

Disability Discrimination Act 1995 and mental illness

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The Disability Discrimination Act 1995 came into effect in stages from December 1996 to alleviate some of the disablement experienced by those with long-term physical or mental impairments. It covers a number of areas within the experience of all people: employment, property, access to goods and services, public transport and education, and places new responsibilities upon those providing such services: employers, service providers and landlords.

People with mental illness in both primary and secondary care may well have been unfavourably treated because of these illnesses and, as such, are entitled to redress under the Act. Many of these people will not be aware that they have a disability and thus covered by the Act. In the United Nations 1993 statement upon disability, the *Standard Rules on Equalisation of Opportunities for Persons with a Disability*, disabilities arising from physical and mental illness have been treated equally. This Act continues the attempt to provide parity in rights and legislation for those with mental illness. The UK now joins North America and Australia in introducing anti-discriminatory legislation. Previous constitutional bills of human rights in these countries have been no safeguard against discrimination. Such bills can only make generalisations and not the specifics that are needed to apply to a minority group who actually are different from a society's norm.

The Office of Population Censuses and Surveys' survey of disability in Great Britain (Martin *et al*, 1988) estimated that there were just over six million adults with one or more disabilities in Great Britain, 70% of whom were aged 60 or over. Mental disorders comprise 13% of the impairments causing disability in adults living in private households and 56% of the impairments of those in communal establishments. They form an increasing proportion of the impairments as disability becomes more severe. The British psychiatric morbidity survey revealed a substantial social disability, evidenced by greatly reduced levels of economic activity and impaired daily functioning in both those with psychotic and neurotic disorders (Jenkins *et al*, 1998). Under similar USA legislation, those with

mental illness form the second largest category of claimants (13%) behind back problems (18%).

Definition of disability

Disability, derived from any of the potential models whether 'medical' or 'social', is a continuum ranging from very severe to very slight, and a threshold must be set to decide who is and is not covered by laws and services. With operationalised criteria for diagnosis, psychiatrists, unlike many other doctors, should be familiar with this concept. Section 1 of the Act defines disability as

"a physical or mental impairment which has a substantial and long term adverse effect on a person's ability to carry out normal day to day activities"

All five criteria within this definition must be met.

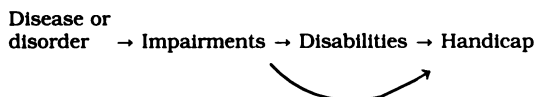
A mental impairment "includes a clinically well recognised mental illness and what is commonly known as a learning disability" (Disability Discrimination Act 1995: DL70). Certainly for the latter group there can be a recognition of disability (e.g. ability to concentrate, learn or understand, without a clinically recognised impairment) (*Walton v. L.I. Group*, further details available from the author upon request). Furthermore, and importantly for psychiatrists, the following are specifically excluded: addiction to alcohol, nicotine, or any other substance (unless resulting from medical prescription); a tendency to set fires, steal, physically or sexually abuse others; and exhibitionism or voyeurism. People who have a disability, and people who have had a disability for a period of time but no longer have one, are covered by the Act. Guidance for employers gives a specific example of someone who has recovered from a disabling clinical depression who is covered in the Act (Disability Discrimination Act: DL170. What employers need to know).

A long-term adverse effect is one which is detrimental and has lasted or is expected to last 12 months. A person who had had a single episode of schizophrenia should be covered if the disabled period, and the prodromal phase could

be included if disabling was greater than 12 months, even if now well and with no likelihood of relapse. Those with fluctuating conditions are also covered if the substantial adverse effects are likely to recur. Greater clarity should be provided by cases in the near future. At present the cases of mental illness that have come to tribunals so far have not helped: a woman with bipolar affective disorder won her case for unfair dismissal while a man with schizophrenia, whose symptoms were well controlled, was initially ruled not to qualify as disabled. This latter case was finally successful at appeal. Despite its unclear nosological status, chronic fatigue syndrome has been counted as an impairment which can lead to disabling effects. Genetic predispositions, such as those with the dominant gene for Huntington's disease who have not yet developed impairments, are not covered.

The level at which an effect is 'substantial' is not very helpfully defined as 'more than minor'. As well as affecting physical and sensory abilities, those of concentration, learning, understanding and perceiving danger are included. Psychological impairments such as hallucinations and delusions are not specifically covered. However, unlike American legislation, any detrimental effect of medication is not considered, just the underlying impairment. Impairments which would produce substantial effects but for medical treatments are included. Three examples are given in the guidelines, one of which is "the inability to remember and relay a simple message correctly". In the case cited above the Industrial Tribunal used qualifying criteria for the Disability Living Allowance. Effects which are at present minor but likely to become substantial because of the progressive nature of the impairment are also covered by the Act.

The reliance of the disability criteria on "the ability to carry out day to day activities" appears to have been based upon the World Health Organization's *International Classification of Impairments, Disabilities and Handicap* (World Health Organization, 1980). In this schema the dimension of disability is defined in terms of basic activities and the individual's limitations in performing them, as opposed to noticeable clinical signs (impairments) and the individual's relative disadvantage in certain roles due to the response of society (handicap). This is demonstrated diagrammatically as:



Within this schema impairments would be seen as psychopathology, including intellectual and memory dysfunction, and handicap as

impaired role (e.g. occupational, performance). It is these two areas that the psychiatric literature has concentrated on, yet we are now asked to consider the dimension of disability in supporting our patients. This may require a paradigm shift in the mind-set of many clinicians to that of the professions allied to medicine (e.g. occupational therapy). (The schema has, however, been criticised as reflecting too great a medical model of the disablement process and on using terminology that many find offensive. It is currently being revised and piloted within the UK and internationally.)

Areas covered by the Act

Employment

Employers are known to discriminate against those who have or have had a mental illness (Manning & White, 1995; Glozier, 1998). It is now unlawful for an employer to treat a disabled person less favourably than someone else because of their disability unless there is a good reason. This includes matters such as recruitment, training, promotion and dismissal, for temporary, contract and permanent staff. It does not prevent employers from enquiring into the health conditions of a prospective employee. Employers have a duty to make reasonable adjustments in the workplace to overcome the effects of the disability. These adjustments might include altering working hours, which may allow for early morning sedation, allowing absences for treatment during working hours, and providing supervision for those who lack confidence. A reasonable level of absenteeism is "little more than what the employer accepts as sick leave for other employees" (Disability Discrimination Act 1995: DL70 Employment). The "reasonableness" of the adjustment is decided on a case by case basis and takes into account the effectiveness of the adjustment, its costs and disruption and the resources of the employer. This has been tested legally in *Cox v. Post Office* where the Tribunal highlighted the insignificant cost of adjustment compared to the Post Office's financial resources (further details available from the author upon request). There also exists an Access to Work scheme which will pay for the majority of the costs. Employers with fewer than 20 employees and certain uniformed occupations are currently exempt from the Act, and this level will fall to 15 employees this year. If it is felt that there has been unfair discrimination or a failure to make reasonable adjustments the (potential) employee makes an application, within three months, to an industrial tribunal.

Access to goods and services

The Act affects anyone supplying goods, facilities or services to the public. It is illegal to refuse to serve, offer a service at a lower level or on different terms to a disabled person (e.g. asking for a larger deposit). There are some caveats to this, such as if the changes required to alleviate discrimination fundamentally contravene the way a business is conducted (e.g. a restaurant will still be able to require a certain level of behaviour). One of the assumptions implicit within the Act is a parity of disability. If the criteria for disability are met then one is disabled, regardless of whether the initial impairments arose from a physical or psychological cause. Again this has not been tested but it would logically follow that services, such as those supplied by a local council, should not discriminate on the basis of the cause of the disability. This may well have implications, for example equal access to travel cards or meals on wheels for those who cannot get around their locale or prepare meals from whatever type of impairment, it is the disability that is important.

Selling or letting property

Unreasonable discrimination by vendors, lessors and their agents is now illegal. With many people with disability arising from psychiatric disorder living in the community this may have implications for housing associations and their ilk who provide the bulk of this accommodation. It would apparently be illegal to charge a higher rent to someone who neglected the upkeep of their property because of their disability.

Education

The Act contains specific measures requiring educational establishments, for both children and adults, to provide information about admission and access to those with disabilities, and to ensure fair treatment. Again there is an assumption of parity for the disabled of whatever cause.

Transport

The Government will in future be able to set minimum standards for new public transport vehicles though this will predominantly affect those with disability arising from neuromuscular impairments.

Role of mental health professionals

Psychiatrists and the mental health team have a number of possible roles in the application of the Disability Discrimination Act 1995.

Clinical

Some knowledge of the Act by clinicians taking detailed histories and looking for psychosocial precipitates and perpetrators of mental disorder could be useful in detecting discrimination and unfavourable treatment in areas such as employment and housing. Reduction in these environmental stressors (possibly construed as entrapment or danger events) may well ameliorate overall disablement and aid clinical treatment. Acknowledgement of the stigma and discrimination that psychiatric diagnoses produce, and that the clinician is taking steps to reduce these, may engender a better relationship.

Rehabilitation

For those involved in rehabilitation a joint emphasis on fostering strengths and reducing impairments through methods from social skills training to cognitive restructuring is recommended (Hafner, 1996). The multi-disciplinary team is ideally placed to examine the environmental factors acting as barriers to someone's participation in society. The Disability Discrimination Act should give legislative leverage to changing employer's practices and making supported work more available (Beyer & Kilsby, 1996). The services provided by employment rehabilitation centres and placing, assessment and counselling teams, though not ideal (Floyd, 1998) should aid in the establishment of 'reasonable adjustments' for individuals.

Legal

The field of employment is an area where clinical reports will increasingly be required. Although the disabled person themselves may well be the best person to consult upon potential work adjustments, the guidance for employers recommends that expert advice be considered. Cases that have gone to tribunals have often relied upon medical testimony in deciding whether or not the applicant meets the disability criteria (further details available from the author upon request).

Advocacy

There is no legal aid for applicants under the Act. Some have relied upon trade unions or Citizens' Advice Bureaux. MIND and other organisations have been able to act as advocates in a few cases. The system of advocacy, both statutory and voluntary, for many with mental illness is well placed to help with this representation and requires advocates to be informed of the Act.

Research

For many purposes our reliance upon psychopathology may be adequate. It is becoming apparent that appreciation and measurement of disability has many applications: prediction of length of stay in hospital (Boot *et al.* 1997), vocational capacity (Massel *et al.* 1990), and as a mediator of the psychological effects of chronic medical conditions (Ormel *et al.* 1997). Research into the disability associated with mental illness will give a greater understanding of resource needs and the individual consequences of tackling environmental factors.

Policy

In a service of limited resources based upon individual need it has been recommended that disability be one of the determinants of need (Slade *et al.* 1997). Whether someone meets criteria for disability set out in the Act could form part of the determination of level of care under the Care Programme Approach or assessment for inclusion in the Supervision Register. It could well form part of a minimum data set (Glover *et al.* 1997). The legal definition is not too dissimilar to that used for subscales four, five and 10–12 of the Heath of the Nation Outcome Scales rating (Wing *et al.* 1996) and a composite rating could be derived with little effort to ascertain whether someone would be covered by the Act.

Conclusion

The Disability Discrimination Act should be valuable assistance in improving the lives of those with mental illness and their participation in society. An understanding of its nature and remit by clinicians can only aid this process.

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