MENTAL IMPAIRMENT IN THE AMERICANS WITH DISABILITIES ACT

Albert M. Drukteinis, M.D., J.D.

In 1990 the Americans with Disabilities Act (ADA) was signed into law with the purpose of creating a level playing field for the physically and mentally disabled in the work force. Title I of that act specifically requires equal employment opportunity for individuals considered disabled. At the front end, this prohibits employers from discriminating against the disabled in their hiring practice. Specifically, employers cannot turn away applicants who are impaired or who have a record of impairment or who they regard as impaired, if the applicants are otherwise qualified to perform the essential functions of the job. At the back end, employers must make reasonable accommodations to keep employees who become impaired or whose impairment is discovered. Since forty-three million Americans have some form of disability, the ADA has more than a trivial impact on the workplace and has far reaching social implications. With mental impairment, the potential impact is even greater and perhaps far more than was ever originally intended by Congress.

Epedemiological statistics on mental impairment and mental illness vary widely. Some studies report that 2% of the population has a serious mental illness. Others say that as many as 20% of people have some form of mental impairment. Still others predict that in the course of a lifetime, one out of every three people will suffer from a mental or emotional disorder. The ADA anticipated this and therefore tried to restrict the impairments that it protects to substantially limit one or more of the major life activities of an individual. Being substantially limited can mean either unable to perform or significantly restricted. Clearly, in physical impairments such as blindness, paralysis, or cerebral palsy, the limitation is visible but, in mental impairments the limitation is often invisible and, therefore, can be based at times almost entirely on a person's subjective account. Because of this, workers with mental impairments may gain both a needed opportunity under the ADA or an exploitive advantage.

The majority of ADA claims for mental impairment are by individuals with mental retardation. Some of them have visible signs of their condition, but even if they do not, intelligence testing produces an objective measure of their limitation in intellectual functioning. In spite of this many of them are able to perform quite adequately in the workplace, often with only minimal accommodation. The next most common mental impairments claimed under the ADA are the serious mental illnesses such as Schizophrenia and Bipolar Disorder (formerly Manic Depressive illness). These individuals may or may not have visible signs of their impairment but usually have an extensive record of hospitalization or psychiatric treatment that documents their illness and limitations. Individuals with these illnesses, too, can often lead productive lives with accommodation and should not be arbitrarily excluded from the workplace. Many of them, in between episodes of exacerbation of their symptoms, can be valuable and productive employees. Whether or not the ADA has actually helped these groups of people is not clear. Some statistics show that since 1990 a third invoking the Act improved their status initially, but did not advance much further over time and may have even regressed in status eventually. Nonetheless, for them the ADA provides an important safety net. The more difficult problem is with impairments and illnesses that are not as visible and not as objectively documented.

With increased medicalization in our society today, the numbers of psychological disorders and syndromes have grown as well. There are now approximately four hundred official mental disorder diagnoses (Diagnostic and Statistical Manual of Mental Disorders IV, American Psychiatric Association), more than twice the number that were identified thirty years ago. They include a host of mood

disorders, anxiety conditions, personality trait disturbances, compulsions, sexual aberrations, and addictions. With the ease of making a psychiatric diagnosis because of the blurry boundaries of many criteria, mental health clinicians will invariably find a disorder in anyone that comes through their door. Being distressed alone, for example, can readily be diagnosed as a significant psychiatric condition, Major Depression. All that it takes is two weeks of having sadness, diminished interests, poor sleep, tiredness, and difficulty with concentration. None of these complaints are visible beyond what the individual subjectively reports or wants to project. Surely there are conditions of Major Depression which represent real illnesses that are treatable and should not be discriminated against, but who is depressed and who is just distressed are often indistinguishable. Again, the ADA requires a substantial limitation in one or more of major life activities, but it is difficult to argue that it's not substantial if someone says they are too tired to work or can't concentrate on their work or are too nervous around other people.

Under the ADA, reasonable accommodation requires modification of the hiring practices to ensure that otherwise qualified applicants with a disability are not excluded, and modification of the workplace to enable those individuals to perform the job if they are able. Each case must be evaluated on its own merit. In mental impairments the most frequently used accommodations are flexible leave, time off for mental health treatment, tolerance for odd behavior, written instructions, and flexible schedules. When the impairment is not visible such accommodations can be disruptive to other employees, especially if there is a perception of inappropriate privilege. If that perception is due to the stigma that still exists in our society about mental illness, then complaints may not be justified. On the other hand, if the perception is due to recognition that someone has exploited the employer and has taken unfair advantage, then this can have a very damaging effect on employee morale.

Numerous problems arise with mental impairments under the ADA. For example, in the area of addictions, the behavior of abusing alcohol and drugs may not qualify as an impairment, but the condition of addiction might. How far does an employer need to go to accommodate the habit? Which behavior is voluntary and which is involuntary? Another example is with conduct disorders such as sexual compulsions and other undesirable behavioral traits. Typically these are not considered a mental impairment under the ADA, but such disorders often overlap or accompany other more traditional psychiatric conditions such as mood or anxiety disorders. It is not unusual, therefore, to see both diagnoses. It is also not unusual to see the inference that if it was not for the mood disorder, the maladaptive behavior would not be present. How much should an employer have to tolerate in this regard? Even if there is a diagnosis of an emotional disorder, don't employees have responsibility for their actions? Does the behavior constitute actual clinical symptoms, or is it merely willful aberrant conduct? Yet another example is the difficulty determining whether employees are unable to perform job functions or are merely unwilling to perform them. How often do we use the phrase, PHI just can't do it!" when we really mean, "I just don't want to do it." Who can objectively and scientifically make that distinction in a subjective mental impairment?

The Social Security Administration has also grappled with this issue and has adopted what is known as the treating physician rule which gives great weight to the clinician who should know the patient the best. But mental health clinicians invariably become allied with their patients and accept their patients' complaints at face value. In a clinical setting where no other agenda exists, this is probably reasonable. But, when special accommodations or other relief is being sought, the clinicians' objectivity is highly suspect. Beyond that, clinicians who are not familiar with the specific nature of the work other than

what patients tell them, may not be in the best position to draw conclusions about how the mental impairment will affect work performance and what accommodations are necessary. Blanket statements such as stress free environment are almost meaningless and yet frequently used. Sometimes rehabilitation counselors and vocational experts may be in a better position to identify the feasibility of workplace accommodations. They are often trained in facilitating reentry to work and make personal site visits. But, even here, they will have to rely on subjective accounts of mental impairment which may not be easily translated to objective job tasks.

As workers in this country face job uncertainties, layoffs, downsizing, and increased pressure for productivity, the likelihood of distress is high. The subjective nature of mental impairment under the ADA allows one avenue of relief. Litigation in this area can be expected to increase.