds mental health block grants, the categorical Federal support of community mental health and social service programs (table 5-2) (28).[9]

[8] Prior to October 1992, CMHS and NIMH were both part of NIMH.

[9] It is relevant to note that P.L. 102-321 identifies service providers other than Community Mental Health Centers, including psychosocial rehabilitation agencies, as potential block grant fund recipients.

BOX 5-2: Disability and Business Technical Assistance Centers

The National Institute on Disability and Rehabilitation Research (N IDRR) has funded 10 regional Disability and Business Technical Assistance Centers—DBTACs—since 1992, The 10 DBTACs represent one of the Federal Government's principle sources of ADA technical assistance. They aim at providing employers, people with disabilities, and others with responsibilities under the ADA with information, training, technical assistance, and referrals to local sources of ADA information and expertise These centers currently are funded with 5-year grants, but NIDRR's aim is to develop a system whereby the regional centers eventually will be regarded as State and local resources and affiliated with State and local governments For this reason, the DBTACs are encouraged to establish relationships with State and local agencies throughout their regions

To help identify needs and coordinate activities, the DBTACs have organized regional, State, and local advisory committees made up of representatives from small and large businesses, State and local service providers, citizens with all types of disabilities and their family members, and disability support and advocacy groups To reach as many people with an interest in the ADA as possible, the DBTACs are developing mailing lists of people with disabilities; employers; personnel and recruitment agencies, business groups such as chambers of commerce, small business associations, better business bureaus, minority business associations, and others; State and local government agencies; disability advocacy groups, and service providers The mailing lists are used for direct-mail campaigns to draw attention to the provisions of the ADA and the DBTACs resources, and to generate information for data bases and reference guides on local sources of ADA information and expertise. Each of the DBTACs provides a toll-free technical assistance hot line for information and referrals. Also, the DBTACs provide training sessions, including regional conferences, and State and local workshops, and presentations.

Several DBTACs have focused to some extent on psychiatric disabilities Their advisory committees and mailing lists include individuals with psychiatric disabilities and advocacy/consumer groups representing this constituency. One DBTAC in Washington State helped to craft language for the 1993 State Civil Rights Act barring discrimination in employment for people with mental disabilities, and helped to develop training about workplace accommodations for people with psychiatric disabilities Another DBTAC is working cooperatively with IBM to develop a self-paced software program about Title I of the ADA with situational examples that will include accommodating people with psychiatric disabilities in the work place The Northeast DBTAC in Trenton, New Jersey is developing a televised panel discussion, "Making the ADA Work Reasonably Accommodating People with Mental Illness, " which features a successful employee with a psychiatric illness, an employment specialist, and an employer, The Southwest DBTAC is working with the Texas Rehabilitation Commission to develop a model training program on the ADA and people with psychiatric disabilities

Technical assistance hotline requests concerning psychiatric disabilities generally form only a small percentage of total requests, however. This suggests that employers and the general public do not yet see the ADA as being related to psychiatric disabilities or they do not see the DBTACs as providing such information The majority of those requests for information are from individuals with psychiatric disabilities or their employers, followed by mental health agencies, therapists, and rehabilitation counselors People with psychiatric disabilities typically ask how to approach employers about an accommodation, whether it is necessary to document psychiatric disability, how such documentation is used, and the procedure for deciding an appropriate and reasonable accommodation. Employers usually ask whether they can request documentation of a psychiatric disability, what types of accommodation are appropriate, and how to determine the existence of a direct threat.

SOURCE Off Ice of Technology Assessment, 1994

TABLE 5-2: Fiscal Year 1993 Budget for Center for Mental Health Services

Program	Amount (In $1,000)
Demonstrations	
Community Support Program (CSP)	$12,201
Child and Adolescent Service System Program (CASSP)	12,201
Homeless	21,419
Prevention	—
Subtotal, Demonstrations	$45,821
Mental health services for children	$4,903
Clinical training	2,956
AIDS training	2,987
Protection and advocacy	20,832
Projects for Assistance in Transition from Homelessness (PATH)	29,462
Mental health block grant	277,919
Total, CMHS	$384,880
Total full-time staff	142

NOTE: Excludes funding for program management. The fiscal year 1993 appropriation enacted by Congress consolidated funding for each of the centers and the office of the administrator into a single line Item entitled program management.

SOURCE: Center for Mental Health Services, 1993.

Although employment is not a top priority for CMHS, several programs and activities sponsored by the CMHS touch on the issue. Perhaps most significant are those efforts undertaken by the Community Support Program (CSP). CSP was created in 1977 for people with severe psychiatric disabilities, not institutionalized, but rather living in communities (14). Under this program, States receive funds for community services, including psychiatric and general medical care, housing, social supports, and case management services. Lauded by many as an innovator and stimulus for much needed services,[10] CSP has supported a few activities relevant to employment and the ADA. Of the 26 research demonstration projects it funds, 6 focus on vocational rehabilitation and other employment-related services, including supported education. The total amount dedicated to these projects is $7 million over 3 years; in fiscal year 1993, costs totaled $802,000.

As mentioned in the previous section, the CMHS, through CSP, cofunds with NIDRR two national rehabilitation research and training centers, at Boston University and Thresholds National Research and Training Center in Chicago, Illinois. These centers conduct research, disseminate knowledge and information, and provide technical assistance on service approaches to increase employment opportunities and successes for this population. The CMHS provides approximately $600,000 each year to support the centers.

CSP is a leader in Federal support for the psychiatric consumer movement (see ch. 2).[11] Thirteen 3-year consumer-operated service demonstration projects, totaling approximately $4 million, recently completed their Federal funding period. Through a small contract ($18,000), the program results are being analyzed and synthesized. The report, available in 1994, will provide information on the supervision needs, problems encountered, and accommodations used by consumers employed by these projects. Also, CSP provides $700,000 per year to two national consumer self-help centers: Project Share in Philadelphia, Pennsylvania, and the National Empowerment Center in Lawrence, Massachusetts. Each center conducts some technical assistance activities related to employment and reasonable accommodations (28). For example, the National Empowerment Center conducted a national teleconference with consumers and consumer organizations in approximately 30 States to educate them on the ADA and to discuss how to ask for reasonable accommodations. Project Share conducted training for the business community on hiring people with psychiatric disabilities.

[10] The greatest impact of the CSP is not so much to bring about or fund widespread development of comprehensive community-based services, but rather to create a conceptual framework for the services provided to people with severe mental disorders in the community (29).

[11] While support of the consumer movement generally is considered an important function of CSP, a recent report of the Inspector General of the U.S. Department of Health and Human Services notes complaints that the support may be skewed toward certain sectors of the movement and thus may not be representative (29).

Approximately 20 percent of the efforts of both centers are directed toward employment issues.

CSP has supported some ADA-related activities, although significant funding has not been devoted to this subject. CSP produced a special issue of "Community Support Services Network News" in December of 1991 that focused on the ADA's provisions (3). Also, a 1992 survey of CSP participants provided information about the kinds of accommodations that may be useful to people with psychiatric disabilities (28). Earlier this year, an in-house training session, in which outside experts were invited to talk to CSP and other CMHS staff, was devoted to the ADA. And CSP contracted with a rehabilitation/ADA expert consultant to conduct case studies on reasonable accommodations and prepare a technical assistance document (12).

The program for the Protection and Advocacy for Individuals with Mental Illness (PAIMI), administered by CMHS, was signed into law in 1986 (P.L. 99-319) and reauthorized and amended in 1988 and 1991. Annual formula grant allotments are made to existing Protection and Advocacy (P&A) Systems that were previously designated by the Governor in each State to protect and advocate for the rights of persons with developmental disabilities under the Developmental Disabilities Assistance and Bill of Rights Act (P.L. 94-103, as amended, 42 USC 6012). In fiscal year 1993, CMHS allocated nearly $21 million in funds to P&As. These PAIMI programs engage in administrative, legal, systemic, and legislative activities to protect and advocate for the rights of individuals who have a significant mental illness or emotional impairment and are inpatients or residents in public or private residential facilities or have been within the last 90 days, and specifically, to investigate incidents of abuse and neglect.

While employment issues are not a major priority, PAIMI programs have both received and provided training on issues concerning the ADA and psychiatric disabilities **(15).** Based on an April 1993 survey conducted by the National Association of Protection and Advocacy Systems (NAPAS) to which nearly 50 percent of the P&As responded, most reported having received some form of training about the ADA.

OTA's analysis indicates that the CMHS has supported some activities related to employment, the ADA, and psychiatric disabilities. With its focus on community services and consumer participation, the CMHS could play a more useful role in research and service provision, and especially technical assistance. Indeed, among the strongest conclusions of the DHHS Inspector General report was the need for the CMHS to increase and improve its technical assistance (29). However, support for activities concerning the ADA and employment can be characterized as very modest to date, with approximately $1.5 million dollars-1.4 percent of the non-block grant budget—spent in fiscal year 1993. Various factors likely contribute to the limited support for employment and ADA-related issues. First, because the ADA is a relatively new statute, many Federal and non-Federal researchers and policy makers have yet to become actively engaged in this issue. Furthermore, employment is not a priority at the CMHS. No office, budget line, or specific legislative language addresses this topic. Funding is also an issue. In the last fiscal year, funding for programs under the CMHS declined by 6 percent, which translated into cuts for all but two of the CMHS's existing programs. This decrease in funding follows a decrease in purchasing power in the area of services (excluding the block grant program) of 1.1 percent per year between 1980 and 1992 (23). It is important to note, however, that services purchasing power increased an average of 13.4 percent per year since 1986. Finally, the development of new programs and priorities have likely been stalled by the reorganization of the CMHS in 1993.

NATIONAL INSTITUTE OF MENTAL HEALTH

NIMH is the nation's top supporter of mental disorders research (box 5-3). Recently reunited with the National Institutes of Health by Public Law 102-321, the vast majority of NIMH's fund-

BOX 5-3: National Institute for Occupational Safety and Health

The Occupational Safety and Health Act of 1970, which pledged "safe and healthful working conditions for working men and women. .." created the National Institute for Occupational Safety and Health (NIOSH), NIOSH, part of the United States Centers for Disease Control and Prevention (CDC) in the Department of Health and Human Services (DHHS), is the Federal institute charged with conducting research and making recommendations for the prevention of work-related diseases and injuries. Its responsibilities, supported by $108 million in fiscal year 1993, include: conducting research and developing methods for evaluating work place hazards; responding to employer and employee requests to investigate possible hazardous working conditions; recommending methods for preventing occupational disease, injury, and disability to the Occupational Safety and Health Administration (OSHA), the Mine Health and Safety Administration (MSHA), industry, and employee organizations; and providing education and training to prepare individuals for careers in the field of occupational safety and health.

Eight current in-house and three extramural research projects related to psychological disorders include studies in various work environments on the relationship between work practices and organizational factors (leadership, communication style, etc.), stressors, performance, and health effects. Total funding for these stress related activities equals $786,962, 0.73 percent of NIOSH's total budget. Other stress-related activities include two American Psychological Association—NIOSH national meetings on stress and the work place; an analysis of data on the relationship between suicide and different occupations; and the development of an improved questionnaire for assessing job stress and strain. Nothing in NIOSH's current research portfolio addresses the relationship between work and disabilities in general, psychiatric disabilities specifically, or the ADA. However, the Senate Report "Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Bill 1993" (Report 102-397) requested that NIOSH provide recommendations to the Senate Appropriations Committee on the ADA. In response to this request, NIOSH responded that with "appropriate and additional resources and staff ," the agency could best address the ADA by focusing on the health and safety implications of employing people with disabilities,

SOURCE National Institute for Occupational Safety and Health, 1993

ing-more than 70 percent of its budget in fiscal year 1991—goes to basic biomedical and behavioral research and clinical studies (23). Services research is also part of NIMH's mandate, with the Services Research Branch in the Division of Epidemiology and Services Research forming the focal point for support of investigator-initiated research on mental health services. To underscore the need for services research, the U.S. Congress mandated that 12 percent of the NIMH budget be dedicated to mental health services in fiscal year 1993, and 15 percent in subsequent years. Recently, NIMH published a plan for services research: *Caring for People With Severe Mental Disorders: A National Plan of Research to Improve Services (27).*

As part of its services research portfolio, NIMH supports studies of disabilities and employment (box 5-4). However, relative to the institute's overall budget, little money is spent on this area. OTA requested that NIMH specifically delineate its support for research on: 1) general disability and psychiatric disability, including its characterization, assessment and measurement; 2) vocational rehabilitation, employment issues in general, and the ADA specifically; and 3) public attitudes attached to mental disorders. NIMH provided a list of 32 grants, totaling $9.3 million in fiscal year 1992, 1.5 percent of NIMH's total research budget (26). Of these 32 awards, 7 grants, receiving $3.3 million in fiscal year 1992, focused

BOX 5-4: DEPRESSION Awareness, Recognition, and Treatment in the Workplace

In addition to its support for rehabilitation services and employment research, the National Institute of Mental Health (NIMH) has been working with the business community to promote mental health and combat depression in the work place Organized as a public/private partnership, the DEPRESSION Awareness, Recognition, and Treatment (D/ART) program is a national public and professional education campaign aimed at reducing the prevalence of depressive disorders. The D/ART National Worksite Program is the first to address a specific mental disorder in the workplace. A little more than $100,000, 10,6 percent of the total D/ART budget, was spent on the Worksite Program in fiscal year 1993. Initial activities began in 1989 as a collaborative effort with the Washington Business Group on Health (WBGH). The goals of the work site program, which harmonize with the ADA's mandate include: informing employers about depression and its impact on costs, productivity, employees and their families; initiating multifaceted and integrated approaches to managing depression at the work site; assisting employers in implementing depression-related activities in their companies; and, disseminating employers' experience among other major U.S companies.

Advised by members of the Corporate Leadership Council (CLC)-an employer advisory group composed of human resource and health management professionals from more than 15 Fortune 500 companies—NIMH and WBGH staff developed a six-part comprehensive approach for managing depression in the work place Employee education about symptoms and treatment of depression, management training to identify employees whose work may be affected by depression; employee assistance services for on-the-job support for employees experiencing depression, proper benefit design and management, and data collection and analysis on prevalence, cost, treatment outcomes and attitudes about depression, and the integration of health programs

D/ART has produced a slide presentation for businesses that describes its "Management of Depression" approach In addition, D/ART publishes posters and informational brochures targeted to employees and their families, management personnel, and employers. The publications have been distributed to Fortune 500 employers, business coalitions, and national business, employee assistance, wellness programs, and human resource management organizations. Currently, members of NIMH, WBGH, and the CLC are developing a program to educate employee assistance professionals about depression so that they can perform roles in education, management training, crisis intervention, recognition and appropriate referral, case management, and on-the-job support.

Recently, some D/ART Community Partners also have begun to provide work site education programs about depression Located in 23 States and the District of Columbia, Community Partners are networks of community mental health groups coordinated under the leadership of a single nonprofit mental health agency, usually a local affiliate of the National Mental Health Association, or the National Alliance for the Mentally Ill, Most of the Community Partners receive around $3,500 a year in NIMH funding to conduct D/ART programs, During the spring of 1993, OTA interviewed 23 of the 32 Community Partners. Fifteen of the 23 groups Indicated that they-albeit infrequently-conducted work site programs about depression Of those 15, six—in Indiana, Missouri, New Jersey, Ohio, Oklahoma, and Virginia-explained that work site education activities had been infrequent because they chose to concentrate on other aspects of D/ART's public education campaign. What is particularly significant is that the remaining nine—in Alabama, California, Colorado, Georgia, Maryland, Texas and Utah—said that employers generally were not interested in workplace discussions about mental illness. Many of the partners found that companies may avoid discussions about "AIDS, alcohol, and mental illness—for fear they may offend or make people uncomfortable. " In addition to the issue of stigma, some D/ART Community Partners have found employers reluctant to use the D/ART program because they are concerned that the demand for services will exceed the supply of affordable resources, treatment of depression will be a costly drain on medical insurance benefits, or acknowledging that depression exists in the work place will expose employers to workers' compensation suits

(continued)

BOX 5-4: DEPRESSION Awareness, Recognition, and Treatment in the Workplace (cont'd.)

On the other hand, eight of the Community Partners—in California, Florida, Kansas, New York, North Dakota and Virginia-conducted work site depression education programs frequently and found them to be well received by employers and employees, Many groups combine D/ART educational materials with those of other organizations, such as the National Mental Health Association, the United Way, and the Wellness Councils of America. At least one, in California, conducts programs for employers about the ADA and reasonable accommodations for people with psychiatric disabilities. These groups generally report an increase in calls requesting additional information about depression after presentation of work site programs. While some groups found that working through a company's employee assistance program (EAP) is an effective way to establish a presence in the workplace, others—in Alabama, California, Texas, Utah, and Washington—note that in some companies EAPs are: A bureaucratic response to employees' problems; typically deal with short term, situational problems; do not have sufficient personnel; carry out certain designated duties and are not innovative enough to expand their role to educate people about mental illness. Several of the groups asserted that the success or failure of a work site education program depended on the support it received from CEOs and other company officials.

SOURCE: Off Ice of Technology Assessment, 1994.

specifically on psychiatric disability and vocational rehabilitation.

In addition, NIMH is seeking to increase its research portfolio in this area. In 1993, it awarded a contract to two new researchers in mental disorder-based disability and funded a new grant. The contract examines disability data collected in the Baltimore site of the Epidemiologic Catchment Area (ECA) study (see ch. 3). Its objective is to provide national estimates of disability due to mental disorders as well as some information to be used in developing estimates of benefits for health care reform. The grant examines the extent to which job requirements and health status affect the age specific probabilities of work disability or retirement of persons with severe mental disorders.

NIMH's National Plan also specifically identified the need for research to assist in implementing the ADA. A program announcement, *Research on Disabilities and Rehabilitation Services for People with Severe Mental Disorders,* has been active since 1991 and will remain so through July 1994, when NIMH plans to revise and update it. This request for grant applications encourages research on the characterization and classification of disabilities; the assessment of types and combinations of psychosocial and vocational rehabilitation; vocational incentives and disincentives; various environmental factors that affect disability and rehabilitation, including community and employer attitudes and structure and accommodation of work settings; and implementation and effects of the ADA.

Few researchers applied under the program announcement. Based on conversation with several researchers and individuals at the NIMH, OTA found that several factors probably contribute to the lack of interest. First, the program announcement was the first time NIMH announced it was funding research on disabilities due to mental disorders; in general, it takes about a decade to create a full program of research (26). Secondly, several people in the vocational rehabilitation field stress that the review committees at NIMH, with their expertise and preference for randomized research designs typical of biomedical research, do not respond favorably to the types of studies needed on the issues of the ADA and employment (e.g., longitudinal, survey designs). To stimulate research in this area, NIMH held two workshops. The first focused on the state-of-the-art in disabilities and rehabilitation services research. The second was designed to assist new investigators (or those new

to NIMH research funding) to develop research proposals that would be acceptable to NIMH. In a separate one-day session, the NIMH convened experts in physical disability research to discuss the state-of-the-art in research instrumentation and methodologies for possible use in research on disabilities due to mental disorders.

PRESIDENT'S COMMITTEE ON THE EMPLOYMENT OF PEOPLE WITH DISABILITIES

The goal of the President's Committee in the U.S. Department of Labor is to develop employment opportunities for people with disabilities. Created by President Eisenhower in 1955, the President's Committee has an annual budget of $4.0 million and works with approximately 600 individuals (32). They include employers, training and rehabilitation specialists, educators, labor leaders, veterans organizations, medical and health professionals, service organizations, community leaders, as well as people with disabilities and their organizations and advocates.

The ADA has been a cause celebre of the President's Committee. Before the statute's passage, the President's Committee helped to organize nationwide hearings on disability and discrimination. Justin Dart, Jr., the former chair, headed the 63 public forums of the Task Force on the Rights and Empowerment of Americans with Disabilities. The testimony at these hearings provided key "data" on this type of discrimination and helped to propel the ADA's passage. As recounted by Mr. Dart at a congressional hearing:

> Although America has recorded great progress in the area of disability during the past few decades, our society is still infected by the ancient, now almost subconscious assumption that people with disabilities are less than fully eligible for the opportunities, services, and support systems which are available to other people as a matter of right. The result is massive, society-wide discrimination.

Since the ADA's passage, the President's Committee has maintained its support for this statute by organizing an ADA employment summit on December 2, 1992 and conducting a series of teleconferences across 50 States to review ADA implementation.

Recently, the President's Committee has paid more attention to psychiatric disabilities by focusing on their negative images and perceptions. To help fight the pervasive stigma and discrimination, the President's Committee has organized a "Coalition Against the Discrimination of People with Psychiatric Disabilities" (CADPPD). Building on a 1992 summit of 42 national leaders and organizations concerned with media images of mental illness, CADPPD's goals have broadened, as reflected in their mission statement:

> People with psychiatric disabilities must possess the same inalienable rights and responsibilities as all other human beings. The mission of the Coalition is to eliminate discrimination against people with psychiatric disabilities. The purpose of the Coalition is to serve as a forum to share information, discuss policies and opportunities, and to encourage cooperative action to achieve common goals.

CADPPD work groups are developing language guidelines and position papers on such issues as civil rights, and it has prepared a list of workplace accommodations. The coalition includes a diverse membership, representing such groups as the National Alliance for the Mentally Ill, the National Association of Psychiatric Survivors, the National Mental Health Consumers' Association, as well as professional associations.

The Job Accommodation Network (JAN), located on the Morgan town campus of West Virginia University, provides one of the most practical services available from the President's Committee. With an annual budget of less than $1 million ($825,378) in fiscal year 1993 and a staff of 15, JAN provides information and referrals to employers, rehabilitation and social service counselors, and people with disabilities on workplace accommodations. Receiving approximately 4,500 inquiries each month, JAN represents one of the most comprehensive source of information concerning job accommodations currently supplied by the Federal Government. Just a few years ago

JAN answered very few calls concerning psychiatric disabilities (10). Today, 5 percent of the 4,500 calls each month focus on these conditions. Prior to the ADA's passage, about 60 percent of calls about psychiatric disabilities came from people with such conditions or their families. Since the President signed the ADA, however, only 19 percent of the increasing volume of calls come from these individuals, while 41 percent come from businesses. In addition, 20 percent come from health care facilities, 11 percent from educational institutions, and 9 percent from counselors and other service providers (9). Although JAN has not amassed a great deal of in-house expertise on accommodating people with psychiatric disabilities (11), it has developed a list of mental health services that may provide useful information to employers and others.

SUMMARY AND CONCLUSIONS

The Federal Government has a prominent role to play in the ADA's implementation. Besides the law requiring Federal enforcement, technical assistance and research are needed to guide and inform implementation. This chapter surveyed Federal activities relevant to Title I of the ADA and people with psychiatric disabilities.

The ADA requires the EEOC to enforce Title I and calls for the Commission to issue guidelines and regulations, and to provide technical assistance. Despite the considerable amount of technical assistance activity supported by the Commission, little discussion of psychiatric disabilities has occurred. OTA's inquiry of EEOC field offices determined that EEOC investigators consider themselves in need of more information on psychiatric disabilities. While the EEOC has not traditionally focused on a particular class or type of disability, the lack of knowledge about mental disorders and associated disabilities, even among EEOC investigators, and the complex questions that can be raised by these conditions argue for specific attention. Given current staffing and budgetary constraints, it appears unlikely, however, that the Commission will address this area.

In addition to the EEOC, several other Federal agencies—NIDRR, CMHS, NIMH, and the President Committee—have supported some technical assistance efforts concerning psychiatric disabilities, employment, and the ADA. This assistance has targeted employers and people with psychiatric disabilities. Continued efforts are necessary, as ignorance of these conditions and the law itself apparently abound. Collaboration among the mental health/disability research funding agencies and the EEOC may help assure continued and expert technical assistance in today's constrained budgetary environment.

Research is the final category of Federal activity important for ADA implementation and people with psychiatric disabilities. Federal money spent on disability research is historically small, in comparison to the overall expenditures on health research. The research dollars devoted to psychiatric disability and employment fit this same pattern. The leading Federal funders of disability and mental health research—NIDRR, NIMH, CMHS—spend approximately 1.3 percent of their annual budgets on research and technical assistance combined—less than $15 million last year. However, all three of these agencies have recently increased their commitment to psychiatric disabilities and employment research. The challenge will be sustaining and increasing attention to this topic, in order to generate the types of information necessary to effect optimal ADA implementation and employment for people with psychiatric disabilities. As the different research-funding agencies have distinct missions and cultures, a further challenge will be to develop relevant and appropriate research portfolios: relevant to the real world needs of employers and people with psychiatric disabilities and appropriate to a particular agency's mission. Collaboration and coordination of interagency research funding could help in identifying the relevant and appropriate activities in the most efficient way possible. While mechanisms for communicating across agencies have or do exist, they lie moribund at the present time.

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Appendix 5A: Survey of EEOC Field Offices About Psychiatric Disabilities and the ADA

5A

AL	Birmingham (DO)	IL	Chicago (DO)	OH	Cincinnati (AO)
AZ	Phoenix (DO)	IN	Indianapolis (DO)		Cleveland (DO)
CA	Los Angeles (DO)	KY	Louisville (AO)	PA	Philadelphia (DO)
	San Francisco (LO)	LA	New Orleans (DO)		Pittsburgh (AO)
	San Jose (LO)	MA	Boston (AO)	TN	Memphis (DO)
	Fresno (LO)	MD	Baltimore (DO)		Nashville (AO)
	Oakland (LO)	MI	Detroit (DO)	TX	Dallas (DO)
CO	Denver (DO)	MN	Minneapolis (LO)		Houston (DO)
DC	Washington (FO)	MO	St Louis (DO)		San Antonio (DO)
FL	Miami (DO)	NC	Charlotte (DO)	VA	Norfolk (AO)
	Tampa (AO)	NJ	Newark (AO)		Richmond (AO)
GA	Atlanta (DO)	NM	Albuquerque (AO)	WA	Seattle (DO)
	Savannah (LO)	NY	New York City (DO)	WI	Milwaukee (DO)
HI	Honolulu (LO)				

(FO=Field Office, DO=District Office, AO=Area Office, LO=Local Office)

Question	General response
(1) What formal information, training, or assistance do EEOC field office investigators receive about mental illness?	Investigators at 9 field offices indicated they had not yet received any information, training or assistance about mental illness; 15 said mental disabilities were briefly mentioned in ADA training sessions they had attended; 16 had received small amounts of training or assistance about mental illness: some viewed a videotaped training session, some participated in training sessions conducted by mental health care providers or advocacy groups in their communities, and some did both.
(2) What formal information, training, or assistance do EEOC field office investigators receive about how the ADA's provisions will specifically affect employment for people with psychiatric disabilities?	Nearly all investigators have attended ADA training sessions and/or conferences that discussed ADA provisions. A single example of how this law might affect employment for people with psychiatric disabilities was provided.
(3) Have field office staff received formal or informal assistance from sources other than the EEOC, e.g., local experts on mental illness and psychiatric disabilities such as care providers, Federal, State, or local government agencies (State Mental Health Agency, Community Mental Health Center, Vocational Rehabilitation Agency), representatives of professional or consumer groups (mental health professional associations, Alliance for the Mentally III, researchers at universities), others?	Fifteen of the field offices have received information and assistance from representatives of State vocational rehabilitation offices, mental health advocacy groups, NIDRR's regional Disability and Business Technical Assistance Centers, Mental Health Associations, Independent Living Resource Centers, the Thresholds National Research and Training Center, in Chicago, Illinois, and the National Association of State Mental Health Program Directors, Washington, DC.
(4) If field office staff receive formal or informal assistance from other sources, does it come in the way of a seminar? provision of materials? intermittent contact when specific cases or questions arise? or by other means?	Information and assistance from sources other than the EEOC come in seminars, training sessions, meetings, brown–bag lunches, intermittent contact when a need arises, and written materials.
(5) Would further training, information, or assistance on mental illness and psychiatric disabilities be useful? If so, what types would be useful?	All of the respondents indicated that further information, training, and assistance would be useful in areas such as sensitivity training, information on specific mental illnesses, work disabilities associated with them, and appropriate accommodations.

Appendix A: Workshop Participants

A

Americans With Disabilities Act, Mental Illness, and Employment
April 21,1993

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Note: OTA **appreciates and is grateful** for the valuable assistance provided by the workshop participants. The workshop participants do not, however, necessarily approve, disapprove, or endorse this report. OTA assumes full responsibility for the report and the accuracy of its contents.

Appendix B: Acknowledgments

B

OTA thanks the many individuals and organizations that generously supplied information for this study In addition, OTA acknowledges the following individuals for their review of drafts of this background paper:

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Appendix C: List of Contractor Documents

For this report, the Office of Technology Assessment commissioned two reports on topics related to psychiatric disability and the Americans With Disabilities Act. The reports are available in a single volume (NTIS PB 94-140902) from the National Technical Information Service (NTIS) in Springfield, VA. For additional information, call NTIS at (703) 487-4600.

- *Psychological Testing, the ADA, and Mental Illness,* K.A. Tanasichuk, and K.A. Kirchner, Washington Business Group on Health, 1993.
- *The ADA and Psychiatric Disabilities: Human Resources to Assist in Implementing Title I,* B.D. Emery and L.L. Mancuso, 1993.

These contractor documents were prepared for the OTA assessment entitled *Psychiatric Disabilities, Employment, and the Americans With Disabilities Act. They are* being made available because they contain much useful information beyond that used in the OTA report. However, they are not endorsed by OTA, nor have they been reviewed by the Technology Assessment Board. References to them should cite the contractor, not OTA, as the author.

Appendix D: Acronyms and Glossarv of Te;ms D

ACRONYMS

ADA — Americans With Disabilities Act
ADAA — Anxiety Disorders Association of America
CADPPD — Coalition Against the Discrimination of People With Psychiatric Disabilities
CLC — Corporate Leadership Council
CMHS — Center for Mental Health Services
CPS — Current Population Survey
CSP — Community Support Program
D/ART — DEPRESSION Awareness, Recognition, and Treatment
DBTAC — Disability and Business Technical Assistance Center
DOL — U.S. Department of Labor
DOT — Dictionary of Occupational Titles
DSM-III-R — Diagnostic and Statistical Manual, third edition, revised
EAP — Employee Assistance Program
ECA — Epidemiologic Catchment Area
EEOC — U.S. Equal Employment Opportunity Commission
ERISA — Employee Retirement Income Security Act of 1974
FHA — Fair Housing Act
FJA — Functional Job Analysis
HUD — U.S. Department of Housing and Urban Development
ICIDH —International Classification of Impairments, Disabilities, and Handicaps
IOM — Institute of Medicine
JAN —Job Accommodation Network
JIMS — Job Information Matrix Systems
NAMI — National Alliance for the Mentally Ill
NAPAS — National Association of Protection and Advocacy Systems
NAPS — National Association of Psy - chiatric Survivors
NASMHPD — National Association of State Mental Health Program Directors
NCOD — National Council on Disability
NDMDA — National Depressive and Manic-Depressive Association
NHIS — National Health Interview Survey
NIDRR — National Institute on Disability and Rehabilitation Research
NIMH — National Institute of Mental Health

NIOSH —National Institute for Occupational Safety and Health
NMHCA — National Mental Health Consumer Association
OFCCP — Office of Federal Contract Compliance Programs
PAIMI — Protection and Advocacy for Individuals with Mental Illness
PHA —public housing agency
RSA — Rehabilitation Services Administration
SAMHSA — Substance Abuse and Mental Health Services Administration
SIPP — Survey of Income and Program Participation
SSA — Social Security Administration
SSDI — Social Security Disability Insurance
SSI — Supplemental Security Income
UCDI — Uniform Client Data Instrument
VR — vocational rehabilitation
WBGH — Washington Business Group on Health
WHO — World Health Organization

GLOSSARY OF TERMS

Activities of daily living: Used in various measures of functional limitations, activities of daily living or ADLs are the most basic level of self-care tasks, which typically include such activities as feeding oneself, maintaining continence, using the toilet, bathing, dressing, getting in and out of a bed or chair, and getting around inside the house. See *functional limitation.*

Bipolar disorder: A severe mood disorder characterized by manic and major depressive episodes, with periods of recovery generally separating the mood swings. Psychosis may be present during manic episodes. See *major depression.*

Direct threat: Defined in the ADA as "a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation" (42 U.S.C. 121 11). Under the ADA, employers may include as a qualification standard a requirement that an individual not pose a direct threat in the work place.

Disability: As defined by the ADA, "with respect to an individual: (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment" (42 U.S.C. 12102(2)). In general, disability reflects impairment, its functional sequelae, and environmental supports and demands. Under the functional limitation model of disability, disability refers to impaired performance of a socially defined role, reflecting an impairment or functional limitation and the environmental supports and demands. In the World Health Organization's model of disability, disability is the result of impairment, referring to the inability or restricted ability to perform activities considered within the range normal for humans. See *functional limitation model of disability, impairment, functional limitation, psychiatric disability.*

Disability rights movement: Comprises a coalition of people with various types of disabilities, who work together advocating for disability policies that foster independence, integration, adequate services, freedom of choice, and self-determination.

Disease: Under the World Health Organization system of classifying disability, refers to pathology in an individual. See *pathology, impairment, disability.*

Dysthymia: A disorder under the DSM-III-R involving a chronic mood disturbance, specifically depressed mood, for at least 2 years. Other symptoms may be associated with the periods of depressed mood as well, including: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. See *major depression.*

Empowerment: A fundamental principle held by people with psychiatric disabilities who have organized, empowerment connotes a sense of

personal and social potency; acquiring the ability to make decisions that affect an individual's life. See *disability rights movement.*

Essential functions of a job: Defined in the ADA as "those functions that are not marginal; the fundamental job duties of the employment position. Reasons for calling a task an essential function include: the function may be essential because the reason the position exists is to perform that function; the function may be essential because of the limited number of employees available among whom the performance of that job function can be distributed; and/or, the function 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). See *qualified individual with a disability.*

Fair Housing Act Amendments of 1988: The original Fair Housing Act, passed in 1968, prohibits discrimination in public and private real estate transactions based on race, color, religion, sex, or national origin. The 1988 Amendments extended its coverage to people with disabilities.

Fountain House: Founded in 1957 in New York, it pioneered "clubhouses," an approach topsychosocial rehabilitation that provides for transitional employment services. The club houses place individuals in temporary jobs with onsite support and training. See *Transitional employment.*

Functional limitation: Restrictions on an individual's actions or activities, under the functional limitation model of disability. *See finetional limitation model of disability.*

Functional limitation model of disability: A model of disability that includes four stages on the path toward disability: pathology, impairment, functional limitation, and disability. This model notes that a variety of factors, such as treatment, financial resources, or personal expectations, can impinge on any stage. The model also asserts that disability is not the inevitable result of a pathological condition, impairment, or even functional limitation. See *pathology, impairment, functional limitation, and disability.*

Handicap: Under the World Health Organization's model of disability, a person is said to have a handicap when an impairment or disability limits or prevents role performance for that individual in society. Is equivalent to the term disability in the functional limitation model of disability. Term is generally rejected as stigmatizing in the United States. See *disability.*

Illegal use of drugs: According to the ADA, illegal use of drugs means "the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act" (21 U.S.C. 812).

Impairment: Impairment reflects functional restrictions at the organ level, stemming from either pathologies or other mental, emotional, physiological, or anatomical losses or abnormalities. Under EEOC regulations for the ADA, impairment refers to "any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, heroic and lymphatic, skin, and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities" (56 FR 35735). *See functional limitation model of disability.*

Instrumental activities of daily living: Used in various measures of functional limitations, instrumental activities of daily living or IADLs are activities relevant to independent living, including such things as use of the telephone, travel beyond walking distance, shopping, preparing meals, doing housework and/or laundry, taking medications, managing finances, and doing yard work. See *activities of daily living.*

Major depression: A mood disorder characterized by profound depression, that is, complete loss of interest or pleasure in activities. Other

common symptoms include weight gain or loss, insomnia or excessive sleepiness, slowed or agitated movement, intense feelings of guilt or worthlessness, diminished ability to concentrate, and recurrent thoughts of death or suicide. Bouts of depression commonly recur. Psychosis may also accompany major depression. See *bipolar disorder*.

Major life activities: As defined by the EEOC in regards to the ADA, major life activities are functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. Major life activities are those basic activities that the average person in the general population can perform with little or no difficulty. To be covered under the ADA's first prong of the definition of disability, impairments must substantially limit one or more major life activity. Critics argue that the EEOC definition of major life activities is not useful for psychiatric disabilities. See *disability, impairment.*

Obsessive-compulsive disorder: A mental disorder characterized by recurrent and persistent thoughts, images, or ideas perceived by the sufferer as intrusive and senseless (obsessions) and by stereotypic repetitive, purposeful actions perceived as unnecessary (compulsions). It is generally a chronic condition, with symptoms waxing and waning over time.

Panic disorder: A mental disorder characterized by sudden, inexplicable bouts, or attacks, of intense fear and strong bodily symptoms, namely, increased heart rate, profuse sweating, and difficulty breathing. Panic attacks occur twice a week, on average.

Pathology: Under the functional limitation model of disability, pathology refers to an abnormal change in a normal bodily process or structure that results from such factors as infection, trauma, or developmental process. See *functional limitation model of disability, disease.*

Primary consumer: Refers to individuals with disabilities themselves. See *secondary consumer.*

Psychiatric disability: A disability that flows from a mental disorder. Functional limitations commonly associated with psychiatric disabilities include problems with social interactions, dealing with stress, and concentrating. See *disability.*

Psychosis: A mental state characterized by extreme impairment of the sufferer's perception of reality, including hallucinations, delusions, incoherence, and bizarre behavior. Psychosis is a prominent symptom of schizophrenia. See *schizophrenia.*

Psychosocial rehabilitation: Comprises a broad range of services that assists persons with long-term psychiatric disabilities increase their functioning so that they are successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention. See *Fountain House.*

Qualified individual with a disability: As defined by the ADA, "an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such person holds or desires." See *essential functions of a job.*

Reasonable accommodation: Under the ADA, "the term 'reasonable accommodation' may include: (A) making existing facilities used by employees readily accessible to and usable by individuals with disabilities; and (B) job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities." See *undue hardship.*

Rehabilitation Act of 1973, Title V: Important legal antecedent to the ADA. Sections 501 and 503 require affirmative action in the hiring and advancement of people with disabilities by the Federal Government and any of its contractors

(and, under section 503, subcontractors) receiving over $10,000. These sections forbid Federal executive agencies and Federal contractors and subcontractors from job discrimination against People with disabilities. Section 504 prohibits discrimination or exclusion because of disability in all programs or services offered by recipients of Federal funds and by executive agencies.

Schizophrenia: A mental disorder characterized by disturbance of cognition, delusions and hallucinations, and impaired emotional responsiveness. The disorder consists of positive symptoms (delusions, hallucinations, illogical thought, and bizarre behavior) and negative symptoms (blunting of emotion, apathy, and social withdrawal). See *psychosis.*

Secondary consumer: Refers to family members or others who care for people with disabilities. See *primary consumer.*

Social Security Disability Insurance (SSDI): An income maintenance program operated by the U.S. Social Security Administration. It is an insurance program for those who have become disabled. Eligibility for this program hinges on the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. See *Supplemental Security Income.*

Supplemental Security Income (SSI): An income maintenance program operated by the U.S. Social Security Administration. It is a social welfare program for people who are blind, aged, or disabled. Eligibility for this program hinges on the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. See *Social Security Disability Insurance.*

Supported employment: A term applied to a variety of programs to assist individuals with severe disabilities in paid employment. Supported employment services are integrated into the work setting. 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. See *transitional employment.*

Technical assistance: Any form of information dissemination aimed at assisting with implementation of the ADA, including: brochures, public and video presentations, conferences, training programs, toll-free help lines, computer bulletin boards, clearinghouse activities, posters, or manuals.

Transitional employment: An approach to vocational rehabilitation that places individuals with disabilities in temporary jobs with onsite support and training. See *Fountain House.*

Underwrite: The process by which an insurer determines whether and on what basis it will accept an application for insurance.

Undue hardship: Defined by the ADA as "an action requiring significant difficulty or expense . . . In determining whether an accommodation would impose an undue hardship on a covered entity, factors to be considered include: (i) the nature and cost of the accommodation needed under this Act; (ii) the overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility; (iii) the overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of its employees; the number, type, and location of its facilities; and (iv) the type of operation or operations of the covered entity, including the composition, structure, and functions of the workforce of such entity; the

geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the covered entity" (42 U.S.C. 12111). See *reasonable accommodation.*

Vocational rehabilitation: Comprises a broad range of services that assist persons with disabilities increase their functioning at work. Typically a component of psychosocial rehabilitation. See *psychosocial rehabilitation.*

Workers' compensation: Provides cash benefits, medical care, and rehabilitation services for workers who suffer work-related injuries and diseases. The workers' compensation system, which is enacted by State and Federal laws, operates on the underlying principle that employers should assume the costs of occupational disabilities without regard to fault. Employers covered by workers' compensation are relieved from civil actions involving negligence. Benefits are paid by insurance companies, special State insurance funds, or by employers acting as self-insurers.

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