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The Disability Discrimination Act 1995 and psychiatry: lessons from the first seven years

AIMS AND METHOD

To extract relevant information for clinicians from reported and/or accessible cases involving psychiatric illness brought under the Disability Discrimination Act 1995 (DDA). Institutional databases were searched for DDA cases and relevant guidance from case law extracted.

RESULTS

Over half the cases reaching higher courts involve psychiatric illness. A

number of decisions provide guidance for clinicians wishing to aid their own patients, and those involved as expert witnesses. These cover which conditions are included as impairments (almost everything in ICD–10), what associated effects are to be considered, and the relevance of comorbidity and treatment. Cases often involve recovery of clinical documents that reveal interesting variation in professional standards.

CLINICAL IMPLICATIONS

Virtually all patients of psychiatrists in secondary care would be covered by the DDA. Knowledge of this Act could be used to enhance a patient's access to employment and services, and potentially overcome some of the effects of stigmatisation.

The introduction of the Disability Discrimination Act 1995 (DDA) brought with it obligations upon employers and service providers to not treat the disabled less fairly than others. Later this year, this law will be applicable to all employers, including the police and fire services, and include provision for harassment. Unlike laws affecting race and gender, this is not the same as treating everyone equally, e.g. when returning from sick leave, employees with disabilities should not be treated under standard redeployment policies. Psychiatrists might be affected by this law in a number of ways. First, when, as managers, they are involved in interviewing and employing staff they should be aware of any potential discrimination related to disability. Second, even given the low levels of employment among most patients of general psychiatrists, they might be aware of instances of discrimination that could be directed towards employment tribunals or solicitors. Finally, there has been an increasing requirement for medical reports as more cases reach employment tribunal (ET) and Employment Appeal Tribunals (EATs). A number of judicial rulings from EATs (the superior Court of Record dealing with appeals from the decisions of the ET) have provided benchmarks for clinicians' reports. Over half of these cases involve psychiatric illness and this article aims to summarise them for those involved in such cases.

Assessment of diagnosis and disability

The primary role of the psychiatrist in providing a report is outlined in *Abadeh v. British Telecommunications plc* [2001]; 'the medical report should deal with the doctor's diagnosis of the impairment, the doctor's observation of the applicant carrying out day-to-day activities and the ease with which he was able to perform those functions,

together with any relevant opinion as to the prognosis and the effect of medication'. Generally this assessment will be retrospective: 'the appropriate time at which to adjudicate whether a person is disabled or not is the date of the unfavourable treatment alleged to have been dealt to him' [*Cosgrove v. Caesar & Howie*, 2002]. Contemporaneous materials, e.g. general practitioner (GP) records, are obviously important in assessing this. Legally, and following *Goodwin v. Patent Office* [1999], this assessment involves referencing four separate conditions in order to establish whether a person has a disability.

Does the person have a mental impairment?

Under the DDA, a mental impairment includes an impairment that results from or consists of a mental illness provided that the mental illness is a clinically recognised illness. Helpful guidelines were set out in *Morgan v. Staffordshire University* [2002]. In practice this includes any condition that meets the diagnostic criteria for an illness in ICD–10 (World Health Organization, 1992) or DSM–IV (American Psychiatric Association, 1994). As such, many impairments could result from 'minor' neurotic illnesses such as mixed anxiety and depression, which rarely make it into routine psychiatric practice. The EAT seems to take a relatively, but understandably pedantic, view on this. Clinical descriptions in notes are not sufficient: 'whilst the words "anxiety", "stress", and "depression" could be dug at intervals out of the copies of the medical notes put before the tribunal, it is not the case that their occasional use, even by medical men, will, without further explanation, amount to proof of a mental impairment within the Act... even GPs we suspect, sometimes use such words without having a technical



meaning in mind' [Morgan v. Staffordshire University, 2002]. The observations of the judge also suggested that any report should not only identify the illness, but also describe the presence or absence of symptoms identified in the diagnostic guidelines.

A number of cases have considered myalgic encephalomyelitis (chronic fatigue syndrome). This condition has been considered from an early stage to be an impairment under the Act [O'Neill v. Symm & Co Ltd]. Other medically unexplained conditions that many psychiatrists consider to fall within their remit such as fibromyalgia, irritable bowel syndrome etc are similarly covered. The important issue is not what causes a condition, but whether a body of medical opinion accepts its existence. In addition, physical impairments for which no organic cause can be found and which are presumed to be due to functional overlay, would appear to be covered within the Act. In clarifying previously conflicting results for these conditions Lord Justice Mummery, in the Court of Appeal (a higher court than the EAT) held that 'impairment . . . may result from an illness or it may consist of an illness' [McNicol v. Balfour Beattie Rail Maintenance, 2002].

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. Again, following guidelines that 'it is not necessary to consider how an impairment was caused, if a mental impairment, e.g. depression, results from an addiction then this too is covered' [Power v. Panasonic, 2003].

Finally, a very recent case highlights what may prove a future legal minefield. In Murray v. Newham Citizens' Advice Bureau [2003] the applicant disclosed he had been in prison for stabbing a neighbour with a knife, and was diagnosed as having schizophrenia at the time. Having been turned down for the post, the employment tribunal dismissed his claim for discrimination on the grounds he was rejected for the stabbing incident because of the 'tendency to physical abuse' not his schizophrenia. The EAT held that this tendency was the result of his schizophrenia and so he had been discriminated against on the grounds of his disability. This case raises the spectre of employers (and all service providers) having duties to consider reasonable adjustments to accommodate those with similar histories. Psychiatrists may be asked to predict risk of harm, and in the case of Mr A v. London Borough of Hounslow [1998], even a small elevated risk was considered a 'substantial and material reason' not to employ Mr A, who had schizophrenia.

Unlike similar legislation in the USA, personality disorder has yet to be tested in a reported case as the basis for an impairment, although early ministerial guidance made it unlikely. Given that personality disorder is included in ICD-10 and that some 65% of male prisoners have personality disorders (Fazel & Danesh, 2002) perhaps DDA legislation is the vehicle by which ex-prisoners might improve their prospects?

Does the impairment adversely affect the person's ability to carry out normal day-to-day activities in any one of the following respects?

Paragraph 4(1) of the Act lists day-to-day activities, one of which is required to be affected: mobility; manual dexterity; physical coordination; continence; the ability to lift and carry ordinary objects; speech, hearing or eyesight; memory or ability to concentrate, learn or understand; and ability to recognise physical danger. Work is not considered as a 'normal day-to-day activity'. The definition of these is not a matter for medical evidence [Vicary v. British Telecommunications, 1998]. In addition, even if the person has the physical capability to perform a task, being unable to perform it over a reasonable period would be included. The important case in this respect was that of Goodwin v. Patent Office [1999]. In this case the EAT overturned the initial employment tribunal ruling, and concluded that Dr Goodwin, who had a diagnosis of paranoid schizophrenia and was dismissed because of bizarre behaviour, had an adversely affected ability to communicate and concentrate which was sufficient. Examples of other accepted adverse effects include only being able to read for short periods of time or having to have a nap on the drive to work!

Is the adverse effect substantial?

Substantial is helpfully defined as 'more than trivial'. It is something that goes beyond the normal differences in ability which might exist among people. In Vicary v. British Telecommunications plc [1999] the EAT pointed out that tribunals should determine what is substantial using 'common sense'. In the case above, having to pull over and have a nap was not deemed 'substantial'.

Is the adverse effect long-term (has lasted at least 12 months, the period for which it lasts is likely to be for at least 12 months; or it is likely to last for the rest of the life of the person affected)?

The length of 12 months is taken literally and medical evidence has to attempt to discern when the effects of the impairment became substantial, and for how long. This could be very different to the length of the overall period of illness if prodromal symptoms or residual impairments are taken into account. The currently prevailing view of depression as a chronic relapsing and remitting condition does not appear to be accepted by the courts. The time spent having an impairment with a substantial effect in recurrent episodes does not appear to be 'added up', but each episode seems to be counted anew and requires 12 months. Long-term antidepressant use is construed as 'forestalling the possibility of relapse' rather than maintaining recovery.

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Those with a history of mental impairments are covered under this clause. The landmark case here was that of *Watkiss v. John Laing plc* [1999]. In 1999 Mr Watkiss had applied for the prestigious post of company secretary and been offered the job subject to routine medical examination. Here he disclosed that he had a diagnosis of schizophrenia and that between 1980 and 1991 he had had three breakdowns. He had successfully managed his condition for 8 years and was in good health. The job offer was withdrawn 'on medical grounds', and this decision was challenged by Mr Watkiss. The company admitted to unlawful discrimination under the DDA and paid an undisclosed amount of damages.

The courts appear to have an unusual view regarding likelihood of relapse. In *Latchman v. Reed Business Information Ltd* [2000], the medical evidence was that the risk of a relapse of Ms Latchman's major depression was 50%. Instead of using the population as a comparator and concluding that Ms Latchman had a greatly elevated risk of relapse, the court's view was entirely statistical; 'since it was not more probable than not that a recurrence of the severe depressive episode would happen, it was not "likely" to occur'.

The effect of treatment

Treatment which helps an impairment is not taken into account when considering whether an impairment has a substantial effect. Thus there needs to be the difficult assessment of what the effect would be but for medication (and counselling or psychotherapy). In the case of *Goodwin* the effect of schizophrenia had to be considered in the absence of antipsychotic medication: ascertaining the 'deduced effects'.

It seems difficult to tease out of case law where this leaves the link between the impairment and the effect. Whereas medication for schizophrenia seems to be considered as alleviating an effect but not fundamentally treating the condition, continuing treatment for depression does not seem to be considered as alleviating any underlying effects or consist of treatment for a chronic condition. This might alter on a case-to-case basis. In *Abadeh v. British Telecommunications plc* [2001] the EAT suggested that 'where depression is being treated by medication the final effects of which are not known, or where there is a substantial risk of relapse when the medication ceases, the effects of medication are to be ignored'. In a more recent case, that of *Woodrup v. London Borough of Southwark* [2003], the appeal centred upon a claim that Miss Woodrup would be disabled but for the effects of her psychotherapy. Lord Justice Simon Brown seemed to indicate that the courts would not be lenient in this matter: 'the claimant should be required to prove his or her disability with some particularity' adding that, 'those seeking to invoke this particularly benign doctrine . . . should not be expected to be indulged by the tribunal'.

Potential adjustments

The final decision upon the level of adjustment is a managerial one. Doctors are often asked to make recommendations and there is no body of evidence upon which to base these suggestions. Pamphlets and information sheets abound suggesting reduction in hours, late starting times to accommodate the effects of sedation, etc. A recent exploration of adjustments thought useful by people returning to work included flexible scheduling, training of supervisors, job modification or attempting to change the way others interact with the disabled employee. A recent review of the costs associated with implementing adjustments for people with mental health problems in the USA (MacDonald-Wilson *et al*, 2002) has found these to be minimal, generally at no direct cost or below US\$100. However, most adjustments do have an indirect cost in terms of a reallocation of a co-worker or supervisor's time, hours, or job duties. A theme running through cases is an onus on employers to consult individuals as to what adjustments would suit them and then decide whether they can reasonably be made. Those who require 18 h sleep a day [*O'Neill v. Symm & Co Ltd*, 1998] may find some requests difficult to accommodate.

Disclosure (or 'should I tell them doc?')

For psychiatrists who are asked by their patients whether to disclose an illness to a prospective (or even current employer), there is little guidance. In the USA, if an employee fails to disclose and is dismissed for poor performance they are not protected by the law. However in the UK an employer's lack of knowledge of an employee's disability is not an acceptable defence (in contrast to recent UK cases of 'work-related stress'). If an employer treats someone less favourably for a reason relating to their disability then they are liable [*Heinz Co Ltd v. Kenrick*, 2002; *LB Hammersmith v. Farnsworth*, 2000], regardless of knowledge. Given the stigmatisation of mental illness, then the advice could well be not to disclose.

Knowledge of the disability is just one element in determining discrimination, however, and the ability of an employer to take reasonable steps to prevent a substantial disadvantage accruing to the (potential) employee might be compromised.

Standards of psychiatric practice

Reading through the cases I was struck by the level of obfuscation in clinical practice. Diagnoses in medical records seem uncommon and justification for them (e.g. as formulations) rare. Now ICD-10 has been set as the benchmark for diagnosis there might be fewer cases of unusual diagnosis, e.g. post-traumatic stress disorder following a 'sudden blast of high-pitched, high-volume noise through the left ear of a (telephonist's) headset' [*Abadeh v. British Telecommunications plc*, 2001]. As one judge summed up 'the medical profession does not come out well of this case': a not uncommon observation. All



clinical medical records are recoverable. Clarity in communication and diagnosis is paramount. Writing letters diagnosing an individual as suffering from post-viral fatigue while admitting them to an in-patient cocaine detoxification unit [Hutchison 3g v. Mason, 2003] does not help the employer, the employee or the reputation of psychiatrists.

Summary

Virtually all patients of psychiatrists in secondary care, and many of those seen by experts, from primary care, would be covered by the DDA. Knowledge of this Act could be used to enhance a patient's access to employment and services and potentially overcome some of the effects of stigmatisation.

Declaration of interest

None.

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