

DISABILITY LOOPHOLE

A CRITICAL ANALYSIS OF THE DEFINITION OF DISABILITY UNDER THE DISABILITY DISCRIMINATION ACT 1995

BY

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DEDICATION

This dissertation is dedicated to my two sons –John aged 23 and Jacob aged 3, who in their own way had made me realised that being disabled does not hold any boundaries for me – that anything is achievable.

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ABSTRACT

The aim of this dissertation is to examine the issues concerning Section 1 of the Disability Discrimination Act 1995. When the Act was first passed in December 1995 it was considered to be a major breakthrough in obtaining equality and protection for disabled people.

This research demonstrated how Section 1 of the Disability Discrimination Act is fundamentally flawed. The dissertation starts by considering why disabled people are socially excluded – with such examples as building design, employment issues and inaccessible transport. Using this background it looked at how the anti-discrimination law evolved and its framework developed. Moreover, the research looks at how Section 1 was developed on the medical model and how the concept of disability is gradually moving towards that of a more accessible social model. Through the use of case law it demonstrates how people with mental and physical impairment had been not gained the protection of Section 1, as previously envisaged when the Act was first passed. Furthermore, the research shows how limited the definition of disability is when considering inclusions and exclusions under the legislation.

Finally, the dissertation looks at the new amendments implemented under the Disability Discrimination Act 2005, and whether they are effective in addressing the fundamental flaws of the original Act.

1. INTRODUCTION

The objective of this dissertation is to show that although the Disability Discrimination Act 1995 (hereafter DDA 1995) gave protection to disabled people with obvious disabilities such as people in wheelchairs or blind people, unfortunately, the DDA 1995 had a definition of who was disabled which was simple in concept but created complications if not confusion in practice because it was based upon a narrow and restrictive medical model¹.

Obviously the first line of attack against a claim for discrimination for a Respondent or Defendant would be to challenge whether the Claimant was in fact disabled within the meaning of Section 1 of the Act. This created much case law as to who could be defined as disabled under the Act's definition of disability and who could rely on the protection of the DDA 1995. The aim of this dissertation is to demonstrate this by referring to the mechanisms of Section 1 of the DDA 1995. It should be noted that new amended legislation, which came into force in December 2006 held much promise in overcoming the limitations of the individual complaints approach taken by under Section 1 of the DDA 1995. The new legislation will be discussed in the Conclusion of this dissertation to demonstrate how the deficiencies of the DDA 1995 have hopefully been remedied in the DDA 2005. To understand the meaning of disability it is necessary to distinguish between an impairment and the disability, which stems from it. An impairment is the functional limitation within

¹ See Page 29 for further discussion on Medical Model of Disability

the individual caused by physical, mental or sensory factors. A disability is the loss or limitation of opportunities to take part in normal life in society on an equal basis with others that may be imposed on people with impairment by physical and social barriers.

The protection afforded by the DDA 1995 only extended to those who fell within the Act's definition of a disabled person. When the Act first came into force the definition appeared to be simple and straightforward, but with the passage of time and case law it was not as straightforward as it seemed. One of the failings of the DDA 1995 was that it did not have a clear and definitive definition of disability as such. This led to confusion resulting in a vast amount of case law with regard to the definition of disability. It could be assumed that judicial systems such as Tribunals and Courts could rely on other authorities/legislation to resolve the definition of disability by reference to legislation such as the Mental Health Act 1983 or to criteria for disability welfare benefits such as Disability Living Allowance and Incapacity Benefit. However, if a person met the definition of disability under the Mental Health Act or for eligibility for a disability welfare benefit, this did not automatically afford protection to that person under the DDA 1995. If a person did not meet the criteria as being disabled under the Mental Health Act or for a disability benefit they only needed to show that they satisfied the definition of a disabled person contained in the DDA 1995² but they may not have qualified for a benefit. The different definitions of disability stated in welfare benefits/mental

² S1 of the DDA 1995 – If a person has a physical or mental impairment which has a substantial adverse effect on his/her ability to carry out daily activities this must last or be likely to last for 12 months.

health legislation conflicted with those of the definition of disability in the Act. That meant that there were conflicting legislation and regulations and therefore no clear universal definition of disability to guide Tribunals and Courts when deciding whether a person had a disability or not. Under Section 1 of DDA 1995 a person is defined as disabled who:

“Has a physical or mental impairment, which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.”³

The Tribunal or Court needed to consider the elements of this definition to decide whether a Claimant had a case to bring under the Act. As previously suggested the DDA 1995 created complications, if not confusion in practice. Each element within the definition merits closer attention and the following questions had to be asked:

Did the Claimant have an impairment and did it have an adverse effect on the ability to carry out normal day-to-day activities?

If so, was the adverse effect substantial and was the adverse effect long-term?

The Tribunals and Courts had to consider these issues even before considering moving on to whether that person had been discriminated against.

³ Disability Discrimination Act 1995

If the Claimant could not establish they had a disability then the case failed on the issues of discrimination.

The legislation went on to say the impairment might be a physical or a mental impairment. The Act not only covered physical disability but also those with mental illnesses and those with learning difficulties. Unfortunately, there was no statutory definition for either a 'physical' or 'mental' impairment, nor was there any definition in the Guidance or the Code of Practice. The Act was created to afford protection to the disabled and in certain circumstances this was successful to the extent that there were groups of people who did not fall within the definition of disability, nevertheless they were deemed to have a physical or mental impairment but were not considered to be disabled under the Act. There were also certain conditions (drugs and alcohol addictions), which were and continue to be excluded⁴ by the amended Disability Discrimination Act 2006 and there were restrictions in both physical and mental illnesses.⁵ Even though DDA 1995 was introduced as recently as 1995, disabled people still saw themselves as being treated differently: segregated and separated from normal society, particularly in relation to the employment market, transport and public places. As the definition of disability did not cover some people with impairments it therefore failed in its' obligations to protect all people with disabilities or impairments.

⁴ See Chapter 6 6.3

⁵ See Chapters 4 & 5

Although this dissertation is concerned to critically analyse the definition of disability, a few words to describe how disabled people feel about being disabled are warranted. People with disabilities are often looked on with prejudiced attitudes, patronisation and pity, which are the main responses of able-bodied people towards disabled people. It also has to be said that it is often difficult for able-bodied people to understand the impact of these attitudes and their implications for disabled people. These effects are well described by Jenny Morris in her book "Pride Against Prejudice."⁶ Morris conducted several interviews with disabled people and among the comments she recorded are:

- That we feel ugly, inadequate and ashamed of our disabilities.
- That our lives are a burden to us, barely worth living.
- That we crave to be 'normal' and 'whole'.
- That we suffer and that any suffering is nasty, unjust and to be feared and retreated from.
- That we live naïve and sheltered lives.
- That we should put up with any inconvenience, discomfort or indignity in order to participate in 'normal' activities and events - and that this will somehow 'do us good'.

Morris also argued:

⁶ Morris J. *Pride Against Prejudice Transforming Attitudes to Disability*. London Women's Press 1991

“That it does not take any expertise in psychology to recognise the strength of these assumptions in our society, or just how undermining they are”.

Being disabled can often lead to isolation and despair simply because a person cannot carry out certain functions because of their impairment.

The DDA 1995 was supposedly designed to address discrimination and to give disabled people back their dignity and self-respect. This was a fundamental reason for the Disability Discrimination Act being developed to challenge social perceptions of disability. However, the weaknesses in areas of the Act such as defining who is disabled became the Achilles heel and weakened the Act around the question of legislation allowing for making reasonable adjustments to accommodate the disabled person. In other words, because the Act was so badly drafted, people who could not satisfy the definition of disability did not gain the protection of the Act.

Each Chapter will critically analyse the definition of disability⁷ and this dissertation will make its conclusions as to whether disabled people were getting the protection of the Act they deserved or whether the definition of disability⁸ caused hardship to some disabled people. This will be demonstrated by using primary legislation/secondary legislation, relevant case law, text books, Code of Practice, Guidance, Journals and accessing relevant

⁷ Ibid footnote 2

⁸ Op Cit footnote 7

information relating to different disabilities which can be found on various Charities/Support Groups websites.

2 BACKGROUND

The purpose of this Chapter is to give a general oversight and history of the problems that disabled people face in society, particularly in the employment area. Statistics on disability have been systematically available only relatively recently, but there have been disabled people for centuries. The main difference now is that society as a whole has increased its awareness of disability discrimination amongst disabled people. There are no longer institutions for people with disabilities. On the scale of fifty years ago, when a person, for example, with learning disabilities would have been institutionalised for years and forgotten about by society. Today, society has come a long way in recognising that disabled people have equal rights and liberties. Unfortunately, there are still a number of issues, which cause problems for disabled people. This chapter will deal with the general problems that disabled people still face in society. It will also look at the history of how the anti-disability discrimination developed and the present legislative framework.

History tells us that disabled people, particularly those with mental health or learning difficulties, were often considered as the village idiots. Nevertheless these people were part of the community and were looked after generally by their families. All this changed in 1601 when the Poor Law Legislation dismantled this way of caring for disabled people and provided institutional care in workhouses which were set up to give residential care and training to people with physical or mental impairment. These asylums then developed

into mental hospitals, and patients with both mental and physical impairments were often locked up for years and forgotten about. By the middle of the twentieth century these hospitals were deemed to be a failure and gradually most of them closed down. Their patients were slowly returned to live in the community.

After the Second World War the National Health Service was developed and set up in 1948, followed by the Welfare Services in Hospitals, which later became known as Social Services. In 1948 the National Assistance Act was set up and included disabled people over the age of eighteen. Additionally, disabled people became entitled to welfare benefits, and sheltered employment schemes were set up to develop training and employment prospects. Specialist officers were based in the Labour Exchanges, now known as Job Centres. For the next twenty-five years the only legislation dealing with employment of disabled people was the Disabled Person (Employment Act) 1944 which had very little effect in giving any protection to disabled people. In 1970 the Chronically Sick and Disabled Persons Act was introduced. This Act stipulated that Local Authorities had to keep a record of disabled people living in the community and had to provide certain services to enable physically and sensory disabled people to live in their own homes.

No real headway had been made to reintroduce disabled people back into society. They were still at a disadvantage, particularly in the employment field. Our population consists of a large number of disabled persons and according to an OPCS (Office of Public Censuses & Surveys) (now known as the Office

for National Statistics) survey there are over six million disabled people in Britain, and 14 per cent of the adult population have at least one impairment which causes disability.⁹ The survey estimates there are one million blind and two million partially sighted people. There are also four million people with mobility problems, about five hundred thousand of whom are wheelchair users. There are also five hundred thousand people who have learning disabilities, and that is just the disabled people we know of as reported through the census. There are likely to be many more disabled people who have not been reported in the census or the survey statistics and it has been estimated that by the year 2031 in Britain, the size of the disabled population will have grown to 8.2 million adults, representing an increase of 34 per cent since 1986.¹⁰ There are 22 per cent of adults of working age who have a health problem or a disability,¹¹ representing 10/15 per cent of the general population.¹²

In particular, discrimination is widespread in the work place. 69 per cent of disabled people are unemployed; disabled people are more likely to be unemployed than non-disabled people. Furthermore, disabled people are more likely to be unemployed for longer periods.¹³ Disabled people in employment are more likely to have lower paid, lower status jobs and less

⁹ OPCS Report 1 1988-1989 16 – 26 Disability in Great Britain HMSO

¹⁰ Fowkes A, Oxley P and Heiser B, Cross Sector Benefits of Accessible Public Transport, Joseph Rowntree Foundation, undated 4 - 5

¹¹ Prescott-Clarke, SCPR Survey 1990 p20

¹² Doyle B 1994 New Directions Towards Disabled Workers Rights, Institute for Employment Rights

¹³ Rights for Disabled People, Now Right Now 1994 p7

secure jobs which they are more likely to leave before official retirement age.¹⁴ There are fewer disabled people who have professional jobs compared with non-disabled people; 31 per cent of disabled people have low skilled manual jobs compared with 21 per cent of non-disabled people.¹⁵ It has been stated by Barnes¹⁶ that under-representation of disabled people in employment is not caused by disability discrimination. This has been challenged by two separate studies conducted into hiring practices in the private sector.¹⁷ These studies demonstrated that employers are six times more likely to turn down a disabled person for interview than a non-disabled Claimant with the same qualifications.¹⁸ Schemes have also been set up, for example, a guaranteed interview policy for disabled people. This is supposedly to ensure that employers are practicing good equal opportunities, yet disabled people are still less likely to be successful in a job interview simply because they are disabled.

There are currently around 3.1 million disabled people and only 12 per cent of them are in employment. When employed they are more likely to work part-time or be self-employed. Employment rates vary greatly between types of disability. Some types of disability are associated with relatively high

¹⁴ Barnes C. 1991 Liberty 62-92

¹⁵ Disability and Discrimination in Employment RADAR 1993 p2

¹⁶ Op Cit footnote 13

¹⁷ Fry E. 1986 An Equal Chance for Disabled People: A Study of Discrimination in Employment
The Spastics Society & Graham, Jordan and Lamb: An Equal Chance or No Chance?
The Spastics Society, 1990

¹⁸ Graham P. 1990 An Equal Chance? The Spastics Society

employment rates (such as diabetes, skin conditions and hearing problems) while other groups (such as those with mental illness and learning disabilities) have much lower employment rates. Around three-quarters of those who have a mental illness and two-thirds of those with learning difficulties are out of work and on state benefits. The ILO (International Labour Organisation) unemployment rates for long-term disabled people are nearly twice as high as those for non-disabled people, 10.1 per cent compared with 5.7 per cent. Their likelihood to be long-term unemployed is also higher: 38 per cent of unemployed disabled people have been unemployed for a year or more compared with 24 per cent of non-disabled unemployed.¹⁹

There is also overwhelming evidence that disabled people experience severe economic and social deprivation and are disadvantaged in a number of ways. There are higher rates of unemployment among disabled people and disabled people are likely to live in poor housing. Disabled people often have inferior segregated education by sending disabled children to 'special schools' simply because the Government funding is not always available to put disabled children through mainstream school. As a result disabled people often leave school with no or fewer academic qualifications and are therefore more likely to be forced to be dependent on welfare benefits such as Incapacity Benefit or Income Support and therefore likely to live in poverty. Discrimination prevents

¹⁹ See Chapter 4

many disabled people from participating in the labour market and forces them into financial and social dependency on the State.²⁰

Disability discrimination not only costs disabled people their pride and self respect but it also costs the Government billions of pounds because disabled people cannot enter the mainstream workforce. As a result, disabled people are forced onto welfare benefits. If more disabled people were employed the Government would save money on welfare benefits and increase revenue from tax and national insurance. If just five hundred thousand disabled people were employed, the Government would save a staggering five billion pounds²¹ on welfare benefits. It was only when disabled people campaigned for equal rights that the Government had to be forced to move towards creating anti-discrimination legislation.

Most public transport and public places such as pubs, cinemas, restaurants, courts and churches are inaccessible. This restricts disabled people from having normal and non-discrimination lifestyles. In relation to public transport, only one in eight long distance National Express coaches were accessible to wheelchair users and only 130 British Rail stations were fully accessible. Wheelchair users wishing to use the London Underground were advised to give 24 hours notice of their intention to travel, to go with a non-disabled companion and to avoid the rush hour. There are 4 - 5 million people with

²⁰ Barnes C. 1999 Disabled People in Britain and Discrimination, Hurst and Calgary in association with BCODP

²¹ Ibid footnote 20

mobility impairments but only 80,000 accessible houses. Public information is rarely given in ways that are accessible to people with sensory impairments and to people with learning difficulties. In addition, public meetings and television are rarely accessible to deaf people. At the last general election 88 per cent of the polling stations were inaccessible to disabled people.

So, having established that there are barriers against disabled people in society, disabled people needed comprehensive anti-discrimination legislation, similar to laws, which ban discrimination on grounds of sex or race. The whole concept of a disabled person's lifestyle needs to be taken into account when considering anti-discriminatory law. It is all very well to have equal opportunity rights in the workplace, but if public transport is inaccessible to be able to take that disabled person to work, then the present disability discrimination law is not protecting the rights of the disabled person. There is evidence of discrimination in many walks of life and the failure of past legislation proves that piecemeal legislation does not work. Disabled people need comprehensive legislation banning all aspects of disability discrimination from every area of a disabled person's lifestyle. As a result the DDA 1995 came into force on 2nd December 1996.

2.1 The Evolution of Anti-Discrimination Legislation

It was probably as a result of two world wars, which rendered many servicemen disabled, that the first Act for disabled people was implemented, the Disabled Persons (Employment) Act 1944. The Act provided a Quota

Scheme whereby disabled people would be registered as disabled and required employers to employ a quota of disabled people within its workforce. This quota was set by the Act as 3 per cent. Many employers failed to comply with this provision and the Act was rarely enforced and there were only three prosecutions in the last thirty years. It therefore afforded little or no protections to disabled people.

Disability discrimination was never taken seriously enough to warrant more enforceable disability discrimination legislation until the first anti-discrimination bill for disabled people was introduced by Jack Ashley MP (now Lord Ashley). He (who incidentally is deaf) had followed the recommendations of a committee on Restrictions against Disabled People. This was followed by a succession of backbench bills over the next ten years, with increasing cross-party support, mobilised by the All Party Disablement Group. Because of strong extra-parliamentary activities campaign of voluntary organisations for anti-discrimination legislation were set up to put pressure on the Government, the issue of disability discrimination was on the political agenda. Disability discrimination could no longer be ignored and was given priority by the Government.

The first major breakthrough came in the form of the Civil Rights (Disabled People) Bill. This was introduced as a Private Members Bill by Harry Barnes MP in 1994 and was the seventeenth attempt to introduce anti-discrimination legislation for disabled people. By 1994 the political momentum behind the Campaign, with support from their Back Bench Conservatives threatened to

overturn the Government's fragile majority support. This forced the Government to announce its own proposals to counter disability discrimination. In July 1994 the Government published a consultation paper setting out its alternative to the Civil Rights Bill.²²

The Disability Discrimination Bill was introduced. Its parliamentary progress was hastened to ensure it took precedence over the Civil Rights Bill, re-introduced by Harry Barnes MP in February 1995. The Government wanted at least to have control of the anti-discrimination legislation. Moving the third reading of the Disability Discrimination Act Bill in the House of Commons²³ Mr. William Hague, the then Minister for Social Security and Disabled People said:

"It is a landmark Bill. It is the only comprehensive Bill for disabled people ever introduced by a British Government. It will mark the United Kingdom out as one of the world leaders and the leader in Europe in

²² A Consultation on Government Measures to Tackle Discrimination in the Workplace Against Disabled People, Department of Social Security 1994.

²³ The complete legislative history of the Bill is as follows:

House of Commons: 1st Reading (12th January 1995); 2nd Reading (24th January 1995: HC Deb Vol 253, col 147-239); Committee (31st January 1995 to 28th February 1995: HC Deb, Standing Committee E); Report (27 and 28th March 1995: HC Deb, vol 257, col 697-799 and col 840-904); 3rd Reading (28 March 1995: HC Deb, vol 257, col 904-928).

House of Lords: 1st Reading (29th March 1995); 2nd Reading (22 May 1995: HL Deb, vol 564, col 800-815 and 830-892); Committee 13, 15 and 27 June 1995: HL Deb, vol 564, col 1640-1718, 1723-1784, 1895-1954 and 1975-2054; HL Deb, vol 565, col 608-680 and 686-744); Report (18 and 20 July 1995: HL Deb, vol 566, col 114-141, 168-186, 205-280 and 386-476); 3rd Reading (24th 1995: HL Deb, vol 566, col 969-1080).

the move towards comprehensive anti-discrimination legislation for disabled people. It is a profound measure with significant implications, for every part of the economy.....it sets this country on a clear, workable and unambiguous course to ending discrimination against disabled people. It will make a genuine difference to the opportunities and lives of millions of our fellow citizens...."²⁴

The Government was forced to take a long hard look at how to start tackling the widespread discrimination, which disabled people, suffered. The Disability Discrimination Bill received Royal Assent on 8 November 1995 and was the Government's response to an increasingly effective campaign for comprehensive and enforceable anti-discrimination legislation for disabled people. The DDA 1995 was introduced to abolish discrimination against disabled people in employment and in the provision of goods and services. The introduction of the DDA 1995 was a major victory for disabled people and at last the legislation would end disability discrimination against them. The DDA 1995 introduced, over a period of time, new laws and measures aimed at ending discrimination which many disabled people faced. The Act gave disabled people new rights in the areas of employment, access to goods and services, and buying or renting land or property. The Act also allowed the Government to set minimum standards for public transport.

²⁴ HC Deb, vol 257, col 904 and 928. See the similar comments made by the lead Minister in the House of Lords: HL Deb, vol 566, col 1070.

2.2 The Legislative Framework

Protection against discrimination for disabled people is contained in three principal statutes, namely the Disability Discrimination Act 1995, the Disability Rights Commission Act 1999, and the Human Rights Act 1998. There are various codes, guidance and secondary legislation. The main legislation is contained under the DDA 1995 and is divided into three parts. Additionally to the DDA 1995 the Government, through the Disability Rights Commission Act 1999 established a Government Body called the Disability Rights Commission (DRC) to further the rights of disabled people. This also modified the framework established by the Disability Discrimination Act 1995. Finally the Human Rights Act 1998 also made significant impact in that it protects the rights of disabled people, for example, the right to a fair hearing.²⁵

2.3 Disability Discrimination Act 1995

The DDA 1995 provided a framework to provide redress for disabled people who were discriminated against in various spheres.

Part I (with Schedule 1) established the criteria for determining who were disabled and afforded the protection of the Act.

Part II was concerned with discrimination in the employment field by employers or prospective employers, with provision made to extend the ambit of discrimination protection to include contract workers and trade organisations, specific provisions dealing with leasehold premises,

²⁵ Article 6 Human Rights Act 1998

occupational pension schemes and insurance services. The Employment Tribunal is the forum for litigation arising out of these provisions. The Act made it unlawful for employers with 15 or more²⁶ staff to discriminate against current or prospective employees with disabilities because of a reason relating to their disability. This applied to all employment matters including recruitment and retention of employees, training and development, promotion and transfers and the dismissal process. Additionally, if their employment arrangements or workplace disadvantaged a disabled employee, employers were required to look at what changes they could make to the workplace or the way the work was done, and to make any changes that were reasonable.²⁷ However, employers were not expected to make any changes which breached the health and safety laws.

Under the 1995 Act employers with fewer than 15 employees are excluded from the employment provisions of the Act.²⁸ The Act did not apply to certain operational staff employed by the Armed Forces, Police, Prison Service, Fire Service.²⁹ However, reforms have since remedied these exemptions and registration as disabled under the Quota Scheme³⁰ ended when the employment provisions of the DDA 1995 began on the 2nd December 1996. It meant that disabled people no longer needed to register as being disabled.

²⁶ This provision is now repealed by the DDA 2005

²⁷ Section 6 DDA 1995

²⁸ DDA 1995 S 7 – now repealed by DDA 2005

²⁹ DDA 1995 S 64 – now repealed by DDA 2005

³⁰ The Disabled Persons Act 1944

Part III was concerned with providing remedies for discrimination against disabled members of the general public in the provision of goods and services. Claims arising from discrimination in this field are the subject of litigation in the County Court. This provision in the Act affects anybody who provides goods, facilities or services to members of the public whether paid or free. Private clubs are not included. This means that it is unlawful to refuse to serve someone who is disabled or to offer a disabled person a service, which is not as good as, the service being offered to other people. It is also deemed to be unlawful for someone to run a service or provide goods or facilities in a way which makes it impossible, unreasonable, or difficult for a disabled person to use the goods or services, unless the way in which the service is run is fundamental to the business, for example a darkened nightclub which may affect a visually impaired person, or lack of disabled toilets for wheelchair users.

Parts IV and V were concerned with the provision of education for disabled people and with public transport use. The DDA 1995 did not provide for direct action to be taken against education providers or public transport providers, but rather was concerned to promote greater provision for disabled persons. The Act also ensured the recognition of the needs of disabled people wishing to study and the provisions of better information to parents, pupils and students. Schools have to explain their arrangements for disabled pupils and students and how they will help them to gain access to further and higher education. Institutions have to publish disability statements containing

information about facilities for disabled people and must report to the Government on their progress and future plans. Local Education Authorities have to provide information on their future education facilities for disabled people.

Part VI dealt with the establishment of the National Disability Council, now superseded by the Disability Rights Commission.

2.4 The Disability Rights Commission Act 1999

The National Disability Council established by the Disability Discrimination Act 1995 was in no way comparable to the Equal Opportunities Commission or the Commission for Racial Equality. It was an advisory body only. As a result, the DDA 1995 lacked a motive force for its enforcement and the further development of disability discrimination law. The Disability Rights Commission was created by the DRC 1999 to remedy this deficiency and to ensure that disability rights remained on the agenda.³¹ The Commission's duties are to work towards the elimination of discrimination against disabled persons; to promote the equalisation of opportunities for disabled persons; to take such steps as it considers appropriate with a view to encouraging good practice in the treatment of disabled persons, and to keep under review the working of the Disability Discrimination Act 1995 and the Disability Rights Commission Act 1999. The DRC 1999 gives the Commission an extensive role and numerous powers. It can be anticipated that in the years to come one of the

³¹ Section 2 (1) of the DRC 1999

key roles of the Commission will be the promotion of litigation, which will push forward the law on disability discrimination.

2.5 The Human Rights Act 1998

Firstly, the Human Rights Act 1998 was brought into force in October 2000. The Act brought the European Convention on Human Rights into the sphere of domestic law. The key provision of the Act is that all legislation must be interpreted and given effect, as far as is possible, in accordance with Convention rights. Secondly, it is unlawful for a public authority to act incompatibly with Convention Rights and a new statutory tort is created allowing a direct action to be brought on the right alleged to have been breached. Thirdly, UK Courts must take account of Convention Rights in all cases that come before them. The common law must be developed in accordance with the Convention, and decisions made by the European Court of Human Rights, whilst not binding, must be taken into account.

Much has been written about the Human Rights Act 1998, but whilst debate has focused on such issues as to whether or not the Human Rights Act 1998 has full "horizontal effect" between individuals or indirect effect through the mechanism of the Courts, relatively little has been written as to the practical actions which can be launched to obtain money and other remedies, which could not be undertaken prior to October 2000. The key provision of the Human Rights Act 1998 which will affect disabled people in regulating their relations with the state and public authorities is the right to take proceedings against public authorities for damages or compensation, or other remedies to

protect their human rights which are being infringed or dealt with in a way that is discriminatory. Section 7 HRA 1998 provides:

(1) A person who claims that a public authority has acted (or proposes to act) in a way which is made unlawful by Section 6 (1) may-

bring proceedings against the authority under this Act in the appropriate Court or Tribunal

or:

rely on the Convention right or rights concerned in any legal proceedings:

but only if he/she is or would be a victim of the unlawful act.

If a disabled person wishes to bring a claim for alleged infringement of a right, this Section enables a claim to be brought and potentially a remedy granted. A number of points should be borne in mind. Claims can be brought against public authorities and include Courts or Tribunals and any person who is employed by a public authority whose functions are of a public nature. This does not include private companies and if the nature of the act is private.³² A person will only be a victim of the unlawful act, if they would satisfy the test applied by Article 34 of the ECHR on who is a victim for the purposes of proceedings in the European Court.³³

³² Section 6, HRA 1998

³³ Section 6 (7) HRA 1998.

Proceedings³⁴ must be brought within either a year beginning with the date when the act took place, or a longer period if the Court considers that would be equitable in all the circumstances, but subject to any shorter limitation periods, such as the three month provision for Judicial Review³⁵

2.6 The Secondary Legislation

As a result of the DDA 1995 a wealth of secondary legislation has been generated, which either brings into effect the DDA 1995, or details the application of the provisions within the Act. This secondary legislation consists of the following:

Disability Discrimination (Meaning of Disability) Regulations 1996;³⁶

Disability Discrimination (Questions and Replies) Order 1996;³⁷

Disability Discrimination (Employment) Regulations 1996;³⁸

Disability Discrimination (Exemptions for Small Employers) Order 1998;³⁹
(now repealed)

Disability Discrimination (Services and Premises) Regulations 1996;⁴⁰

Disability Discrimination (Sub-leases and Sub-tenancies) Regulations 1996;⁴¹

³⁴ S 6 (7) S (ii) (a) HRA 1998

³⁵ Section 7 (5) HRA 1998

³⁶ Section 1 1996 / 1455

³⁷ Section 1 1996 / 2793

³⁸ Section 1 1996 / 1456

³⁹ Section 1 1998 / 2618

⁴⁰ Section 1 1996 / 1836

These are the Regulations, which are most commonly relevant, but the reader should be aware there are other Regulations, including the various Commencement Orders, which are too exhaustive to mention here.

2.7 The Codes of Practice

Under the provisions of the DDA 1995⁴² the Secretary of State had power to issue Codes of Practice which were intended to eliminate discrimination and

⁴¹ Section 1 1996 / 1333

⁴² Sections 51 and 53

encourage good practice. The emphasis of the Codes⁴³ was to provide practical guidance. The Codes had statutory admissibility⁴⁴ and had to be taken into account by an Employment Tribunal or Court, if its provisions were relevant.

The Disability Rights Commission were allocated responsibility for the preparation of future codes, The Codes were of immense practical significance in the context of litigation as they established what an Employment Tribunal would normally find to be acceptable employment practice in the context of a disabled person. Little, if any use of the relevant Codes⁴⁵ have been made in County Court litigation.

2.8 The Statutory Guidance

This document was issued by the Secretary of State pursuant to his power to do so under Section 3 of the DDA 1995 . The purpose of the document was to provide guidance to clarify the definition of disability contained in Section 1. It was also intended to provide examples from which an Employment Tribunal or Court could draw assistance in determining the issue of disability and it was

⁴³ Section 53 (3)

⁴⁴ Section 53 (5)

⁴⁵ The Code of Practice for the elimination of discrimination in the provision of employment against disabled persons who have or have had a disability; The Code of Practice in relation to Rights of Access, Goods, Facilities, Services and Premises; The Code of Practice relating to the duties of trade organisations to their disabled members and Claimants.

mandatory.⁴⁶ Part I of the DDA 1995 was concerned with defining who is disabled and accordingly entitled to the protection of the Act. The criteria for establishing who was disabled are drawn from three sources. The first of these was Section 1 of the DDA 1995 . The second was the Disability Discrimination (Meaning of Disability) Regulations 1996⁴⁷ and the third was a document entitled Guidance on matters to be taken into account in determining questions relating to the definition of disability.⁴⁸

Having given a brief history of the problems that disabled people face in society and an overview of the legislative framework this dissertation will now concentrate on Section 1 of the DDA 1995 which will be discussed in the following chapters.

⁴⁶ DDA 1995 S 3(3)

⁴⁷ S I 1996/1455

⁴⁸ Guidance on matters to be taken into account in determining questions relating to the definition of disability'. (ISBN: 01127009559).

3 THE DEFINITION OF DISABILITY

This chapter will analyse views put forward by academic critics, and will compare and contrast the concept of the medical model with the social model.

The model of disability adopted by the DDA 1995 was a medical, rather than a social one. The "social" model of disability recognises "the close connection between the limitation experienced by individuals with disabilities, the design and structure of their environments and the attitude of the general population".⁴⁹ The "medical model" by contrast locates the problem of disability in the disabled person, regarding disability as an individual impairment.

Ann Beggs MP and the disability community had long criticised the medical approach to disability rights. Ms Begg expressed a common view in the House of Commons Second Reading debate on the Disability Rights Commission Act.

"It's not my disability that stops me playing an equal part in society, it's the fact that some people put steps in buildings that I can't get into. I have no limitations in what I can do in a fully accessible building..... it

⁴⁹ See United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, para 5, cited by Doyle B, Disabled Workers Rights, the Disability Discrimination Act and the UN Standard Rules (1996) 25 ILJ 1, 11.

is society that has built the physical barriers and it is people in society who have the attitudes that cause the problem - not the disability".⁵⁰

The Government did not accept the social model concept that it was society that created the barriers against disabled people with regard to environmental issues such as the inability to access a building for wheelchair users. They were probably reluctant to accept the social model because it would mean that major changes would have to be made in society to accommodate disabled people and this meant spending vast amounts of money to make, for example, necessary changes to buildings. The Government preferred the medical model in that the problems that disabled people had in accessing buildings laid with them because it was their medical condition that caused the problems in accessing facilities within society.

Margaret Hodge made this clear in an article for the Newcastle Journal. The newspaper had published criticism by a disability activist of a Government Disability Awareness Campaign.

"Disability is not about victims, tragedy or understanding the person; feeling sorry for someone does not make public transport become magically accessible overnight. Being patronising towards people does not remove physical barriers to allow access to facilities, services or leisure activities. Understanding how difficult it must be and then moving away to get on with life does not ensure that housing providers

⁵⁰ McColgan A. 2000 Discrimination Law, Text Cases & Materials page 454

design and build with access in mind or grant access to mainstream education.”

and she went on to say

“Wonder how men and women in the North East understand the accusation that disability is their problem. That the shopper in the Metro Centre is somehow responsible for oppressing disabled people.”⁵¹

What is increasingly apparent is the gulf between the disability movement's definitions of disability - the social model - and that of the policy makers - the medical model. The social model identifies social barriers and the infrastructure of society as the cause of disability; preventing participation on equal terms and denying equality of opportunity. The medical model refers solely to a physical condition or impairment.

3.1 The Medical Model Approach

In order to analyse the concept of the medical model in contrast to the social model the official definition of the medical model as stated in 1980 by the World Health Organisation is as following:

⁵¹ Op Cit A McColgan at footnote 45

Impairment: a permanent or transitory psychological, physiological or anatomical loss of abnormality of structure or function.

Disability: any restriction or prevention of the performance of an activity resulting from an impairment in the manner or within the range considered normal for a human being.

Handicap: a disability that constitutes a disadvantage for a given individual in that it limits or prevents the fulfillment of a role that is normal depending on age, sex, social and cultural factors for the individual.⁵²

Some academic activists have criticised the medical model of the statutory definition. Finkelstein, for example, argues that the concept of disability was focused on the impairment of individuals as the ultimate cause of disability. He criticised the narrow approach of the medical model but suggested that an alternative approach was emerging as follows:

"The predominant focus of attitudes, help, and research and so on has, as a natural expression of one side of the disability relationship, been towards the disabled person. Nearly all references concerned with attitudes towards disability use the disabled person as the point of focus. The emergent approach is to focus on the behaviour, roles,

⁵² Cooper J. Laws, Rights and Disability. Chapter 1 Working in Partnership with Disabled People by Pickin C.

perceptions and attitudes etc., of the helpers as representatives of a socially determined relationship."⁵³

This emergent approach has developed largely as a consequence of disabled people organising to articulate their own definitions of disability. This leads to a second general criticism of research on the statutory definition of disability, in that it has failed to involve disabled people except as passive subjects.

Davis makes this point:

"Much of the work which has already been done on definitions has been carried out by people who do not themselves experience the daily problems of disability. This has drastically affected the solutions, and in turn has often served to perpetrate discrimination against us, as well as wasting resources on an enormous scale."⁵⁴

The research carried out around the medical model demonstrated clearly that it discriminated against disabled people. There are two aspects of this: first, much research on disability has utilised theoretical models so divorced from the everyday experience of disabled people that:

⁵³ Finkelstein V. 1980 *Attitudes & Disabled People: Issues for Discussion*. New York: World Rehabilitation Fund

⁵⁴ Davis K. 1986 *Developing Our Own Definition: Draft for Discussion*, British Council of Organisations of Disabled People, London

“They have felt victimised by professionals who write articles about the reactions to disability that are based more upon theory than fact.”⁵⁵

A second aspect concerns the fact that much research on disability has contributed little or nothing to improving the quality of life of disabled people. As a consequence of this situation, more and more disabled people are refusing to participate in research designed, controlled and published by able-bodied researchers who are either unaware or lack an understanding of the research issues involved in the social causation of disability and who fail to involve disabled people in the research process.

Caroline Gooding⁵⁶ argued in her book that although the 1995 Act established a new definition of disabled person it did not reflect fundamentally a new understanding of disability. The Act's definition of disability was precisely for this reason one of the most contentious issues during its passage through Parliament. Like the definition contained in previous legislation it focused solely on the inability to perform certain physical or mental functions caused directly by “impairment” of an individual. Gooding went on to explain that the Disability Lobby and their supporters in Parliament criticised the narrowness of the definition of disability under the DDA 1995 and said it was a flawed concept of disability. They argued for a broader definition of disability modelled on that contained in the USA ADA 1990.⁵⁷ Disabled supporters

⁵⁵ Trieschmann R B. 1980 Spinal Cord Injuries, Pergamon Press, Oxford

⁵⁶ Gooding C. 2000 DDA From Statute to Practice. Critical Social Policy (4) 533-549

⁵⁷ See Appendix 1

would have preferred the definition of disability to have included people who were perceived to be disabled and who faced the issues of social discrimination which comes from misconception and stereotype of the discriminator rather than from any intrinsic characteristic of the individual who had experienced discrimination. Gooding went on to state that the DDA 1995 basic definition cannot address the situation of people with no actual physical or mental impairment who nevertheless experience strong social restrictions because of prejudice. An example of this is a person with a severe disfigurement.⁵⁸ This will be deemed to have a substantial adverse effect on their ability to carry out normal day-to-day activities, thus bringing them within the definition of the Act⁵⁹ She also gave examples of people who were excluded from the Act's definition of disability, and these included people who had been diagnosed as HIV positive, having Cancer or MS and would not be protected by the Act.⁶⁰

In summary Gooding pointed out that the DDA 1995 reinforced the medical model by linking the disabled person's physical or mental impairment with the ability to carry out day-to-day activities rather than the social or the environmental issues of society. Furthermore, proof of disability as required by the definition of disability relied on the measurement, assessment and medical treatment or medical evidence of functional activities as they related directly to the impairment.

⁵⁸ See Chapter 6 Section 6.2.2

⁵⁹ DDA 1995 Schedule 1 para 3

⁶⁰ Now amended by new legislation October 2004

The academics that criticised the medical model said that it assumed a lack of ability in any functional area, which had arisen as a result of an impairment stemming from the limitation of the individual to adapt to their condition. This meant that the definition of disability became individualised as a personal incident that had happened to a disabled individual and resulted in "personal tragedy".⁶¹ Under the medical model, Oliver stated, the "impairment" or "abnormality" assumes dominance over the concept of disability and therefore the person with the impairment remains subservient to the terms of 'disabled experts' who may be patronising disabled people. It meant that disabled people were kept as an oppressed and powerless group. Writers argued that disabled people preferred to look at disability as a situation caused by the unsympathetic society who placed the physical barriers to stop them from having an equal right or place within society itself. The medical model, it was argued, reflected society's attitude to disabled people. The medical model also attracted criticism from disabled supporters.

Shearer, for example, captures the need for changes to be made with regard to the medical model in her criticism of the International Year of Disabled People. The official aim of the International Year of Disabled People in 1981 was: helping disabled people in their physical and psychological adjustment in society. The real question she argued is a different one.

⁶¹ Oliver M. 1990 *The Politics of Disablement*. Basingstoke & Macmillan

"How far is society willing to adjust its patterns and expectations to include its members who have disabilities and to remove the handicaps that are now imposed on their inevitable limitations?"⁶²

3.2 Formation of The Social Model Approach

As a consequence of these criticisms, a group known as the Union of the Physical Impaired Against Segregation was formed. The group pioneered a concept which they called a social model, which has become the nucleus of the disability movement. They stated,

"In our view it is society which disabled physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society".⁶³

To understand this it is necessary to grasp the distinction between the physical or mental impairment and the social situation, called 'disability' of people with such impairment. Thus, we define impairment as lacking part of or all of a limb, or having a defective limb, organism or mechanism of the body; and disability as the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people

⁶² Shearer 1981 as quoted by Oliver M. & Sapey B. Social Work with Disabled People 2nd Edition, Practical Social Work BASW

⁶³ Ibid page 22

who have physical impairments and thus excludes them in the mainstream of social activities. Physical or mental disability is therefore a particular form of social oppression.

Oliver analysed both Shearer's and the UPIAS views with regard to advocating a social model of disability. He distinguished differences in their views, arguing that Shearer was asking society "that is able-bodied society" to remove the disabilities imposed upon the impaired individuals, whereas the UPIAS argued that such disabilities will only be removed by disabled people themselves engaged in active 'struggles'. Oliver went on to explain that Shearer's view sees the reduction or removal of disability as something, which may be given, whereas the UPIAS view sees them as having to be fought for. Oliver argued that the two different views had implications for professional practice, which could be analysed by asking the professionals whether they wished to work for disabled people or with them.⁶⁴

Disabled people and academic critics rejected the medical model, which followed the World Health Organisation definition. They preferred a definition of social model, which replaced responsibility for the disabled people's problems firmly with society as follows:

Impairment: lacking part or all of a limb, having a defective limb, organism or mechanism of the body.

⁶⁴ Ibid page 22

Disability: the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from the mainstream of society.

The definition given by the social model of disability is based on the relationship between the person with the impairment and the social and physical environment of society.⁶⁵ This means that the concept of disability rests on the social and economic consequences of being different from the majority of society and that it is society that is to blame – that is, the environment rather than the person with the impairment. Oliver gave an example of housing for disabled people. He explained that the individual model focuses on the problems that disabled people face in terms of getting in and out, bathing, access to the kitchen, the bedroom and so forth. He stated that this approach focuses on the functional limitations of individual attempting to use their own environments. The social model, however, sees disability as being created by the way housing is unsuitable to the needs of particular individuals.

Although Oliver initially said that the definition of disability was a medical model which implies that disability is some “terrible chance event” which occurs at random to unfortunate individuals who have to adapt themselves in society. He pointed to the way charities approach fundraising using strong images of pathos to bear this out. He also stated that the use of emotive

⁶⁵ Oliver M, 1983 Social Work with Disabled People. Basingstoke & Macmillan

language also demonstrates this theory when describing people as “victims” or “sufferers” of a particular condition.⁶⁶ He now argues for the use of the term ‘individual model’. The two fundamental aspects of the individual model are:

1. That it locates the ‘problem’ of disability within the individual, and
2. It sees the causes of this problem as stemming from the functional limitations or psychological losses, which are assumed to arise from disability.⁶⁷

With this quotation he moved somewhat away from the medical model approach of his previous description, which implies that all disabled people have medical problems and that medical experts are the best people to help them⁶⁸. His new individual model goes on to identify society’s failure to ‘provide appropriate services’ and to ensure that the needs of the disabled person are fully taken into account in social associations, such as access to public buildings, unusable transport, segregated education and work arrangements.⁶⁹

Oliver also applied this principle to the employment market. The social model of disability provides equally valuable insights,

⁶⁶ Op Cit footnote 57

⁶⁷ Oliver M. 1996 *Understanding Disability from Theory to Practice*. Basingstoke & Macmillan

⁶⁸ Op Cit footnote 57

⁶⁹ Ibid footnote 63

“The world of work (buildings, plant, machinery, processes and jobs, practices, rules, even social hierarchies) is geared to able-bodied people, with the objective of maximising profits. The growth of large-scale industry has isolated and excluded disabled people from the processes of production in a society which is work centred.”⁷⁰

Oliver explained that in a capitalist society individuals were judged by what they could do and what society could do to help them. Society's perception of disabled people was that they were seen as “dependent” and that this stems not from their inability to work but from the way in which work is organised in modern industrial society. Examples are the inability of a blind person to use the software on a computer or a deaf person being unable to access telephones in an office environment, or the inability of a person in a wheelchair to work on a factory floor because he/she is unable to access machinery that an able-bodied person could do.

Other writers while agreeing that disability should not be linked entirely with illness, and who also state that many disabled people are fit and healthy, are nevertheless convinced that for some people, symptoms do have a disabling effect and that certain medical aspects of disability should be retained within the social model.⁷¹ Yet others state that the social model can be used

⁷⁰ Op Cit footnote 58

⁷¹ Swain J. 1981 Adopting a Lifestyle. Milton Keynes Open University Press pages 11-12

effectively only once a person is medically stable.⁷² According to Finkelstein⁷³ the social model of disability may be most appropriately applied to physical impairments, but it can also include sensory impairments. Examples are deaf people who may be disabled by the increasing use of the telephone, which restricts people who can communicate perfectly adequately at a face-to-face level, or else meetings which may be held in badly lit rooms so that they cannot adequately see other participants and follow their lips. Visually impaired people are also at a disadvantage, for example, the increased use of computers without adapted software to accommodate visually impaired people. Harris⁷⁴ suggests that deaf people who use British Sign Language suffer disadvantages from linguistic isolation in employment situations where the majority of workers are hearing. In fact, pressure is exerted upon deaf workers to behave as much like hearing workers as possible - in effect to 'deny' and make invisible their deafness. She argues that many deaf people work in situations where there is a complete lack of meaningful communication between themselves and colleagues. The disadvantages suffered by deaf people stem from a lack of tolerance and respect for linguistic difference by management and co-workers and as such, become individualised by being seen as problems for deaf workers to solve, rather than for hearing people to view as a challenge.⁷⁵ She also suggests that such a change in attitudes by hearing people and a willingness to learn British Sign

⁷² French S. (eds) *Disabling Barriers, Enabling Environments*, London Sage Publications

⁷³ Finkelstein V, 1980 *Attitudes & Disabled People. Issues for Discussion*, New York World Rehabilitation Fund

⁷⁴ Harris J 1995 *The Cultural Meaning of Deafness* Aldershot; Avebury

⁷⁵ Harris J 1997 *Deafness & The Hearing*, Birmingham Venture Press

Language could radically alter the patterns of disadvantage and provide an empowering environment for deaf people.

The definition of disability under the DDA 1995 reinforced the medical model by linking impairments with the ability to carry out day-to-day activities without allowing for social or environmental variables that may have hindered or exacerbated the effects of the disability. Furthermore, proof of disability was required by the definitions of disability and medical proof was required to show that there was a substantial effect on a disabled person's ability to carry out functional activities as they related directly to the impairment.⁷⁶

The DDA 1995 definition of disability was complicated and put the burden of proof on an individual to prove that their ability to carry out 'normal day-to-day activities' was "substantially" restricted. There is also a complicated section in the DDA 1995 which says that some people who do not come within the definition will nevertheless be considered as disabled, for example some people with progressive illnesses will be covered as soon as symptoms start to appear. Progressive illnesses such as HIV, Cancer and MS are now considered from the date of diagnosis as amended.⁷⁷ The definition will not cover people who have been shown to have a genetic predisposition to an illness.

⁷⁶ Gooding C 1996 Blackstones Guide to the Disability Discrimination Act 1995. London Blackstone Press

⁷⁷ Op Cit footnote 54

It could be said that the rationale for the social model based on disability originally lies with the rationale that women and ethnic minorities are protected currently by the sex and race discrimination laws. A straightforward definition of sex or race based on the issues such as what ethnic group or what sex a person was born with at birth. The emphasis is on the person's sex or skin colour, and society's attitude towards them, but when applying the same principle to disabled people it is the individual disabled person that has the problem and that somehow their disability has to meet the criteria of Section 1 of the DDA 1995. It can be argued that the present definition of disability under the DDA 1995 is still narrow, unlike the definition of disability in other legislation in other countries, such as Australia, USA and Ireland.

In my view, whilst the medical model sees disability as functional impairment, this had three main effects in relation to the DDA 1995 framework. Firstly, the tendency of Tribunals and Courts to rely upon medical issues relating to the nature or the diagnosis of the condition limited the number of individuals who might have been able to claim protection under the DDA 1995⁷⁸. The medical model's interpretation often given to the DDA 1995 excluded individuals who might have been very susceptible to disability discrimination because they failed to establish that they had an impairment or to establish the severity or degree of the disability. The complexity of the procedure due to the medical model might also have deterred potential Claimants from pursuing any potential discrimination claims⁷⁹.

⁷⁸ See Appendix 2

⁷⁹ See Chapter 4 at 4.2.

Secondly, the medical model has wider negative implications for disabled people within the workplace. Placing the focus on the substantial medical impairment and requiring extensive medical evidence of a particular nature of the condition may lead to disabled people being labelled and therefore their disability to act as a stigma. This in turn may have influenced potential employers to believe an individual was less capable of working because he/she was perceived as being different in some way from the majority of the work force who were fully able-bodied or had no mental health issues. It was therefore more likely that the employer might discriminate against that individual. In order for an individual to have benefitted from the DDA 1995 he/she must have firstly spelt out the nature of their condition and then proved that this condition resulted in a level of impaired functioning. Consequently, the focus was on what was wrong with the individual and what that individual could not do. The mechanisms of the DDA 1995 forced Claimants to prove these issues and this often caused unnecessary hardships and distress. Further, such an approach was unlikely to encourage equal consideration of disabled people and individuals who have no physical or mental impairment, rather it reinforces the line between normal and disabled and therefore enforcing segregation for disabled people.

Thirdly, the use of a medical model of disability within the legislative framework failed to address a number of issues where disability discrimination might arise, because the law did not protect individuals from discrimination where they themselves did not suffer from an impairment. The focus of the

law was on substantial impairment rather than on the phenomenon of discrimination itself. Therefore, the DDA 1995 did not cover individuals who suffered from discriminatory treatment as a result of a false perception of disability, for example an individual with a minor hearing problem or a person with sight in only one eye might be discriminated against despite that condition having no substantial effect on their ability to carry out day-to-day functions.

While the definition of disability continues to be based on a medical model, there will continue to be a number of consequences arising out of Court and Tribunal cases, the public and the workplace, which will cause hardship to disabled people simply because the present definition of disability is far too narrow. An ideal solution would be to model the definition of disability on other international laws for instance USA and Australia which have a wider approach with regard to the definition of disability. The USA and Australian wider approach to the definition of disability protects disabled people so long as they can establish they have an impairment regardless of the degree or the severity of that impairment unlike the British approach to the definition of disability which establishes it had to have an adverse and/or substantial effect in their ability to carry out daily activities.

3.3 Nothing Is Perfect!

Since its development there have been criticisms of the social model. Morris⁸⁰ raised the concern that the social model may be just as oppressive as the individual model if it is imposed in such a way as to deny the experience of individuals. She suggests that the danger lies in attempting to compartmentalise the personal feelings and experiences of people rather than grounding the political analysis in them. Crow⁸¹ supports this theory and calls for the inclusion of impairment in the theorising of the social model.

Some disabled people do experience the onset of impairment as a personal tragedy probably because of the way they have been treated in the past, for example bullying at school, inability to secure a job, inability to attend public events because they are inaccessible. All these factors have contributed to **some** disabled people feeling that it is their fault that they are not included or able to take part in society. However, while not invalidating the argument that they are being excluded from a range of activities by a disabling environment, it does mean it would be inappropriate to deny that impairment can be experienced in this way. While such reactions themselves may be due to the extent to which the norms and values attached to the individual model have embedded themselves within our psyche, the values of the social model have

⁸⁰ Op Cit footnote 5

⁸¹ Crow L 1996 Including All of Our Lives: Renewing A Need. A Feminist Reappraisal. Critical Social Policy Issue 16 pages 23/39

been shown to be effective in combating them. Tate⁸² reported on a study which showed that people with spinal injuries who were put on an 'independent living program' at the time of their acute rehabilitation were able to adjust to their new circumstances with less negative psychological effects than those who received a more traditional, medically-orientated service. Individual disabled people have borne testament to the value of the social model to them personally.

It appears that the Disability Rights Commission and other disability movement groups⁸³ have taken a fresh look at the social model of disability and looked at new ways integrate all its complexities. It is important that we recognise the ways in which disability and impairment work together. The social model has never suggested that disability represents the total explanation or that impairment doesn't count – that has simply been the impression we have given by keeping our experiences of impairment private and failing to incorporate them into our public political analysis.⁸⁴

Overall, the social model is the preferable model. The recent legislative changes⁸⁵ have given many disabled people hope and clarity to know that they will be treated as equally and fairly as all able bodied people in society and that due to the recent changes in the laws that disabled people will now

⁸²Tate D G., Maynard F., & Forchheimer M, 1992 Evaluation of a Medical Rehabilitation & Independent Living Programme for Persons with Spinal Cord Injury. *Journal of Rehabilitation* Vol 58 pages 25/8

⁸³ See Chapter 7 at 7.2 The Way Forward

⁸⁴ L Crow 1996 *Exploring the Divide: Illness & Disability*. Leeds: The Disability Press

⁸⁵ Op Cit footnote 78

have a major say in decision making to implement changes in society to combat discrimination.⁸⁶

Crow's statement expresses this succinctly:

"My life has two phases: before the social model of disability and after it. Discovering the way of thinking about my experiences was the proverbial raft in stormy seas. It gave me an understanding of my life, shared with thousands, even millions of other people around the world, and I clung to it."⁸⁷

⁸⁶ DDA 2005

⁸⁷ Op Cit footnote 79

4 PHYSICAL IMPAIRMENT

This chapter will demonstrate how Section 1 of the DDA 1995 has caused difficulties through the passage of time. To be able to demonstrate this, the three segments of Section 1 will be analysed closely using past case law. The three segments to be examined are as follows:

- Substantial adverse effect
- Ability to carry out normal day-to-day activities
- Long-term effect

There is no definition of 'physical impairment' within the Act and this has been the cause of much confusion with Courts and Tribunals. Further complications have arisen where there may be a physical impairment but it does not qualify under the definition of disability because the impairment is not serious enough to gain the protection of the Act. Each segment will now be considered in detail.

4.1 Substantial Adverse Effect

The first segment covers substantial adverse effect. The Guidance states that to qualify for protection under the DDA 1995 the impairment must have a substantial adverse effect on a person's ability to carry out day-to-day activities.

The Guidance accompanying the Act states the requirement that an adverse effect be substantial reflects the general understanding of "disability" as a limitation going beyond the normal differences in ability, which may exist among people. A "substantial" effect is more than would be produced by the sort of physical or mental conditions experienced by many people who experience only minor effects. A substantial effect is one, which is more than "minor" or "trivial.

The aim of this segment is to rule out minor or trivial conditions. These may include temporary conditions such as sprains or minor back injuries or any other form of conditions that have not lasted for more than twelve months. It can be argued, however, that people with physical or mental impairments who do not come under the above list are still being penalised because their condition does not come under the DDA 1995. For example, in the case of colour blindness a person who confuses red with green would be barred from becoming an airline pilot. The Guidance makes clear that it would not be reasonable to regard an inability to distinguish between red and green as having a substantial adverse effect on a person's ability to carry out day-to-day activities although it would be reasonable in the case of a total inability to distinguish colours. The Guidance does not cover people with poor educational records who have a low intelligence level nor does it cover people who are left-handed when they are unable to operate machinery designed for right-handed people. A typical example of a person not covered by Section 1 is a person with a minor visual impairment such as 20/40 vision who may find

it difficult to show that their impairment is substantial enough to have an adverse effect as stated in the Act.⁸⁸

The Guidance⁸⁹, also states that account should be taken of how a person might reasonably be expected to modify his/her behaviour to prevent or reduce the adverse effect of an impairment or disability on normal day-to-day activities. An example given is where a person has a condition, which manifests itself as an allergic reaction to certain substances. An example would be a person with such a condition might reasonably be expected to take steps to avoid these substances. However, it is not always possible to adhere to the Guidance regulations and this can be demonstrated in the following scenario.

A trainee nurse who is allergic to latex has to use latex rubber gloves to perform most aspects of her job. The Guidance states she has to avoid the substance that causes her to have an allergic reaction. In this case it is impossible because she is expected to wear the protective gloves as part of her job. If she does not wear the gloves she would be in breach of health and safety regulations. As a consequence this person has to give up her nursing career as her 'impairment' would not be considered to have an adverse effect,

⁸⁸ Doyle B. Disability Discrimination Law & Practice Jordn 5th Edition.

⁸⁹ Guidance Part 2 para A7-A9

because outside the work place her condition was controlled because she had little or no contact with the latex substance.⁹⁰

The Guidance is based on the test of reasonableness, but what is reasonable? It could be argued that this concept is too wide. An example would be to take two disabled people with similar disabilities, similar jobs and similar environmental issues. One person could perform better than the other because they have a better coping strategy or it simply could be because of a persons' particular personality, for example, one person could be of a nervous disposition and the other person robust. Originally, Courts and Tribunals took the concept of reasonableness and thought that if a person was able to carry out normal day-to-day activities then their impairment could not have a substantial adverse effect. However, this was challenged in the case of Goodwin –v- the Patent Office⁹¹

In this case the EAT reversed its findings that the Claimant, who was a paranoid schizophrenic was not disabled. The Employment Tribunal had thought that the effect of his impairment was not "substantial". The EAT decided otherwise. They took into consideration that the Claimant was unable to carry on normal conversations with his work colleagues and that he had such bizarre behaviour he was considered disabled.

⁹⁰ This was an actual case which took place in my workplace and the potential Claimant in this case had to leave her nursing career to work in the hospital admin office. (Not reported)

⁹¹ *Goodwin v The Patent Office (1999)* IRLR 4 EAT Although this Chapter covers the issue regarding physical impairment this case involves mental impairment and a more comprehensive background of the case is illustrated in Chapter 5 entitled Mental Impairment. Also see Appendix 3 (7) (a) & (b)

The EAT set out their explanation as follows:

“What the Act is concerned with is an impairment of the person's ability to carry out normal activities. The fact that a person can carry out such activities does not mean that his/her ability to carry them out has not been impaired. Thus, for example, a person may be able to cook, but only with the greatest difficulty. In order to constitute an adverse effect it is not the not doing of the acts which is the focus of attention but rather the ability to do (or not to do) the acts.”

Experience shows that disabled people often adjust and adapt their lives and circumstances to enable them to cope for themselves. Thus, if a person whose capacity to communicate through normal speech was obviously impaired, they might well voluntarily choose to live on their own. If one asked such a person whether they managed to carry on their daily lives without undue problems, the answer might well be yes, yet their ability to lead a normal life had obviously been impaired. Such a person would be unable to communicate through speech, and the ability to communicate through speech is a capacity, which is needed to carry out normal day-to-day activities whether at work or at home. If asked whether they could use the telephone or ask directions, or which bus to take the answer would be no. Those might be regarded as day-to-day activities contemplated by the legislation, and a person's ability to carry them out would clearly be regarded as adversely

affected.⁹² The reasoning behind their decision was that the disability must have an adverse affect on a person's day-to-day activities regardless of whether the affected activities were tasks carried out at work or home. Indeed, it can be said that if the disability affects the person's home life then it is likely to affect their work life.

A person can still have an impairment but it may not have a substantial adverse effect and therefore the impairment will not be classed as a disability. This can be demonstrated in the cases of Foster v Hampshire Fire and Rescue Service⁹³ in which a woman suffered from both asthma and migraine and Foord v J A Johnson & Sons⁹⁴ which held that the Claimant did not have a disability which had a substantial effect.

It can, however, be argued that in both of these cases the Claimants have conditions which affect their ability to carry out tasks. It is questionable in the case of Foord v J A Johnson & Son⁹⁵ whether, had the Claimant worked full time, for example, 8.00 am to 4.00 pm, the Act would have afforded her the protection she sought. Indeed, her ability to do her job would have been affected, and so it could have been argued that the employer would have then had to make reasonable adjustments by way of providing reduced hours and frequent breaks. Many people with physical impairments can only work part-

⁹² Ibid footnote 85

⁹³ EAT/1303/97 (23 06 98) Harveys. See Appendix 3 (1)

⁹⁴ ET Case No S/200300/97 Appendix 3 (2)

⁹⁵ Ibid footnote 88

time and even if they worked full-time the Act would suggest that their disabilities had a substantial adverse effect and therefore would meet Section 1 of the Act. The reasonable adjustment mechanism⁹⁶ would apply and the disabled person could ask for reduced hours, hence making them part-time. The effect of the impairment still has the same impact whether a disabled person works part-time or full-time. What is contentious is whether they should then be excluded from the protection of the DDA 1995 because they have chosen to work part-time since their impairments prevent them from working full-time.

The Guidance states that consideration should be given in respect of a persons' disability that has a substantial adverse effect and to also take into consideration how long a disabled person takes to carry out day-to-day activities.⁹⁷ The Guidance also states consideration should be given to environmental issues affecting a disabled persons' disability, for example, temperature, humidity, time of the day, how tired the person is or how much stress he/she is under as in the case of Ekpe -v- Commissioner of the Metropolis Police⁹⁸ this Claimant suffered from a muscle wasting condition in her right hand. The employer may be expected to make adjustments to work systems to reduce the impact on the employee's disability if the environmental factors affect an employee's ability to do their work.

⁹⁶ DDA 1995 S 6

⁹⁷ Guidance Part II para A2-A3

⁹⁸ 2001 ICR 1084 EAT See Appendix 3 (3)(a)

There has been much case law involving cases where the Claimant was perceived to have disabilities but their impairments did not meet the requirement as having a substantial adverse effect.

In the cases of Cook v Kitchen Range Foods,⁹⁹ Thorpe v-Royal Hospitals NHS Trust¹⁰⁰ and Alexander -v- Driving Standards Agency¹⁰¹ these cases involved allegations that Claimants had been discriminated against on the basis, respectively, of a back injury, having sight only in one eye, and having an epileptic fit. In all three cases, Tribunals ruled that the Claimants' medical conditions did not have a substantial adverse effect on their ability to carry out normal day-to-day activities as required by Section 1.

4.2 Ability to Carry Out Normal Day-To-Day Activities

This second segment involves the ability to carry out 'normal day-to-activities'. The DDA 1995 only protected people whose abilities to carry out 'normal day-to-day activities' were impaired. The Act did not define 'normal day-to-day activities' but paragraph 4 (1) of Schedule 1 states that an impairment is to be treated as affecting a person's ability to carry out normal day-to-day activities only if it affects one of the following: mobility; manual dexterity; physical co-ordination; continence; ability to lift, carry or otherwise

⁹⁹ 36 EORDCLD pg 4 See Appendix 3 (4)

¹⁰⁰ 36 EORDCLD pgs 11-12 See Appendix 3 (5)

⁹³ 36 EORDCLD pg 4 See Appendix 9 (6)

move everyday objects; speech, hearing or eyesight; memory, or ability to concentrate, learn or understand or perception of the risk of physical danger.

4.3 The Meaning of 'Normal'

The Guidance provides that the term normal day-to-day activities does not include activities which are normal only for a particular person or a group of people. Therefore, only activities which are normal for most people and carried out by most people on a daily or frequent regular basis can be considered.¹⁰² The test is an objective one whereby, for example, shopping, cleaning and cooking are all considered to be normal day-to-day activities. In the landmark case of *Goodwin –v- The Patent Office*¹⁰³ the EAT set out the Guidelines to determine whether a person is “disabled” within the meaning of the Act.

The Guidance¹⁰⁴ also states that the direct effect of an impairment must also be taken into consideration when assessing whether the impairment falls within the statutory definition. An example of this would be where a person has been advised by his/her GP to change his daily routine or to refrain from doing a normal day-to-day activity on account of his/her impairment, or where an impairment can cause pain or fatigue so that while the normal day-to-day activities will be performed the person may not be able to repeat the tasks

¹⁰² Guidance Para C2

¹⁰³ Op Cit footnote 85

¹⁰⁴ Guidance Para C6

over a substantial period of time, or indeed might avoid lifting or carrying heavy objects such as a vacuum cleaner. Often this rule can cause hardship on individuals who suffer mental health illnesses such as depression. People suffering from mental illnesses such as depression most commonly complain of difficulties with concentration. Other areas may also be affected such as physical co-ordination, perception of the risk of danger, speech, hearing or eyesight. In addition, the Guidance¹⁰⁵ will also look at how stress and fatigue may take their toll on physical areas such as mobility, or the ability to lift or carry every day objects. The Guidance¹⁰⁶ makes it clear that the effects of fatigue generally must be taken into account. However, interestingly stress in itself is not classed as a disability.¹⁰⁷ Additionally, for people with mental health illness, the Guidance¹⁰⁸ states that:

“Account should also be taken of whether, although the person can physically perform a task, he/she is unable in practice or sustain this over a period of time”,

The above guidelines have caused difficulties and confusion in early case law as demonstrated in the case of Leonard –v- Southern Derbyshire Chamber of Commerce¹⁰⁹ where the Claimant suffered from clinical depression. The Tribunal concluded that despite the Claimant’s problems she was still

¹⁰⁵ Guidance Para 4 (1)

¹⁰⁶ Guidance Para C6

¹⁰⁷ See Chapter 5

¹⁰⁸ Guidance Para C7

¹⁰⁹ IRLR 19 EAT 1 See Appendix 3 (8)

managing to carry out day-to-day activities and they held that she did not have a disability under the DDA 1995. This decision was appealed and the EAT stated that:

“The Tribunal’s findings clearly stated that the Claimant was unable to sustain an activity over a period of time.”

In the EAT’s view they stated that:

“The Tribunal had failed to take proper account of the affect of the tiredness on the Claimant’s ability and that they found it difficult to see how the Tribunal could have concluded on the evidence that there was no substantial affect on her ability to carry out day-to-day activities”.

The Guidance also makes it clear that work related activities do not come under this heading, in that it makes it clear that the term ‘normal day-to-day activities’ does not include work of any particular form because no particular work is ‘normal’ for most people.¹¹⁰ This therefore, means the inability to perform a particular task at work would not bring a person within the definition of a disabled person, unless there was also an adverse impact on the person’s normal day-to-day activities and this is illustrated in the cases of Hudson -v- The Post Office¹¹¹ where the Claimant was a driver and Quinlan –

¹¹⁰ Guidance Para C3

¹¹¹ ET Case No 3100773/98 See Appendix 3 (9)

v- B & Q¹¹² where the Claimant had underwent heart surgery. These may have been borderline cases in which the Claimant may have gained some redress from the Act. Questions to ask would be with regard to the effect on the field of vision and whether there is a correlation in the number of accidents to the individual or peers and/or any anxiety caused by the lack of sight. Undoubtedly, there is an effect that partial sight has on a person's life, whether in the home or in the workplace, that needs to be taken into consideration. There is evidence that many people with sight in one eye lead full social and working lives – equally there are many others for whom it can have a debilitating effect. Unfortunately, there is the age factor involved in this process; whether the sight loss was sudden, or of a gradual nature and whether any rehabilitation services had been received by the individual, through either Local Authorities or Voluntary Organisations, or through Company Insurance Schemes. The latter case returns to the issue of reasonable adjustments¹¹³ being made through the DDA 1995. Therefore, it could be said that the Tribunal had failed to consider the above issues and to consider whether the employer could have made any attempts to make any adjustments, such as to find alternative work for that person. Clearly, this is a failure on the part of the DDA 1995 to consider the environmental impact on the physical and mental impairment of that person. In the case of Quinlan v B&Q plc¹¹⁴ the Tribunal stood by its decision that the Claimants were not disabled and the EAT upheld that decision.

¹¹² EAT Case No: 1386/97 See Appendix 3 (10)

¹¹³ DDA 1995 S 6

¹¹⁴ Op Cit footnote 106

In relation to gender focused activities such as applying make up and nail varnish for example which are performed by females rather than by males, the Tribunal held in the Ekpe –v- The Metropolitan Police Commissioner 2001¹¹⁵ that putting make up on or putting rollers in hair were not normal day-to-day activities, because they were carried out almost exclusively by women. However, the EAT said that this was plainly wrong because it would exclude anything done by women rather than men, or vice-versa as not being normal.

In the case of Coca Cola Enterprise Ltd v Shergill¹¹⁶ the Tribunal had relied on the part of the Guidance, which states that the playing of games and sports does not constitute normal day-to-day activities for the purpose of S 1(1) of the Act. The EAT set aside an Employment Tribunal's decision that an employee who was unable to cycle or play snooker or football because of his physical impairment was not a disability within the meaning of the Act.¹¹⁷ It may have been advantageous had the EAT expanded its view on what it meant when it stated that if a person suffers from an impairment of mobility such that a person is unable to engage in 'normal endeavours at fitness', then that person is likely to be disabled. The question that needs to be asked here is, "what are normal endeavours of fitness?" The phrase could cover such activities as going for a brisk walk or swim for fifteen minutes, or light gardening, which are the kind of activities that the Government has promoted

¹¹⁵ Op Cit footnote 92

¹¹⁶ EAT003/02 See Appendix 3 (11)

¹¹⁷ S1 (1) DDA 1995

in advertising and on television campaigns designed to promote fitness among the population. Such a view is consistent with the examples of adverse effect given in the Guidance¹¹⁸, for example the inability to travel a short journey as a passenger in a vehicle; inability to walk other than at a slow pace or with unsteady or jerky movements; difficulty in going up and down stairs; inability to use one or more forms of public transport, and the inability to go out of doors unaccompanied.

In its final report in December 1999 the Disability Rights Tasks Force made a number of recommendations for future reform of the definition of disability in the DDA 1995.¹¹⁹ In commenting on the exclusion of work activities from "normal day-to-day activities", the Disability Rights Tasks Force explained that:

"We considered whether the reasons for not including work as a normal day-to-day activity had been clearly explained in Statutory Guidance and was understood by legal advisers and Employment Tribunals. The reasons were, firstly, that there was no single occupational role that is common for most people and secondly many activities carried out as part of particular occupations, were exceptional and not normal."¹²⁰

¹¹⁸ Para C 14

¹¹⁹ Disability Rights Tasks Force From Exclusion to Inclusion : A Report of the Disability Rights Task Force For Disabled People (1999 London Df EE) Chapter 3

¹²⁰ Op Cit footnote 112

The Task Force continued:

"We therefore felt the exclusion of exceptional activities was acceptable. However, many of the activities carried out in employment are not exceptional and would be quite normal outside the work place."

For example, if a person with Repetitive Strain Injury cannot operate a keyboard in the workplace and does not use a keyboard at home, this does imply that he/she is not covered by the Act. Operating a keyboard outside the workplace is a normal day-to-day activity for very many people, even if it is not for the potential Claimant he/she is likely to be covered by the DDA 1995 definition.¹²¹

The above quotation still leaves the rationale for the exclusion unclear. Employees, who are, on a substantial and long-term basis unable to perform tasks at work by reason of physical or mental impairment, would seem to be among those who most needed the protection of the DDA 1995. This exclusion makes their civil rights at work depend upon whether the activities affected happen also to be "normal day-to-day activities", or whether they happen to be other such activities also affected. The activities covered in Schedule 1 of the Act¹²² form an arbitrary list which are:

- mobility,

¹²¹ Ibid footnote 114

¹²² DDA1995 para 4

- manual dexterity
- physical co-ordination
- continence
- ability to lift, carry, or otherwise move every day objects
- speech, hearing or eye sight
- memory, or ability to concentration, learn, or understand
- perception of the risk of physical danger

Many practitioners, including myself as a Solicitor, and advisors will have found themselves trying to squeeze conditions into one or other category. Those with mental impairments¹²³ as the Disability Rights Tasks Force recognised, are at particular risk of finding themselves excluded (e.g. agoraphobics and those with impairments to social interaction and feeling.)

4.4 Long Term Effects

A further criteria which had to be met under Section 1 of the DDA 1995 was that the substantial adverse effect of an impairment had to be long-term. This requirement ensured that temporary or short-term conditions did not come under the protection of the DDA 1995.¹²⁴ The definition of long-term is that a condition qualifies if it lasted at least 12 months, or is likely to last 12 months, or is likely to last for the rest of the life of the person affected

¹²³ See Chapter 5 Mental Health Impairments

¹²⁴ Schedule 1 Para 20 (1)

The criteria listed above have always been problematic and uncertain. A typical scenario would be an employee suffered a sudden onset of mild depression and is dismissed within six months of his employment. This person would have no redress under the current employment law and depending on their service¹²⁵ they would only have a claim for unfair dismissal. However, if that person has less than twelve months service, then they have no claim for unfair dismissal or disability discrimination. Even if they do meet the twelve months qualifying period to make a claim for unfair dismissal, this may still fail on the grounds of capability due to the inability to do their job. Another example would be a person with a broken leg in plaster, who may be refused entry into a public house or a restaurant. This person does not qualify for protection because he/she does not satisfy the criteria of long-term effect – it is merely an illness or an injury.¹²⁶

The aim of the twelve-month qualifying time period is to exclude people with impairments that are short-term or temporary. The Tribunal takes the view that with current impairments that have not lasted twelve months; they will have to decide if the substantial adverse effect of the impairment is likely to last twelve months. When deciding how long an impairment has lasted, or is likely to last, or more likely to last, the Guidance states it is to be determined at the date of the Tribunal hearing and not at the date of the discriminatory

¹²⁵ In order to make a claim for Unfair Dismissal a Claimant must have 12 months continuous service

¹²⁶ Doyle B. Disability, Discrimination, Law & Practice. Jordan's 5th edition

act.¹²⁷ The Guidance also states that a Tribunal should take into account the total period for which the effect of the impairment exists including any time before the discriminatory act as well as time afterwards¹²⁸.

This approach was confirmed by the EAT in the case of Greenwood v British Airways plc¹²⁹ in which the Claimant suffered from nervous tension. The Tribunal took the incorrect approach when they decided that the Claimant's depression was not long-term because at the date of the alleged discriminatory act he was fit and well and the depression was not likely to recur. The EAT held that the wording of the Guidance¹³⁰ which makes it clear that in assessing the effect of an impairment it is right to take account of the total period for which the effect exists, provides sufficient authority for requiring a Tribunal to have regard to the adverse effect of an impairment up to and including the date of the hearing. It was not correct to consider the adverse affects only at the moment in time when the alleged discrimination took place.

The wording of the Guidance¹³¹ also protects those people who may, for example, have a sudden onset of deafness or blindness. They could rely on the protection of the DDA 1995 if they were dismissed within say six months

¹²⁷ Para b7

¹²⁸ Para b8

¹²⁹ ICR 969 EAT See Appendix 3 (12)

¹³⁰ Para b8

¹³¹ Para B 8

of their impairment. All that person needs is to show that the impairment is likely to last more than twelve months.

The requirement that an impairment is long-term clearly applies to all impairments, but in practice seems to have been problematic and relevant in the cases of depression. The following three cases have been used to illustrate the complexity and hardship caused around people who suffer from depression¹³².

In Farrell -v- The Hammersmith Hospital NHS Trust & ors¹³³ the Claimant suffered from bouts of depression in 1994 and again in 1996. To comment on this case, it has to be said that the restricted time limits under the DDA 1995 caused hardship to pregnant women during and after pregnancy and in particular in relation to post-natal depression issues. As the current law stands maternity leave is only granted up to nine months paid leave and thereafter the remaining three months unpaid. Nevertheless most women, for the purposes of financial reasons have to return to work after six months. If she was suffering from post-natal depression and then consequently went off sick with this depression she would be deemed not to have any protection under the DDA 1995 because it would be very difficult to prove that the post-natal depression would be likely to last more than twelve months.

¹³² See also Chapter 5 Mental Impairment

¹³³ ET Case No: 2200918/97 See Appendix 3 (13)

In the cases of Butler –v- Eastleigh Housing Association Ltd¹³⁴ the Claimant became depressed following incidents at work and Jobling –v- Corporate Medical Management Ltd.,¹³⁵ in which the Claimant suffered from depression the Tribunals found that the Claimants were not deemed disabled for the purposes of the DDA 1995. The last two cases show that each of the Claimants impairments could have had fluctuating effects, in that the effects of an impairment, for example depression, does not have to remain the same during the twelve month period. The Guidance confirms that provided the impairment continues to have or is likely to have a substantial adverse effect on the person's ability to carry out normal day-to-day activities throughout a period of less than twelve months, there is a long-term effect for these purposes. In other words, even if an Claimant who suffers from depression was able to prove that his/her depression was likely to last more than twelve months he/she would still have to prove that his depression has an adverse effect on his/her ability to carry out day-to-day activities.

4.5 Recurring Conditions

The DDA 1995 also provided that if a person had a disability which had a substantial adverse affect on his/her ability to carry out normal day-to-day activities, but which subsequently ceased to have that affect, it would be treated as continuing to have such a substantial adverse affect. For example, a person who had an illness or disability which was in remission, or if they are

¹³⁴ ET Case No: 3101121/97 See Appendix 9 (14).

¹³⁵ ET Case No:703101/2001 See Appendix 9 (15)

in good health, would still have the protection of the Act if it could be established that the affect of the disability was likely to recur. This provision covered impairment such as epilepsy and multiple sclerosis, or someone who was asthmatic. However, seasonal allergies, such as hay-fever, were specifically excluded, but it could be argued that for a person who suffers from severe hay-fever the effects are recurring and can be substantial for a brief time, therefore can also be said to have an adverse affect on that person's ability to carry out their day-to-day activities. Nevertheless hay-fever and seasonal conditions are specifically excluded from the regulations.¹³⁶

The Guidelines state that an impairment 'with recurring effects' in a person whose condition is likely to recur, means that it is more likely than not that the effect will recur. If the effects are likely to recur beyond twelve months after the first recurrence then the condition should be treated as long-term. The Guidelines go on to state that judging likelihood of recurrence, account should be taken of all the circumstances, including any reasonable expectations that the person concerned should take steps to prevent the recurrence.

The likelihood of recurrence can be an issue in cases involving epilepsy where, except in the most severe cases, the condition is symptom-less between seizures and this can often cause confusion and hardship to people who suffer from epilepsy as in the case of Alexander -v- Driving Standards Agency.¹³⁷ The Claimant in this case lost her job. She was unable to continue

¹³⁶ Disability Discrimination (Meaning of Disability Regulation) 1196 Section 1 1996/1455

¹³⁷ Op Cit footnote 95

to work as a driving test examiner and could not rely on the protection of Section 1 of the DDA 1995 because she could not prove that she had a recurring condition in that she could not establish that her impairment would recur or be likely to recur. In addition to this the DVLA guidelines¹³⁸ also state,

“it is possible to apply or re-apply for a Category A B or P licence as long as you have been free from seizures completely for one year or only experienced sleep seizures for a period of at least three years and the DVLA/DVLNI is satisfied that as a driver you are not likely to be a source of danger to the public”

and under these Guidelines she was not allowed to continue to drive. Consequently her employers dismissed her, but were not deemed to be disabled for the purpose of the Act.

4.6 Progressive Conditions

There is also a special provision made for persons with progressive conditions. If a person has a progressive condition such as Cancer, Multiple Sclerosis, Muscular Dystrophy or HIV and has had an impairment affecting normal day-to-day activities, but which has not yet had a substantial adverse affect, he/she is deemed to have an impairment with a substantial adverse affect if the condition is likely to result in such an impairment.

¹³⁸ www.epilepsy.org.uk/info/driving-criteria.html

In order for persons with impairments such as HIV, Cancer and MS to have gained the protection of the DDA 1995 the Guidance pointed out that for the rule to operate. Medical diagnosis of the condition is not in itself enough, there had to be some effect on the person's ability to carry out day-to-day activities.¹³⁹

The following cases illustrate this rule: In Aves -v- Bournemouth International Airport Ltd¹⁴⁰ the Claimant was diagnosed as HIV positive and in Cox -v- Careeragent Ltd., t/a Bell Toyota Ltd.¹⁴¹ the Claimant was diagnosed as having a malignant tumour. It was held that both Claimants could rely on the fact that their disabilities had a substantial effect on their ability to carry out day-to-day activities

However, In the case of O'Donnell -v- the Ministry of Defence¹⁴² the Claimant suffered from Ankylosing Spondylitis. He did not qualify as being disabled because his condition had already occurred or did not have a progressive condition.. Therefore, accordingly the Employment Tribunal held that the Claimant did not have a disability.

Therefore the Guidance¹⁴³ will only apply where "the condition is likely to result" in the person having an impairment which has a substantial adverse

¹³⁹ The Guidance para 8 (1) (a)

¹⁴⁰ ET Case No: 3101789/98 See Appendix 3 (16)

¹⁴¹ ET Case No: 1700896/98 See Appendix 3 (17)

¹⁴² ET Case No: 3101421/97 See Appendix 3 (18)

¹⁴³ Para 8

effect. This was reinforced in the case of Mowat-Brown -v- the University of Surrey¹⁴⁴ where the Claimant had MS. The EAT in this case found that the Claimant's MS was not a progressive condition. They based their decision on a medical expert's report which stated that it was difficult to give an accurate prognosis for an individual with MS and accordingly the EAT found no error on the Employment Tribunal's decision and dismissed the Appeal. This rule has obviously caused hardship to the Claimants in the above cases because both had impairments which affected their daily living and were conditions which were not likely to improve. However, in the case of Diamond -v- Fagnani¹⁴⁵ where the Claimant also had MS, the Employment Tribunal found that the Claimant's MS was a progressive condition for the purpose of the Act and this therefore conflicts with the Mowatt-Brown -v- University of Surrey¹⁴⁶ case.

As previously illustrated the first two cases involving MS clearly show there was confusion and conflict with regard to progressive illness. As a result the criteria for progressive illness has now been amended¹⁴⁷ which occurred in October 2004. The amendment states that once a progressive condition is diagnosed, in particular for Cancer, HIV and MS then it will be deemed to be a disability at the date of the diagnosis or the prognosis. The amendment was made in particular to protect people with Cancer, HIV or MS, whose condition would not immediately have an adverse effect on their ability to carry out day-

¹⁴⁴ IRLR 235 EAT See Appendix 3 (19)

¹⁴⁵ ET Case No:6004314/99

¹⁴⁶ Op Cit footnote 138

¹⁴⁷ Disability Discrimination Act 1994 as amended by the DDA 2004

to-day activities, but later as the condition got worse it would then have an adverse effect on their ability to carry out day-to-day activities.

4.7 The Effects of Medical Treatment and/or Disability Aids

A disabled person may have a disability, which is controlled by medication or the use of aids, such as a motorised wheelchair or a hearing aid. It would seem that once the medication or the aid take effect, then that person would no longer be deemed to be disabled as their disability would not have any adverse effect on their ability to carry out day-to-day activities. Yet, if the medication or the aid were to be removed, they would then be deemed to be disabled. Nevertheless, the person with the aid, such as the motorised wheelchair or the hearing aid may still be treated unfairly and be seen as being disabled simply because they use these aids to cope with their disability. However, protection is given to people in such circumstances.¹⁴⁸

The Guidance provides that an impairment which would be likely to have a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities, but for the fact that medication or aids are being taken to treat or correct the impairment, would still be deemed to be treated as a continuing impairment amounting to a disability. Measures can include, but are not limited to, medical treatment and the use of prosthesis. The DDA 1995 Act does not define what is meant by an 'aid' but in the case of Vicary –

¹⁴⁸ Para 6 (2)

v- British Telecommunications¹⁴⁹ in which the Claimant suffered from an upper arm condition, the EAT took the view that aids were things such as Zimmer frames, sticks or wheelchairs and not household objects such as automatic can-openers.

The DDA 1995 also does not have a clear definition of medical treatment. In the case of Kapadia v London Borough of Lambeth¹⁵⁰ the Claimant suffered from reactive depression. The EAT stated that counselling sessions with a Consultant Psychologist constituted such treatment. However, if a disabled person is advised by a medical consultant to behave in a certain way in order to reduce the impact of a disability they might, after treatment be disregarded under this provision of the DDA 1995. A typical such impairment would include diabetes being treated by taking or injecting Insulin.

The provision does not apply to vision, which can be corrected by spectacles or contact lenses.¹⁵¹ The term correctable, by spectacles or lenses under the Act seems to say that a person who has a sight impairment but does not use spectacles or contact lenses that might otherwise correct the sight loss would not qualify as a disabled person. Therefore, it has to be said that this provision only applies to a person who has a sight impairment, which is deemed to be an involuntary disability. If a person with sight impairment chooses not to have corrective surgery to rectify the sight impairment, they would be excluded from

¹⁴⁹ 1999 IRLR 680 EAT See Appendix 3 (20) (a)

¹⁵⁰ 2000 IRLR 14 EAT See Appendix 3 (21)

¹⁵¹ Para 6 (1) 6 (3) (a)

the protection of the DDA 1995. The Guidance continues, however, by stating that the only effects on the ability to carry out normal day-to-day activities to be considered are those, which remain when the spectacles or contact lenses are used or would remain if they were used. This provision itself seems to cause confusion because on one hand this provision is stating that it does not apply to vision which can be corrected by spectacles or contact lenses, but on the other hand the provision goes on to state that the only effects on the ability to carry out normal day-to-day activities to be considered are those which remain when spectacles or contact lenses are used. So, in effect this is contradictory because the Guidance states that people with vision impairment using spectacles or contact lenses are not protected by the Act, but then goes on to say that with the effects on the ability to carry out day-to-day activities by a person using spectacles or contact lenses, the remaining effects and the ability to carry out day-to-day activities can be taken into consideration when looking to the protection of the Act.

Having demonstrated through some relevant case law how the DDA 1995 was ineffective and piecemeal the definition of disability is such that it causes confusion and conflict. The definition has caused hardship to both people with both physical and mental impairments. The Government needs to consider the definition of disability with that of the Americans With Disabilities Act¹⁵² (ADA). Using the Americans definition of disability would ensure that disabled people receive the protection of the Act that they deserve. All that is required

¹⁵² See Appendix 1

under the ADA is that a person has a disability regardless of what degree or severity the disability is. Under Section 1 of the DDA 1995 this has, through the passage of time caused conflicting case law as demonstrated in this Chapter and hence making the process of fairness and justice piecemeal and gives little or no protection if a person with an impairment cannot satisfy the criteria under Section 1 of the DDA..

5 MENTAL IMPAIRMENT

This Chapter deals with the issues of mental impairment and in particular the problems that people with mental impairments face both in society and in particular, trying to establish they have a mental impairment which fulfils Section 1 of the DDA 1995. Not so long ago, perhaps 50 years ago, people with mental health problems and learning difficulties would be considered to be a burden and a risk to society. Subsequently they would be institutionalised and forgotten about. The attitude of people both nationally and worldwide would be that people with mental health issues served no purpose in society.

Today, one in four people suffer with some mental health problem at some time in their lives.¹⁵⁴ Examples of mental illness range from mild depression to conditions such as schizophrenia and bi-polar depression, agoraphobia, eating disorders, anxiety, sexual deviation, stress, post-traumatic stress disorder, headache, paranoia, psychopathy, stammering and transsexualism. One of the major difficulties is that a mental health problem may be invisible and many people did not satisfy Section 1 of the DDA 1995. Whilst a physical impairment can be seen, for example, a person with a mobility issue may be a wheelchair user or a deaf person may wear a hearing aid or a blind person may use a white cane, there is nothing to indicate that a person with mental health issues may have a mental impairment other than their erratic or unusual behaviour. For example, a person may be seen as being eccentric or

¹⁵⁴ Department of Health Press Release October 1998

be a loner but this does not necessarily mean they have a mental impairment. As previously discussed¹⁵⁵ the notion of physical disability is problematic and a psychiatrically diagnosed illness can also be problematic. There is still no agreement about what a mental impairment is or what mental illnesses are.

An American commentator, Szasz¹⁵⁶ said:

“Psychiatry is a house of cards held up by nothing more or less than mass belief in the truth of its principles and the goodness of its practices. If this is so, then psychiatry is a religion, not a science, a system of social controls, not a system of treating illness”.

Those who do believe that ‘mental illness’ is a physical or psychological disease, disagree about its causes. Some think that mental illness is caused by chemical hormonal or other physiological disorders, others that it is caused by genetic defects, others that it is caused by environmental factors such as early childhood problems and traumas and still others that it is caused by a combination of factors. With no agreement about what mental ill health is, it is not surprising that there is no consensus on how those with a psychiatric illness should be treated – whether the treatment is by doctors or other professionals such as counsellors.

¹⁵⁵ See Chapter 4

¹⁵⁶ Szasz 1989 *Law Liberty & Psychiatry*, New York Syracuse University Press

The current edition of the International Classification of Mental and Behavioural Disorders¹⁵⁷ published by the World Health Organisation, uses the term 'disorder' to define mental impairment. The term 'disorder' is used throughout the classification so as to avoid even greater problems inherent in the use of terms such as 'disease' and 'illness'. 'Disorder' is not an exact term, but it is used here simply to imply the existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance alone, without personal dysfunction, should not be included in mental disorder as defined here. The last sentence is a reminder that diagnosis, hospitalisation and forced treatment should not rest on social disapproval alone. It is not so long since the days when women were found to be insane and committed to mental institutions with no symptoms of mental illness other than producing an illegitimate child.

Today, conditions in society for people with mental health issues have vastly improved but still need further improvements. The introduction of the DDA 1995 was to address the exclusion that people with mental health issues faced, but this failed in this objective. This failure will be discussed at length later in this chapter.

¹⁵⁷ See Appendix 4

5.1 An Overview of the Definition Of Mental Health Impairment

There is no definition of mental impairment in the DDA 1995, but the Guidance¹⁵⁸ states that the term includes a wide range of impairments relating to mental impairment, including learning disabilities. However, Schedule 1¹⁵⁹ also contained a limitation on the protection of mental health disorders by the Act to a person by providing that an impairment resulting or consisting of a mental illness was only included if the mental illness was "clinically well recognised".¹⁶⁰ Therefore, if a Claimant with a mental impairment wanted to pursue a claim for disability discrimination, a Tribunal would have to look at whether the mental illness or impairment that the Claimant was suffering from was an illness that was clinically well recognised.

The definition of mental impairment under the DDA 1995 caused problems and conflict especially for the Medical Profession and Tribunals and caused hardship to Claimants trying to pursue a claim for disability discrimination on the grounds of a mental impairment. To the majority of Doctors and Psychiatrists the term mental illness means a mental illness under the Mental Health Act 1983 and this would include illnesses such as schizophrenia and manic depression which are also often called psychosis illnesses. The present definition of a mental impairment does not include many of the conditions listed in the World Health Organisation International Classification

¹⁵⁸ Guidance para 13

¹⁵⁹ Schedule 1 para 1

¹⁶⁰ Op Cit footnote 149

of Diseases.¹⁶¹ This does not cover conditions such as those arising from emotional distress, for example anxiety and depression which most people experience at some point in their lives.

The Government proposed to replace the Mental Health Act 1983 with a new Act and published a draft Mental Health Bill in 2002. The Government made a formal announcement on 23 March 2006 that Ministers had decided to abandon the controversial draft Mental Health Bill. Two versions of the Bill had been published in 2002 and 2004. Both provided strong resistance from everyone involved in the mental health system. MIND is glad that the Government has responded to this widespread criticism by withdrawing the Bill. Instead, different legislation will be put forward that will leave the current Mental Health Act 1983 in place, but make some important changes.¹⁶²

Under the previous Bill the focus was on “mental disorder” and the new definition of the term is:

“an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain”.

This attracted widespread criticism. It had been said that critics say the new definition could cover epilepsy; alcoholism and drug abuse and make people suffering from one of those diseases vulnerable to compulsion. The new

¹⁶¹ Ibid footnote 149

¹⁶² www.mind.org.uk

definition in the Bill was extremely broad and it may have also covered someone who has sustained traumatic damage to a fully developed brain, for example, a brain injury caused by a road traffic accident.¹⁶³

Under the current Mental Health Act 1983 and in particular, if the previous Mental Health Bill had passed as law, it would have caused confusion because by Section 68 (1) of the DDA 1995 it made clear that the definition of a mental impairment used in the DDA 1995 was not the same as that used in the Mental Health Act 1983, although Section 68 (1) went on to add that the fact that a mental impairment is covered by the Mental Health Act 1983 did not prevent it from being a mental impairment under the DDA 1995. Nevertheless, confusion would have arisen if the new Bill was implemented which covers alcoholism or drug abuse which make people vulnerable and therefore would only have been covered by the Mental Health Act. However, drug abuse and alcoholism are excluded from the protection of the DDA 1995 Act.¹⁶⁴ Effectively, the issues of drug abuse and alcoholism conflict with that of the Mental Health Bill and with Section 68 (1) of the DDA 1995 1995. The Mental Health Bill would have allowed anybody suffering from alcoholism or drug abuse to be recognised as having a mental health illness. This would have conflicted with the DDA 1995 definition of mental impairment which specifically excluded alcoholism and drug abuse. The DDA 1995 exclusions stated that drug addictions and alcohol abuse were covered by the DDA

¹⁶³ Hewitt D, Reading Between the Lines. New Law Journal 5.11.04

¹⁶⁴ See Chapter 6

1995¹⁶⁵ therefore, if the new Mental Health Bill has been passed this would have clearly caused a conflict of laws and cause widespread confusion and criticism.

To claim protection under Section 1 of the DDA 1995 a person firstly had to establish that they were disabled. The starting point was to establish whether the impairment was properly classed as a mental impairment or in fact it should have been treated as a physical impairment. In order to establish whether a mental illness falls under the Act it had to be recognised as a clinically well-recognised illness¹⁶⁶ and the Code of Practice gave practical guidance in relation to mental illness.¹⁶⁷ It has been established from previous cases and decisions that the mental illnesses claimed under the DDA 1995 were likely to require much medical evidence, possibly from a specialist medical report. The types of cases that required careful consideration are those in which a person experienced physical symptoms, which had no underlying physical cause. Impairment may not have been regarded as a physical impairment if it had a mental cause rather than a physical one. In Rugamer v Sony Music Entertainment UK Ltd and McNicol v Balfour Beatty Rail Maintenance Ltd¹⁶⁸ it was held that employees suffering from "functional" or "psychiatric" overlay – a mental condition in which a person claims or believes he/she is suffering from a physical injury, but the medical expert is

¹⁶⁵ Disability Discrimination (Meaning of Disability) Regulations 1996 Section 1 1996/1455

¹⁶⁶ Op Cit footnote 149

¹⁶⁷ Para 14 states that a clinically well-recognised illness is likely those specifically mentioned in the World Health Organization International Classification of Diseases.

¹⁶⁸ IRLR 644 EAT

satisfied that there is no organic cause for the symptoms and believes that the person's symptoms result from their mental state. In both cases the Tribunal found that the Claimants did not have a physical impairment. It is arguable that if a person's mental condition, for example in the previous two cases, cannot be shown to be a clinically well recognised illness, the Claimants will have no redress or protection under the Act either for a physical or mental impairment.

However, in the case of Hobbs –v- College of Ripon & York St Johns¹⁶⁹ another division of the EAT held that a physical impairment does not involve a rigid distinction between an underlying defect of or in the body or on the evidence of the manifestation or effect on the other. It was therefore decided that impairment could be something that results from an illness rather than being the illness itself. In this case the EAT decided that the Claimant symptoms could be described as a physical disability, and in the absence of a medical report stating that her symptoms were either a physical or mental impairment, the Tribunal had been entitled to infer she had a physical impairment. The McNicol case was appealed and the Disability Rights Commission intervened as an interested party arguing that the correct approach to adopt in such cases was that taken in the Hobbs case. The Court of Appeal dismissed the case but approved the approach of Mr Justice Lindsay in the Hobbs case. From these cases useful precedent case law has been laid down to assess the effects of impairment rather than its cause.

¹⁶⁹ IRLR 185 EAT

In a case where the impairment is properly categorised as mental impairment the next question to ask is "is it clinically well recognised" as stated in the Guidance¹⁷⁰

A clinically well recognised illness is a mental illness which is recognised by a respected body of medical opinion and these would include organisations such as the World Health Organisation's International Classification of Diseases"

It is interesting to note that the Guidance does not require that an illness should be included in ICD-10 to be clinically well recognised. Tribunals and Courts have, however, been reluctant to conclude that a mental illness is clinically well recognised unless there is expert medical evidence such as a medical report.

5.2 Problematic Issues Involving Mental Impairment

5.2.1 Conflicting Case Law on establishing a Mental Impairment

To gain the protection of the Act a person with a mental impairment had to prove that they had a disability under the DDA 1995.¹⁷¹ A clinically well recognised illness is a mental illness which is recognised by a respected body

¹⁷⁰ Para 13

¹⁷¹ Op Cit footnote 1

of medical opinion and these would include organisations such as the World Health Organisation's International Classification of Diseases"¹⁷²

It must affect one or more of the group of activities contained in the DDA 1995. This list of day-to-day activities inadequately captures the effects of many forms of psychiatric impairments. These can be for example, impairments typically which have an impact on thinking, feeling or social interactions, which are not, specified capacities under the DDA 1995 definition.

Since the establishment of the DDA 1995, case law has shown that meeting the requirements to satisfy Section 1 of the Act with regard to a mental impairment have been problematic if not confusing. This will be demonstrated by using relevant case law and a starting point is the landmark case of Goodwin v The Patent Office¹⁷³ The Claimant, a paranoid schizophrenic was dismissed because of his bizarre behaviour. The Claimant issued proceedings for disability discrimination. The Tribunal held in this case that the Claimant did not have a disability because the effects of his mental illness on his ability to carry out normal day-to-day activities were not "a substantial effect". The Claimant's representatives appealed and the EAT overruled the Tribunal's previous decision stating that the evidence presented led to the conclusion that an employee who had paranoid schizophrenia had a disability within the meaning of the DDA 1995. In the above case Mr Justice Morrison quoted:

¹⁷² Op Cit footnote 149

¹⁷³ Op Cit footnote 85 Appendix 3 (7) (b)

“It seems to us most surprising that any Tribunal should conclude that a person, admittedly diagnosed as suffering from paranoid schizophrenia and who has been dismissed partly because of what one might call bizarre behaviour consistent with that diagnosis, fell outside the definition of disability.”¹⁷⁴

He also advised Tribunals to exercise their inquisitorial powers under Rule 11¹⁷⁵ when determining whether an individual has a physical or mental impairment.

In the *Rugamer and McNicol*¹⁷⁶ cases the EAT had to consider whether either Tribunal, having decided to analyse whether the Claimant suffered from a mental impairment even though he had not made such a claim, had erred in failing to undertake an in-depth inquiry into the question before finding against the Claimant. While noting the comments of Morison J in the *Goodwin* case¹⁷⁷ that the role of the Employment Tribunal includes an ‘inquisitorial element’ the EAT said in the cases of *Rugamer and McNicol*¹⁷⁸ that:

“The role of the Tribunal is not thereby extended so as to place on it the duty to conduct a free-standing inquiry of its own or to require it to

¹⁷⁴ Op Cit footnote 85

¹⁷⁵ Employment Tribunals Rules of Procedure 2001

¹⁷⁶ Op Cit footnote 160

¹⁷⁷ Op Cit footnote 85

¹⁷⁸ Op Cit footnote 160

attempt to obtain further evidence beyond that placed in front of it on the issues raised by the parties”.

Accordingly, the EAT held that the Tribunals had acted appropriately in considering the issue of the Claimants' possible mental impairments without first requiring further medical evidence. This view was further endorsed by Mr Justice Lindsay in Morgan –v- Staffordshire University¹⁷⁹ where the Claimant was assaulted by her supervisor and consequently her GP signed her off work. Mr J Lindsay he stated,

“Tribunals are not inquisitorial bodies charged with a duty to see to the procurement of adequate medical evidence.....but that is not to say that the Tribunal does not have its normal discretion to consider adjustment in an appropriate case.”

The approach in the Morgan –v- Staffordshire University¹⁸⁰ case is that Tribunals are not inquisitorial bodies, clearly conflicts with the Goodwin case¹⁸¹ which previously stated they should exercise their inquisitorial powers. It is interesting to note in the Goodwin case that if the EAT had not ruled that the Tribunal should have used its' inquisitorial powers then the Claimant may not have succeeded in his disability claim. This new approach clearly causes hardship to Claimants because people with mental impairments may be

¹⁷⁹ 2002 IRLR 190 See Appendix 3 (22)

¹⁸⁰ Ibid footnote 171

¹⁸¹ Ibid footnote 171

unable to conduct their own affairs, let alone represent themselves or make an application to the Employment Tribunals on the grounds of disability. Therefore, it is arguable that Tribunals and Courts should be seen to exercise their powers to investigate issues around mental impairment to ensure that people with mental impairments have access to justice and a fair hearing. Failure to do so will result in a fundamental breach of Article 6 of the Human Rights Act¹⁸²

Below, consideration is given to five conditions, which have given rise to a number of cases on the question of mental impairment: stress, post-traumatic stress disorder, depression, dyslexia and eating disorders.

Employees who are absent from work suffering from 'stress' may not necessarily be deemed to be disabled for the purpose of the Act. A person must demonstrate that they have a physical or mental impairment and in particular in the latter case that they have an illness which is clinically well recognised. In the following two cases Tribunals have held that stress alone is not a clinically well recognised illness within the meaning of Section 1¹⁸³ of the Act and cannot therefore be considered disabled. In the case of Naylor -v- Newsquest (Wiltshire) Ltd¹⁸⁴ and Taylor -v- The Planning Inspectorate¹⁸⁵ it was held that stress was not a mental impairment as it was not a clinically well

¹⁸² Human Rights Act 1998 Article 6

¹⁸³ Schedule 1 para 1 (1)

¹⁸⁴ ET Case No 1402404/97

¹⁸⁵ ET Case No 5302523/00 See Appendix 9 (24)

recognised illness. In particular, in the landmark case of Morgan -v- Staffordshire University¹⁸⁶ Mr Justice Lindsay made it clear that loose terms such as anxiety, stress or depression alone will not be proof to amount to a mental impairment and he stipulated that more detailed medical evidence would be required. However, it has to be said that employees complaining of stress may also be suffering from a stress-related illness, such as clinical depression, which had been triggered or exacerbated by the levels of stress, which they have to cope with. In addition to this, high stress levels may also exacerbate physical conditions such as diabetes or high blood pressure Walton v Mascot¹⁸⁷ the Claimant had diabetes and sufferers may therefore have a claim under the Act.

As stress itself does not constitute a disability, a failure to recruit or a dismissal based on a person's propensity to suffer from stress will not amount to unlawful discrimination. In order for a Claimant to succeed in such a disability claim they must show that the stress is related to a disability and this can be difficult to prove as illustrated in the case of Taylor -v- The Planning Inspectorate¹⁸⁸ where the Claimant had IBS, migraine and stress. The Tribunal held that the employer's concern about the Claimant's propensity to suffer from stress was the sole reason for their decision to withdraw the job offer and that reason was not related to a disability, the discrimination claim

¹⁸⁶ Op Cit footnote 171

¹⁸⁷ ET Case No 2305250/00 See Appendix 9 (23)

¹⁸⁸ ET Case no 5302523/00 See Appendix 9 (24)

could not succeed. It is interesting to note that the above case might have been decided differently if the Tribunal had found that the Claimant's propensity to suffer stress related to a disability for example, her diabetes or migraine, and providing that the circumstances satisfied the conditions of being defined as a disability. If this had been the case then the employers would have subjected her to a detriment for a reason related to her disability.

Although stress is not a clinically well-recognised illness, a severe stress reaction such as post-traumatic stress disorder is potentially capable of constituting a disability. In the cases of Delamaine –v- Abbey National plc¹⁸⁹ in which the Claimant was subject to a robbery at work and Abadeh –v- British Telecommunications plc¹⁹⁰ in which the Claimant whilst at work suffered a sudden blast of high pitched noise. These cases, which at first glance appear to satisfy the definition of post-traumatic stress failed to gain the protection of the DDA 1995

The Tribunal accepted that the post-traumatic stress disorder amounted to a mental impairment, but held that it did not amount to a disability in the Claimants' case because it did not have a substantial affect on their ability to carry out normal day-to-day activities. In the previous two cases although the Claimants were considered to have post-traumatic stress the Claimants still failed to gain the protection of the Act because their condition was not severe enough. These cases illustrate that post-traumatic stress disorder has to be

189 ET Case No 2305204/97 See Appendix 9 (25)

¹⁹⁰ ICR 156 EAT See Appendix 9 (26)

more than substantial to gain the protection of the Act. The argument is how traumatised does a person have to be to qualify for protection.

In relation to depression, Tribunals and the EAT have had difficulties in holding that depression is potentially capable of constituting a disability. Whilst most people suffer from mild depression at some point in their lives, some people suffer such severe depression that their condition constitutes a clinically well recognised illness. When looking at depression it is a question of the degree of depression that the Claimant suffers from for a Tribunal or Court to determine. In the cases of Kapadia –v- London Borough of Lambeth¹⁹¹ the Claimant suffered from reactive depression and in Jones –v- The Selcare Trust¹⁹² the Claimant discovered a lump in her breast. Both the Claimants had a long history of serious medical problems and depression and were deemed to be disabled for the purposes of the Act. In the case of Ward v Signs by Morrell Ltd¹⁹³ the Claimant complained he was dismissed because he had suffered from depression for 12 months and in the case Cockhill –v- The Insolvency Service¹⁹⁴ the Claimant suffered from clinical depression between 1990 and 1994 at which time the depression ceased. The Tribunals had to consider the degree of depression that the Claimants suffered from. It was held that the Claimants did suffer from a depressive illness. But in the case of

¹⁹¹ Op Cit footnote 144

¹⁹² ET Case 2404641/97 See Appendix 9 (27)

¹⁹³ ET Case No 2106342/97 (See Appendix 9 (28))

¹⁹⁴ ET Case No 2200168/908 See Appendix 9 (29)

Cassidy -v- The Benefits Agency¹⁹⁵ where the Claimant also suffered from depression, it was held that the Claimant did not have a disability.

There are no clear guidelines to determine whether depression can be classified as a mental impairment. It depends on the degree of the depression, whether it is severe enough to gain the protection of the DDA 1995. As there are no clear guidelines when measuring depression, a medical expert's report will normally be required to determine whether the depression is severe enough to qualify as a disability. This can cause hardship to the Claimant because the general rule is that the Claimant must fund the medical report themselves and this could cost several hundreds of pounds – the burden of proof is on the Claimant to prove that they are disabled.

Further problems have arisen in relation to time factors of when to take into account when a disability started. In Cruickshank v VAW Motorcast Ltd¹⁹⁶ It was held that the time in which to assess a disability as whether it has a substantial effect on normal day to day activities is at the date of the alleged discriminatory act. The EAT also stated that any evidence that an impairment has recurred since that date should not be taken into account. This is a departure from the earlier case of Greenwood v British Airways plc¹⁹⁷ in which the EAT held that the Tribunal had erred by considering the question of disability only at the date of the alleged discriminatory act. Under the

¹⁹⁵ ET Case No 1900624/97 See Appendix 9 (30)

¹⁹⁶ IRLR 24 EAT See Appendix 9 (31)

¹⁹⁷ Op Cit footnote 123

Guidance¹⁹⁸ it is made clear that the Tribunal should consider the adverse effects of the Claimant's condition up to and including the Tribunal hearing. The Tribunal had failed to consider the actual recurrence of Greenwood's depression from August 1997 to the date of the Tribunal hearing. The EAT concluded that the Tribunal's decision was wrong and the EAT decided that Greenwood had a past disability within the meaning of Act¹⁹⁹ and on that basis it was unnecessary for them to express a view on whether the substantial adverse effect of his impairment was likely to last 12 months for the purpose of Section 1 of the Act.

Overall cases involving depression have been considered as piecemeal if not confusing and unless the Claimants can establish that their depression is clinically well recognised their claim will fail. It could be argued that if a person who suffers from depression qualifies for disability benefits²⁰⁰ then they could be deemed to be disabled as the Department of Work & Pensions will have conducted a thorough investigation of their mental impairments by way of independent medical expert's reports and have trained case workers to assess that person's mental impairment but nevertheless even if a person suffering from depression qualifies for disability benefits, they may still not be protected under the DDA because their depression is not severe enough.

¹⁹⁸ Code of Practice

¹⁹⁹ DDA S 2

²⁰⁰ such as Disability Living Allowance and Incapacity Benefit

According to the British Dyslexia Association, dyslexia is often referred to as a specific learning difficulty and can affect reading, spelling, writing, memory and concentration. The Association estimate that around four per cent of the population are severely dyslexic and a further six per cent have mild to moderate problems. Dyslexia is listed in the ICD-10²⁰¹ and it is potentially capable of constituting a mental impairment under the DDA 1995. This was confirmed in the case of Holmes –v- Bolton Metropolitan Council²⁰² where the Claimant had dyslexia. It could be argued that dismissing a dyslexic employee may be justified if the employer had tried, but if unable to make any further adjustments that will enable the employee to perform his tasks satisfactorily.²⁰³ Furthermore, it could also be argued the Claimant who has only got mild to moderate dyslexia will not come under the protection of the DDA 1995. Again it is a question of degree of their condition. Factors are not taken into account that just because a person suffering from dyslexia cannot, for example, complete a job application form may nevertheless be intelligent people, but will still not be defined as disabled.

People with eating disorders such as Anorexia and Bulimia Nervosa, although these are recognised as mental impairments under ICD-10²⁰⁴ they may not always gain the protection of the DDA 1995 as illustrated in the case of Gittins

²⁰¹ See Appendix 4

²⁰² ET Case No 2403516 See Appendix 9 (32)

²⁰³ Henderson -v- Scottish Widows Fund and Life Assurance Society ET Case No S/400692/97

²⁰⁴ See Appendix 4

-v- Oxford Radcliffe NHS Trust²⁰⁵ the Claimant had bulimia nervosa (an eating condition). Eating disorders can be life threatening and serious in their nature but yet would not be deemed to be a disability.

Having looked at various mental health illnesses and case laws, it clearly shows that conflicting case laws and the DDA 1995 was a piecemeal legislation and there were no clear guidelines to guide Tribunals and Courts to decide who is or not disabled within the meaning of Section 1 of the Act. It is traumatic for Claimants with mental health impairments to be subjected to and questioned about their impairment even before considering the discrimination issues.

5.2.3 Problems Involving Medical Evidence And Procedures

In order to establish that a Claimant has a mental impairment, medical evidence plays an important role in Tribunal or Court proceedings involving disability discrimination claims, particularly around mental impairment. It was established by the Department for Work and Pensions in 2001 that in over 40 per cent of cases that reach the Employment Tribunal in relation to a preliminary and/or main hearing, the Tribunal considered medical evidence.²⁰⁶ Employment Tribunals frequently have to consider medical evidence, not only in relation to the nature of the impairment suffered by the Claimant, but also as to the effect and, if the condition has not lasted twelve months, whether it is

²⁰⁵ EAT 1220/00 See Appendix 9 (33)

²⁰⁶ DWP In-house Report 1991

likely to last that long. One of the problematic areas involving medical evidence is that there may be conflicting medical reports presented by either side. Sometimes the medical report might simply reflect different views within the medical profession itself. A typical example of this is the doctors' opinions which can be divided as to whether, for example, ME or Chronic Fatigue Syndrome is an illness and if it is, whether the cause is physical, mental or a combination of both. In addition to this, conflict can also be created where the legal concept of impairment and disability for the purpose of the DDA 1995 are different from the accepted medical concept of those terms. It is important therefore, that Employment Tribunals attach the correct weight to medical evidence and that they know what they should accept and what to reject unless they have good reason to do so. It is important for Employment Tribunals to realise that they are not medical experts and should not reject uncontradicted medical evidence. In the case of Kapadia -v- London Borough of Lambeth ²⁰⁷ of the EAT found that the Employment Tribunal had erred in holding that there was no evidence that the Claimant's impairment had a substantial adverse effect. The Respondent's medical report stated that:

"The Claimant's symptoms of anxiety and depression contributed a mental impairment of sufficient duration and severity to have had a substantial and long term effect on his ability to carry out normal day-to-day activities".

²⁰⁷ Op Cit footnote 144

The Claimant's doctor's report stated that the Claimant had considerable difficulties in concentrating, that his sleeping patterns were affected and that he experience degrees of agoraphobia. None of this evidence had been contradicted by the employers. The EAT stated that:

"Although they could foresee situations where an Employment Tribunal may for a good reason reject un-contradicted medical evidence, this was not such a case. The Employment Tribunal had simply disregarded the medical evidence, which the EAT said was a wholly impermissible approach for a Tribunal to take".

Similarly, in Edwards -v- Mid-Suffolk District Council ²⁰⁸ the EAT held that Tribunals are required to analyse all the medical evidence themselves and not rely on medical experts to make the decision that the Claimant is disabled. The Employment Tribunal cannot reject that evidence without explaining why. The EAT concluded that the Tribunal's failure to consider the Claimant's doctor's evidence independently rendered the rest of the Tribunal's findings in relation to his ability to carry out his duties to be flawed. This seems to be a bizarre concept, on one hand Tribunals must be expected to be impartial when considering medical evidence, but it also has to be said that medical experts are more qualified to comment on the effect of a disability and on a person's ability to carry out daily activities.

²⁰⁸ ICR 616 EAT

Additionally while Tribunals must consider all the medical evidence presented to them they must not delegate to doctors their responsibility for determining whether a Claimant is disabled or not as in the case of *Vicary –v- British Telecommunications plc*²⁰⁹ It was also stated the Tribunal must make their own assessment of the evidence and not be overawed by the opinion of a medical expert as to whether the Claimant's condition falls within the statutory definition. Typically, there are two scenarios here to consider. In the case of *Kapadia –v- London Borough of Lambeth*²¹⁰ Tribunals are expected to take the medical expert's opinion into consideration, but in the case of *Vicary –v- British Telecommunications plc*²¹¹ Tribunals are told not to delegate their responsibilities to medical experts – the question to ask is who are the medical experts here, the judicial system or the medical experts? Clearly there are no clear guidelines when assessing medical evidence and this again can cause confusion, if not hardship to any Claimants trying to pursue a claim for disability discrimination. Tribunals and Employment Appeal Tribunals should take the approach that County Court/High Courts take and let the medical experts analyse the medical evidence to decide whether an impairment is deemed to be a disability for the purpose of the present disability legislation.

²⁰⁹ 1999 IRLR 680 EAT See Appendix 3 (20) (b)

²¹⁰ Op Cit footnote 144

²¹¹ Op Cit footnote 143

The onus of producing the medical report lies with the Claimant. In a research study, "Monitoring the DDA 1995"²¹² this research report shows that the nature of the cost and the process for obtaining and examining medical evidence in relation to the definition of disability was raised as a major barrier for potential Claimants making a claim at an Employment Tribunal. It shows that even if the Claimant successfully produced evidence that they met the definition of disability, it puts the Claimant under tremendous stress and uncertainty, leaving Claimants to settle or withdraw the claim. In addition, the cost of obtaining medical evidence and still is a major barrier, particularly as the cost has to be met by the Claimant and their representative(s) who are likely to be from a "Not For Profit" organisation. It should also be noted that there is no Legal Services Commission funding for employment cases to obtain a medical report, therefore the cost of obtaining a report must be met by the Claimant who may well be on welfare benefits and therefore unable to afford such a report. Furthermore, obtaining medical evidence can entail huge and very stressful delays and Claimants may feel that they have been discriminated against and have to begin their case by describing all the functional restrictions created by their physical or mental impairment in relation to the things that they cannot do. This had the effect of putting or making the Claimant feel as if they are on trial and not the Respondent who has discriminated against them. Problems arise where an unrepresented Claimant, particularly one who has a mental impairment, will have to show that they have a mental impairment, that it results from a mental illness and

²¹² Meager N, Doyle B, Evans C, Kersley B, Williams M, O'Regan S and Tackey N (1998) Monitoring the Disability Discrimination Act 1995, London Department for Education and Employment

that it is clinically well recognised. Clearly the Claimants with a mental impairment may find it difficult to prove these issues because of the nature of their illness and may never pursue their claim for discrimination because they do not have the mental capacity or the will to do so.

Difficulties may arise where the mental illness is controlled by medication. The mental impairment must have a substantial and long- term adverse effect but it may only be substantial for short periods of time due to the Claimant taking medication to control the mental impairment. The only way the definition can be met is if it can be established that the effect is one which is recurrent²¹³ and meets the requirements of the Guidance.²¹⁴ On a physical impairment a person may well be able to control their impairment by for example, avoiding substances to which a person is allergic which could trigger their physical impairment. In the case of a mental impairment this could be difficult for a person with mental impairment to do as often they may be irrational in their behaviour and for example, refuse to take or forget to take their medication due to side effects of their illness, for example, lack of concentration or tiredness.

When disabled people make a claim for a disability benefit they have to undergo a medical examination to qualify for the benefits. It would therefore

²¹³ See Chapter 4 Physical Impairment at 4.5

²¹⁴ Para b 5 "the likelihood of recurrence should be considered taking all the circumstances of the case into consideration including what a person could be reasonably be expected to do to prevent the recurrence."

be sensible to use the fact that people on disability benefits should automatically be deemed as disabled. This was recommended by the Disability Rights Commission in their Response Paper. It recommended that people who are in receipt of certain State Benefits, such as Disability Living Allowance or Incapacity Benefit should automatically be allowed to be deemed disabled, the reason being that they have gone through a strict process of medical assessment to obtain state benefits.²¹⁵

The Disability Rights Commission also recommended in their Response Paper²¹⁶ that alterations should be made to be Tribunal procedures to allow, in particular where the issue of definition of disability is in dispute that both parties must agree, or the Tribunal must consider it necessary that medical evidence should be obtained in order to assess whether the Claimant meets the criteria of Schedule 1 of the DDA 1995 and that Tribunals should order and fund a joint medical report. Tribunals have now amended their procedure rules so that they now have the power to authorise payment for medical reports. However, according to the Disability Rights Commission Casework Team²¹⁷ this procedure is not used because many Claimants are reluctant to pay for the expensive medical evidence required because they have to pay for the report first. They then have to apply to the Tribunal for the cost to be reimbursed. Payment for the report is of course at the discretion of the Tribunal as an administration matter and the Claimant may not necessarily be

²¹⁵ Disability Rights Commission (DRC) Mental Health Advisory Group

²¹⁶ Ibid at footnote 208

²¹⁷ Op Cit footnote 206

given back the monies they are owed for the medical report. Some reports can be quite expensive and Claimant may not have the money to fund this upfront and are often wary that the Employment Tribunal will not reimburse them.

5.2.3 Conflicting Medical Procedures

According to the Guidance²¹⁸ a mental impairment includes a mental illness only if it is a 'clinically well recognised illness' and that the illness` is one that is recognised by a respected body of the medical profession. The Guidance²¹⁹ states it is very likely that this would include those specifically mentioned in publications such as the World Health Organisation International Classification of Diseases, commonly referred to as the ICD-10.²²⁰ The ICD-10 is one of the two main diagnostic classification systems used by the psychiatric professions and the other is called the DSM-IV.²²¹ Both manuals are used to identify mental disorders. The ICD-10 manual is used in the UK whereas the DSM-IV is used in the USA.

²¹⁸ Paras 13 and 14

²¹⁹ Para 14

²²⁰ This is a reference which is to the World Health Organisation International Classification of Diseases and Related Health Problems, 10th Revision, Vol 1 1998, although the World Health Organisation does also publish a manual of clinical descriptions and diagnostic guidelines called 'The ICD-10 Classification of Mental & Behavioural Disorders` reprinted in 1998 also see Appendix 4

²²¹ The American Diagnostic & Statistical Manual of Mental Disorders, 4th Edition, 1994 also see Appendix 4

These manual procedures are not identical and may have different diagnostic procedures for a particular condition. The application of both ICD-10 and DSM-IV can therefore produce different results according to which medical manual is used. This is clearly illustrated in the case of *Blackledge v London General Transport Services Ltd.*,²²² in which the Claimant claimed he was suffering from post-traumatic stress disorder. The Tribunal when considering the case, had applied the two different medical classifications contained in the ICD-10 and the DSM-IV of post-traumatic stress disorder to determine whether the Claimant had a mental impairment. Both classifications have a number of similar criteria for example both required the witnessing of any exposures to an exceptional catastrophic event, but there are important differences between the two classifications. Firstly, the DSM-IV requires the disturbance to cause clinically significant distress or impairment in social, occupational or other important areas of functioning, whereas the criteria ICD-10 does not. Secondly, under the criteria of ICD-10 this generally requires the disorder to arrive within six months of the traumatic event, whereas under the criteria of DSM-IV there is no time limit but the medical reviewer is expected to specify if the onset of symptoms is at least six months after the stress or the event.

After considering evidence from two different medical experts the Tribunal found that the Claimant was not suffering from any mental health impairment with the result that it was unnecessary for them to consider the further

²²² EAT 1073/00 See Appendix 9 (34)

questions under Section 1 (1) of the DDA 1995, namely whether his condition had a substantial and long term effect on his ability to carry out normal day-to-day activities. The Claimant appealed to the EAT, who found that the Tribunals had applied the different aspects of both classifications and the EAT also held that the Tribunal should have used the ICD-10 because this is the classification that is recognised by the National Health Service. In reaching this view the EAT added that the additional requirement in the DVM-IV of determining that the person suffered clinically significant distress or impairment in functioning seemed to be more relevant to deciding the effect on functions which a mental impairment has than to deciding whether a mental impairment exists under Section 1 of the DDA 1995.

So, technically the DVM-IV would have been more appropriate in deciding what or was not a mental health impairment as opposed to the ICD-10 manual which is silent on this, but has to be considered because it has been approved under the National Health Service.

5.3 Procedure/Guidelines to Establish Mental Impairment

In *Morgan v Staffordshire University*²²³ the EAT set out guidelines for parties seeking to establish the existence of a mental impairment.

These are:

²²³Op Cit footnote 171

- That it is for the Claimant to identify how they will establish that their illness is clinically well recognised and to adduce the necessary evidence.
- That the Claimant should clearly identify what their mental impairment is and the Respondents should indicate whether that impairment is an issue and if so, why.
- The parties should then be clear as to what has to be proved or rebutted.
- Proof of a mental illness specifically mentioned in a publication such as ICD-10, which is a very wide professional acceptance for example the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM - IV).
- An ICD-10 illness such as depression, anxiety or stress will not of themselves suffice unless there is credible medical evidence from a medial expert such as a Consultant or Psychiatrist.
- If a GP's letter is used with regard to a mental impairment this evidence is likely to be disputed because it would be deemed to be generalist medical evidence, therefore further medical evidence from a Specialist Consultant will also be required to establish a mental impairment.

The present Guidelines in Morgan -v- Staffordshire University²²⁴ have addressed some of the difficulties in establishing an impairment, but it has to be said they are still considered as being unjust and unfair to people suffering from mental health issues. The difference is that people with physical impairments are able to represent themselves as opposed to people with mental impairments will find it difficult to represent themselves simply because their disability affects their brain or mind.

5.4 Proposed Reform, A Recommendation For Establishing People With Mental Impairment

5.4.1 Introduction

As previously demonstrated people with mental health issues are clearly experiencing particular difficulties establishing the protection from the DDA 1995. The expectation of social exclusion in particular people with mental health issues can lead to observed differences, isolation, discrimination and exclusion which in turn activate mental health problems in an endless vicious circle. As a result, people with mental impairments face social exclusion. To try and address this project in the form of the Social Exclusion Unit Consultation 2003 (SEU) was set up by the Disability Rights Commission (DRC). The DRC were invited to submit its recommendations on improving

²²⁴ Op Cit footnote 171

the protection for people with mental health issues. The Disability Rights Commission recommended that the SEU do the following:

- Support key reforms of the Disability Discrimination Act proposed by the DRC,
- give evidence that the key civil rights law serves mental health service users least effectively. In particular:
- The DDA 1995 definition of disability needs to be amended and the Statutory Guidance to be revised to better reflect the actual impact of psychiatric disability on people's lives.

The DDA 1995 is proving inadequate in addressing recruitment problems in particular for people with mental health issues. The aim should be to reduce the actual incidence of discrimination in recruitment. The DRC stated that the law should be changed so that disability related enquiries before a job is offered should be permitted only in very limited circumstances.

The Project also aimed to promote wider social participation through:

- Removing antiquated discriminatory policies, such as the bar on jury service to people receiving psychiatric treatment.

- Promoting equality in public services – including health and education. This means taking substantial action to reduce inequalities in health and active preparation for a Public Sector Duty.²²⁵ It is also essential to address the rights of people with mental health problems plus other impairments since 75 per cent of disabled people have at least two impairments.²²⁶
- Implementing Independent Living for mental health service users, through access to independent advocacy and direct payments. Mental health service users need access to Advocates to support them in securing rights and services, just as people with physical impairments need `personal assistants` to support them with physical tasks of daily living.

5.4.2 Mental Health and Social Exclusion

Mental health issues lead to observed differences, isolation, discrimination and exclusion, which in turn exacerbate mental health problems in an endless vicious circle. A critical question here is how to best break the cycle and it is therefore vital to rely on evidence.

²²⁵ Duty To Promote Equality Among Disabled People DDA 2005

²²⁶ DWP (2002) Disabled for Life?

The most powerful conceptual overview and analysis of best evidence is in Link & Phelan. They argue that `stigma`²²⁷ operates through four processes:

- Distinguishing between and labelling human differences;
- Linking the labelled persons to undesirable characteristics'
- Separating `them` (the labelled persons) from `us`, culminating in
- Status loss and discrimination that lead to unequal outcomes or life chances.

They also argue,

“It is entirely dependent on social, economic and political power. It follows that the process cannot be disrupted without addressing power imbalances; education and positive promotion, whilst important, are not enough on their own”.²²⁸

The usefulness of different conceptual terms such as stigma, discrimination and social exclusion has been analysed elsewhere.²²⁹

²²⁷ The usefulness of different conceptual terms such as stigma, discrimination and social exclusion has been analysed elsewhere eg. See Sayce 1998 Stigma, Discrimination and Social Exclusion, What's in a Word? Journal of Mental Health 7, 4: 331.-344

²²⁸ Link & Phelan (2001)

²²⁹ Sayce 1998 Stigma, Discrimination & Social Exclusion, What's in a Word? Journal of Mental Health 7, 4: 3310344

The DRC went on to quote in their response to the Social Exclusion Unit Consultation Paper 2003²³⁰,

“We believe that certainly in the case of people with mental health problems, the DDA 1995 has failed to fight stigma. With its exceptions, exemptions and complex definitions, the DDA 1995 has embroiled disability people in complex legal arguments and stressful Tribunal cases, with outcomes which have in some cases seemed an affront to common sense”.

The DRC also stated with regard to employment issues that by September 2000²³¹ 8,908 cases have been brought under Part II of the DDA 1995.²³² In their analysis of Tribunal decisions it revealed the nature of the disability of those people whose cases proceeded to a hearing. The DRC commented with the following analysis:

“In comparison with the labour force as a whole, Claimants in DDA 1995 cases are substantially more likely to have depression or anxiety”.

People with mental health problem issues were amongst the least likely to win their DDA 1995 claims.²³³

²³⁰ Disability Rights Commission (DRC) Mental Health Advisory Group

²³¹ See Appendix 2

²³² Part II of the DDA deals with discrimination in the work place

²³³ See Appendix 2

The DRC constructed tables illustrating these statements.²³⁴ The table clearly shows that people with mental health problems are likely to lose at an Employment Tribunal. They only have a success rate of 18 per cent compared for example, with people with diabetes who had a success rate of 39 per cent or people with hearing difficulties who had a success rate of nearly 29.8 per cent.²³⁵

This survey²³⁶ clearly demonstrates that people with mental health impairments are put at a disadvantage and are more likely to lose their Tribunal case because they are unable to meet the requirement, for example, of the impairment being "clinically well recognised". Even if they do meet this requirement it is still unlikely that they will be able to represent themselves and therefore this could be considered to be a breach of their Human Rights Act 1995 Article 6 – the right to a fair hearing.

The DRC responses to the Social Exclusion Unit Consultation Paper²³⁷ made various recommendations on improving the protection for people with mental health impairment. They proposed the following recommendations:

²³⁴ Ibid footnote 223

²³⁵ Ibid footnote 223 See Appendix 2 for a more comprehensive comparison in relation to success rates with other forms of disabilities

²³⁶ See Appendix 2

²³⁷ Op Cit footnote 221

The requirement that the mental illness be clinically well recognised should be removed. Under the DDA 1995 it stated that a mental illness must be clinically well recognised to satisfy the definition of disability under Section 1 of the Act. There is no such requirement to other forms of mental or physical impairment. The Advisory Group in this paper recommended that this provision should be reviewed and consulted on commenting:

“We appreciate the policy desire behind the inclusion of clinically well recognised conditions to prevent abuse through people claiming non-existent or unproven conditions, but we receive no evidence that a removal of the term would bring into coverage any such condition”.

The Advisory Group went onto say that there is no evidence from case law that the restriction had fulfilled its declared role of excluding absurd conditions unrecognised by reputable clinicians or moods or minor eccentricities.²³⁸

Additionally reported cases show that the requirement to prove that a condition is clinically well recognised is disadvantaging some people with genuine mental health conditions. This was a major concern for Claimants' representatives' interviewed in monitoring the DDA 1995.²³⁹ A common problem was that many people with quite a rare mental illness may not have had a clear diagnosis or may have had different diagnosis at different times

²³⁸ Hague W, The Minister for Disabled People Hansard HCdeb Finding Committee Ecol

²³⁹ Doyle B. Monitoring the Disability Discrimination Act 1995 London Dept. for Education Employment. Prescott H Clarke SCPR Survey 1990

which would have made it difficult to satisfy this element of the definition. Therefore, the need to prove that a mental health impairment is clinically recognised caused hardship to Claimants if they could not pigeonhole their mental health impairment such as depression, anxiety or panic attacks into one of the criteria lists under the Guidelines of the World Health Organisation International Classification of Diseases. A person suffering from depression would no more be likely to fabricate his/her symptoms than an individual with unexplained but disabling physical conditions

The Advisory Group also recommended that for people suffering from depression,²⁴⁰ whose depression had a substantial adverse effect on their day-to-day activities, the requirement that the effects last twelve months should be reduced to six months. Previously, to qualify as a disability, a mental impairment had to have a substantial adverse effect it must either have lasted for or be likely to last for twelve months; if the effect was shorter it must be have shown to be likely to re-occur and last for twelve months.²⁴¹ Therefore the Advisory Group recommended a reduction in the time limit targeted at people with depression because it was found that many cases were lost because the Claimants failed to satisfy the time requirement that their depression had lasted or was likely to last for more than twelve months.

²⁴⁰ See Chapter 5

²⁴¹ Disability Discrimination Act Schedule 1 Para 2

²⁴³ Disability Discrimination Act Schedule 1 Para 2

In this Chapter it has been demonstrated how people with mental health impairments can face exclusion simply because the mechanisms of Section 1 of the DDA 1995 do not allow those people to bring a claim because their mental health problems cannot be defined as a disability. Even if they do succeed in bringing a claim under Section 1 of the DDA 1995 they still face the hurdle of having to represent themselves at a Court, and in particular at a Tribunal where so few solicitors or legal representatives will take the case on because they are not guaranteed their legal costs. Additionally there is no legal aid to pursue an employment claim. Further complications are added when there is conflicting medical evidence or rather lack of medical evidence because the Claimant is unable to pay for a medical report.

Although some proposals have been implemented under the "New Duty to Promote Equality" as (amended by the DDA 2005)²⁴³ such as the removal that a mental health impairment be "clinically well recognised"²⁴⁴ the Claimant still has to satisfy Section 1 of the DDA 1995 in that his/her mental health impairment has a substantial and adverse effect on his/her ability to carry out daily activities. An ideal solution would be that if a person was on disability benefits such as Disability Living Allowance or Incapacity Benefit then they should automatically be deemed as being disabled. The disability laws²⁴⁵ are still failing to protect people with mental health issues and unless major changes are made to the legislation, people will still face social exclusion within society. It could be argued that this particular group of people are no

²⁴⁴ Chapter 7 page 127

²⁴⁵ DDA 1995 & 2005

better off than they were fifty years ago because they integrate into society rather than be institutionalised; they still face segregation and exclusion within society because of their mental illness.

6 INCLUSIONS AND EXCLUSIONS

6.1 Inclusions

Having demonstrated in the previous Chapters²⁴⁶ the definition of disability is not as straight forward as it seems, this Chapter is focused on other areas of disability which are either limited or excluded from the protection of the Act. As previously stated²⁴⁷ the Act's definition of disability was one of the most contentious issues during its passage through Parliament. It focused solely on inability to perform certain physical or mental functions caused directly by impairments of an individual. This approach was criticised as overly restrictive and stemming from a flawed conceptualisation of disability. The disability lobby argued for a broader definition of disability modeled on that contained in the ADA whose definition would have included those people perceived to be disabled.²⁴⁸ Such an approach would have focused on the issue of social discrimination – which stems from the misconceptions and stereotypes of the discriminator rather than any intrinsic characteristic of the individual who has experienced discrimination

Furthermore, for the avoidance of doubt the following areas of disability will be discussed, however, there are many other disabilities that cannot be covered because of limitations on this piece of research

²⁴⁶ See Chapters 4 & 5 on definition of physical and mental health impairments

²⁴⁷ See Chapter 1

²⁴⁸ See Chapter 2

The findings of discussing the following list of disabilities :

- HIV
- MS
- Cancer
- Deformity and disfigurement
- Restricted Growth
- Albinism
- Stammering
- Autism
- Aspergers Syndrome

demonstrate the further problems that disabled people face in trying to establish that they meet the criteria of the DDA.

6.2 Limitations

6.2.1 Limitations on HIV, Cancer & MS

There were limitations on HIV, Cancer and Multiple Sclerosis until very recently when the DDA 1995 was amended in October 2004. People suffering from these conditions have encountered difficulties in meeting the criteria under Section 1 of the DDA 1995 . Prior to the amendments to the DDA 1995 the situation was for example, that an HIV sufferer was only deemed to be disabled once his ability to carry out normal daily activities was affected and

this is illustrated in the case of Aves –v- Bournemouth International Airport Ltd.²⁴⁹

Before the recent reforms cancer sufferers would not be deemed to be disabled if the cancer has no present effects or is in remission as illustrated in the case of Cox –v- Careeragent Ltd., t/a Bells Toyota.²⁵⁰ Although the Tribunal found that he was not suffering from a substantial adverse effect, the condition was deemed to be a progressive condition and that he had some pain which was sufficient for the Employment Tribunal to find that he was deemed to be disabled under the Act. Nevertheless, this deliberation must have had a traumatic effect on the Claimant simply because Section 1 did not address the issues surrounding people suffering from cancer. What if this scenario would have been different whereby the tumour would not have been found to have a substantial adverse effect on his ability to carry out his day-to-day activities? What if the Claimant did not suffer from any pain, in order to satisfy the progressive conditions?²⁵¹ The Guidance points out for this rule to operate, a medical diagnosis is not by itself enough, there has to be some other effects on the person's ability to carry out normal day-to-day activities.²⁵² Therefore, if a person is suffering from HIV, MS or the early stages of cancer then previously they were not covered by the Act because their impairment

²⁴⁹ Op Cit footnote 134

²⁵⁰ Op Cit footnote 135

²⁵¹ Statutory Guidance para 8 "in that as soon as a person with a progressive condition experiences symptoms which have any effects on his/her normal day-to-day activities he/she will be deemed to be as having a disability"

²⁵² Statutory Guidance para A 15

would be deemed to be an illness, which may not have had an adverse affect on their ability to carry out day-to-day activities and therefore could not be deemed to be a disability.

These restrictions have caused unnecessary hardships and discrimination to these groups of people, as they still need to take time off work to attend hospital for medical treatment or medical tests. The employer can simply dismiss that person for having time off work, and if he has less then 12 months continuous employment he will not be able to bring a claim for unfair dismissal or disability discrimination because he does not satisfy Section 1 of the DDA 1995 as being disabled. In December 2003 the Government took the welcome and long waited step of publishing a Draft Disability Discrimination Bill for pre-legislative scrutiny. As a result of that Bill the DDA 1995 was amended to extend the definition of disability to include people with HIV, cancer and multiple sclerosis to be deemed as disabled from the point of diagnosis. The previous guidelines did not guarantee protection under the DDA 1995. The provision to extend the definition of disability to cover cancer suffers has now been implemented by the DDA 1995 (amended by DDA 2004)

6.2.2 Limitations On Deformity And Disfigurement

The DDA 1995 was ambiguous with regard to the social and legal aspects of disfigurement and deformity. The DDA 1995 basic definition could not address the situation of people with no actual physical or mental limitations who nevertheless experienced strong social restrictions because of prejudice.

Thus people who are highly stigmatised because of severe disfigurements did not fall within the Act's core definition and had to be brought in as an exceptional group. The Department of Health statistics indicate that over one million people in the United Kingdom suffer a facial injury every year and this is a serious and significant social problem²⁵³. Under the Act an impairment which consists of a "severe" disfigurement was deemed to have a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities.²⁵⁴

The Act²⁵⁵ made it clear that severe disfigurement was to be treated as having a substantial adverse affect on a person's ability to carry out normal day-to-day activities. Disfigurement alone was not sufficient to qualify for the protection of the Act. In addition to this, deformity did not form any part of the definition of disability in the Act, nor does the word appear in the Act. The word deformity appears in the Children's Act 1989.²⁵⁶ A child is recognised to be disabled if he is blind, deaf, dumb or suffers from mental disorders of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity. Therefore, under the Children's Act the word congenital deformity is sufficient to amount to a disability, but disfigurement is not even

²⁵³ New Law Journal 1527061 (1925) 20 Dec 2002

²⁵⁴ Schedule 1 para 3 (1)

²⁵⁵ Disability Discrimination Act 1995

²⁵⁶ Section 17

mentioned. When the DDA 1995 came into force it recognised severe disfigurement as a disability but deformity is not mentioned nor recognised.²⁵⁷

It is not enough just to be ugly for example, to suffer from a hare-lip or some minor facial deformity. The Disability Discrimination Guidance does not even define what a disfigurement is, or how severe a disfigurement has to be. The Act fails to protect and limits the Protection offered by the Act in relation to deformity and disfigurement. To demonstrate this, in the first scenario a young man is injured riding a motorbike and is not wearing a helmet. He suffers a severe disfigurement and is therefore within the protection of the Act. However, for the second scenario, a young girl suffers from a mild congenital deformity. She applied for a job as an airhostess or a fashion model but is turned down on account of her appearance. She would be deemed not to be within the protection of the DDA 1995. Both of these examples show that a person has been discriminated against because of their appearance. Unfortunately, only the young man involved in the motorbike accident will gain the protection of the Act.

Unfortunately, when the Act was drafted in 1995 the criteria for disability were based on physical or mental impairments and based on the medical model rather than the social model, which reflects cultural or environmental factors and therefore would not reflect society's attitude or prejudice.²⁵⁸

²⁵⁷ Enright S, Deformity, Disfigurement & Disability New Law Journal 20.12. 02.

²⁵⁸ See Chapter 3 on medical model –v- social model

Sean Enright²⁵⁹ explained in relation to deformity and disfigurement that they are similar in meaning, but are subtly different concepts which may overlap and may on occasion be used interchangeably, not always appropriately. Generally a disfigurement affects personal appearance and it may be congenital, for example birthmarks or a hair-lip, or it can be acquired by scarring, palsy or burns. A deformity, however, is a condition of abnormal anatomy. It is on the body's structure rather than the appearance and it may have certain forms of disfigurement, but it also affects the bodily functions. Deformity may also be congenital or acquired. It can consist of dwarfism, clubfoot, curving of the spine or some other structural or bone deformity and it can be external or internal affecting one or more of the body's organs.²⁶⁰ So, a person can have a deformity but may not be disfigured or severely disfigured and therefore comes outside the protection of the Act unless he can bring himself within Schedule 1²⁶¹ of the Act. This means that for deformity to come within the Act it must affect the ability to carry out normal day-to-day activities,

“and it must affect one of the following: mobility, dexterity, co-ordination, continence, ability to lift, carry, move every day objects, speech, hearing or eye sight, memory, concentration, ability to learn, to understand or perceive”

²⁵⁹ Op Cit footnote 245

²⁶⁰ Ibid footnote 247

²⁶¹ Para 4

Therefore, a person may have a deformed spine but would still be able to carry out daily activities but would not come under the protection of the Act. However, if the person with the deformed spine was so deformed that his ability to carry or lift or walk properly, then this would be deemed to be a disability because their daily activities are substantially effected and therefore would be deemed to be a physical disability. From a social point of view people's attitudes to this person would be patronising or offensive. The Act did not recognise these problems around deformity and caused undue hardships to people who had deformities.

Three conclusions can be drawn here. Firstly, a deformity may include disfigurement but that it is by no means always the case. Secondly, a person may have a deformity but may not be disfigured or severely disfigured and therefore outside the protection of the Act unless he could bring him/herself within one of the criteria in Schedule 1 to the Act as described above. Thirdly, a disfigurement was not categorised under the DDA 1995 by their disability unless it amounted to a severe disfigurement.

This suggests that the DDA 1995 was too restricted and narrow and the best way forward would be that if any disfigurement or deformity that had a significant adverse impact on 'personal appearance', should have been sufficient to gain the protection of the Act. The mere fact that a person suffers from disfigurement or deformity in itself should have allowed them the protection of the DDA 1995 in order to ensure that people were not denied services, jobs or education simply because of their appearance.

6.2.3 Restricted Growth

The Act also appeared to be silent with regards to people with restricted growth (Dwarfism). People with restricted growth may not have been deemed to be disabled under Section 1 of the Act because they are able to carry out the majority of daily activities. Yet it can be argued that people with restricted growth can encounter difficulties in their daily life such as not being able to reach an item on a high shelf in a supermarket or being unable to climb a high step on to a bus or train. In addition to the physical features they also have to face prejudice from society and are often ridiculed by name calling such as 'midget'.

There is no case law with regard to restricted growth, but it was highlighted in a BBC Radio 4 broadcast that people with restricted growth were constantly being discriminated against because of their size, but were unable to seek the protection of the DDA 1995 because their impairment did not have a substantial adverse effect.²⁶²

The psychosocial disadvantages may be more distressing than physical symptoms, especially in adolescence. In adult life people have to face social prejudices, which reduce social and marital opportunities, reduced

²⁶² BBC Radio 4 broadcast entitled "Discrimination Against People with Restricted Growth" November 2005

employment opportunities, low self-esteem and interference with ordinary activities of daily living such as driving.

6.2.4 Albinism

Society's attitudes about albinism have a tremendous effect on the people with the condition. There is very little case law with regard to who people who have this condition. Neither the disability campaigners nor those with the condition agree about whether albinism is defined as a disability. Albinism is a unique condition in that it segregates that group of people as looking different. However, under the DDA 1995 people with albinism did not gain the protection of the Act because they were still able to carry out normal day-to-day activities, though they may still have been able to gain protection under the DDA 1995 if they had a sight impairment.²⁶³ Not all people with Albinism would be protected because although they look different they will be subjected to name calling and discrimination simply because they look different. However, in the USA under the ADA²⁶⁴ some people with albinism are protected as being someone who has a physical impairment that substantially limits one or more of one of the major life activities and therefore needs protection from discrimination.

²⁶³ Sight impairment might also meet the requirement that it must be substantial.

²⁶⁴ NOAH (The National Organisation for Albinism and Hypopigmentation)
www.albinism.org/publications/social.html. See Appendix 5

6.2.5 Stammering

Protection with regard to stammering or stuttering was restricted by the Act. A stammer can be a disability that is defined as a physical or mental impairment, which has a substantial and long-term adverse affect on a person's ability to carry out day-to-day activities. The less obvious speech disabilities are dealt with under the Guidance.²⁶⁵

People with a severe stammer are deemed to be disabled and are protected by the Act.²⁶⁶ A question that may be asked is about the level of stammering that a person has to have to fall within the protection of the Act? The Guidance²⁶⁷ says that both clarity of speech and how normal the rhythm of speech is relevant. It also says that the inability to articulate fluently due to a minor stammer or stutter or speech impediment is not a disability. People with minor stammers were therefore not protected by the Act. Moreover, the Act did not extend to people who are mistakenly believed to be disabled, for example a person who has a slight speech impediment, who is mistakenly assumed to have a learning disability, or a person who has a lisp.

The Act, therefore, failed to cover people with minor stammers or stutters and unfortunately, the DDA 1995 and Guidance were silent on this issue. The

²⁶⁵ "Account should be taken of how far a person is able to speak clearly at a normal pace and rhythm and to understand someone else speaking normally in the person's native language. It is necessary to consider any effects in speech, patterns or which impede the acquisition or processing of one's native language, for example by someone who has had a stroke."

²⁶⁶ Para C12

²⁶⁷ Para C12

legal question for the Court or Tribunals to consider is whether the adverse effect of the stammer on the ability to carry out normal day-to-day activities is a 'substantial one'.

There are certain issues concerning stammering that arise when considering whether or not it would come under the definition of disability. It may take a person with a stammer longer than average to say things or it may be that the environment exacerbates the stammer, for example, a person going for a job interview may stammer more, but still would not have been covered by the Act because under normal circumstances they only have a minor stammer. The ideal solution would be that all people with stammers, regardless of whether their stammer is minor or not it should be defined as disabled and therefore protected. Unfortunately, there is as yet little case law around this area. In the case of *Shaughnessy v The Lord Advocate*²⁶⁸ where the Claimant was a lawyer with a stammer was turned down for a job and he complained under the DDA 1995. There are various grounds on which the decision could be disputed but probably the most serious is that the Tribunal looked at what the Claimant did rather than what he was able to do. This seems contrary to the EAT decision in the *Goodwin* case²⁶⁹ and indeed to the wording of Section 1 of the Act. The numerous situations that the Claimant avoided wherever possible (as acknowledged even in the employer's medical report) were therefore taken into account by the Tribunal only to the limited extent that the Claimant could not avoid them. On the basis of this decision, a person who, with the

²⁶⁸ ET S/401513/99 2000 Appendix 3(35)

²⁶⁹ See Appendix 3 (7(b))

encouragement of his speech therapist starts going into talking situations which he would normally avoid, he now stammers more because he is doing this would be more likely to be "disabled" after the therapy than before it.

One of the main weaknesses of the Act in relation to stammering was within the definition of stammering. The Guidance²⁷⁰ states that the requirement that an adverse effect be substantial reflects the general understanding of "disability" as a limitation going beyond the normal differences in ability, which may exist among people. A "substantial" effect is more than would be produced by the sort of physical or mental conditions experienced by many people which have only "minor" effects. A "substantial" effect is one, which is more than 'minor' or 'trivial'. This sets out the principle of what is meant by "substantial": Therefore it could be argued that a stammer that goes beyond the normal differences in fluency, which may exist, between people. Stammering is characterised by sometimes simply not being able to get the word out, or sometimes having to use some special speech technique to get the word out. This is not the kind of dysfluency, which non-stammers have - for example when a person is unsure of how to say what he wants and maybe stumbles while trying to sort it out. Therefore if any effect of a stammer is substantial, any stammer will be a disability unless it simply has no effect in normal day-to-day situations. This is inconsistent with the Guidance notes.²⁷¹

²⁷⁰ Part II Para A 1

²⁷¹ Para C 19 These say that it is not reasonable to see a minor stutter as a "disability". However, the notes are not law, and one might argue that the nature of stuttering seems not to have been fully considered in the light of the general principle²⁷¹ and that accordingly the general principle should be followed rather than the faulty application of the principle to stuttering.

6.2.6 Autism and Asperger's Syndrome

People with Autism and Asperger's Syndrome are also limited to the protection of Section 1 of the Act. This can be demonstrated in a case²⁷² which was challenged by the DCR when the Employment Tribunal concluded that the Claimant who suffered from Asperger's Syndrome did not qualify for the protection of Section 1 of the Act. The reason given was that his condition did not impair his ability to carry out day-to-day activities. This decision was appealed and the EAT held that the condition fits within the ability to understand, which covers understanding of broad human social interaction. The case had been remitted back to the original Employment Tribunal to consider whether the adverse affect of the condition on the Claimant's ability to understand is adversely affected to a substantial extent.

6.3 Exclusions

Certain conditions²⁷³, such as alcoholism and drug abuse, are specifically excluded from the scope of the Disability Discrimination Act. Although the Guidance has no legal status in itself Tribunals must take account of any

²⁷² Case unnamed – the Disability Rights Commission www.drc-qb.org/.

²⁷³ Disability Discrimination (Meaning of disability) Regulations 1996 1995 states that 'addiction to alcohol, nicotine or any other substance is to be treated as not amounting to an impairment for the purposes of the Act' unless the addiction was 'originally the result of administration of medically prescribed drugs or other medical treatment'.

matter it contains relevant to the issue to be determined.²⁷⁴ The Guidance²⁷⁵ confirms that it is not necessary to consider how an impairment was caused, so, for example, people with liver damage following alcoholism would have a disability within the meaning of the Act.

In the case of *Power v Panasonic UK Ltd.*,²⁷⁶ the Claimant appealed against the ET decision in that she was deemed not to be disabled. The EAT considered the Tribunal's finding that the Claimant's phobic anxiety was not a disability within the Disability Discrimination Act 1995. Before the EAT, the Claimant argued that the Tribunal's decision in this regard was perverse. The EAT, however, held that although there may have been some errors in the Tribunal's conclusions, its findings could not be said to be perverse. The EAT allowed the appeal on the first point only and remitted the case.

It could be argued that the use of alcohol or drugs which excludes a person from seeking protection from the Disability Discrimination Act can cause hardships simply because their impairment does not come under the definition of disability, even though specialist health and social services are provided to these groups and are described for life as 'recovering alcoholics' or 'recovering drug users'. This means that they can go into regression at

²⁷⁴ S.3 (3) Disability Discrimination Act 1995. The list is unlimited but for the purpose of this dissertation only conditions such as drug and alcohol addiction are discussed.

²⁷⁵ Para 11

²⁷⁶ IRLR 151 EAT See Appendix 3 (36)

anytime for the rest of their lives – thus a life long disability. Yet in today's society alcohol or drug abuse is becoming more problematic and is not recognised as an illness. People, who are affected by their own personal problems such as stress or bereavement, may often turn to alcohol or drugs for comfort, with the result that they become socially excluded from society if they become addicted to these substances. Their addiction will be seen by the Act as being a social or self-inflicted issue rather than a disability one. It is interesting to note that a person with a drug or alcohol addiction can make a claim for a welfare benefit called Disability Living Allowance and under the regulations the Claimant can claim this benefit if they have a drug or alcohol dependency problem.²⁷⁷

The above-mentioned disabilities are by no means exhaustive. It has been demonstrated in this chapter that people who are perceived as having a disability may not automatically be covered by the DDA 1995. It has to be argued that unlike the sex and race discrimination laws where both women and men are protected under the Sex Discrimination Act and all ethnic minorities are protected under the Race Relations Act, unlike the DDA where a person has to meet the definition of disability under Section 1 of the Act 1995 even before tackling the discriminatory act. Overall, the limitations and the exclusions of the Act can cause real hardships and social exclusions to these people who cannot meet the definition of disability under the Act. Unlike

²⁷⁷ Disability Living Allowance – reg. CDLA/778/2000 (32/01) Alcohol dependency is capable in itself of being a physical or a mental disability. Account should be taken of the response to treatment and awards should be made for limited periods to allow for automatic review.

the Australian and American Disability Laws all that is required is to show that a person has a disability whereas under British legislation people who are perceived to be disabled may not always be able to rely on the protection of the Act.

7 CONCLUSIONS

7.1 What Is The Preferred Approach?

The definition of disability within the DDA 1995 is not a fair approach because if an individual cannot prove they have a disability, which comes under the definition, they will not be protected. It is contended that a discrimination law should focus on discrimination: not how impaired or functionally limited a person is but how much they are discriminated against. What the law asks is "are you disabled enough by an impairment to deserve fair treatment" – not "are you disabled by discrimination?"

Previously the Government argued that a definition based on the social model would be too wide and would cover the whole population. However, this is not the case of other equality laws – the Sex Discrimination Act makes discrimination on the basis of gender illegal for men and women, the Race Relations Act protects anyone, black or white from racial prejudice. All discrimination laws should be based on the same principle, the right to fair treatment and equality. The DDA 1995 cannot be excluded from this principle simply because the problems faced by a disabled person do not happen because of their impairment, but because of social attitudes and social exclusion barriers.

Having discussed some points of comparison between Australian and American disability laws²⁷⁸ this conclusion will now focus on what the best approach to a more effective disability law will be.

Under the British approach, disabled people have been framed by an altogether paternalistic, charitable approach, keeping disabled people dependent. There have been many studies proving disabled people suffer discrimination and segregation.²⁷⁹

In this dissertation it has been argued that the DDA 1995 failed to acknowledge or protect disabled people. This has been demonstrated by looking closely at physical²⁸⁰ and mental impairments,²⁸¹ and its limitations and exclusions.²⁸² It has also looked closely at how the definition of disability is modelled.²⁸³

The findings of this research overview of the DDA comes to the same conclusions as Lord Lester, a prominent civil liberties lawyer, who has described the law as

²⁷⁸ See Appendix 1

²⁷⁹ See Chapter 2 on Definition of Disability

²⁸⁰ See Chapter 4

²⁸¹ See Chapter 5

²⁸² See Chapter 6

²⁸³ See Chapter 2

“Riddled with vague, slippery and elusive exceptions, making it so full of holes that it is more like a colander than a binding code”.²⁸⁴

It has been demonstrated that the definition of disability²⁸⁵ contained in the Act was fundamentally flawed and although it offered protection to some disabled people it failed to protect a large percentage of disabled people²⁸⁶ who did not meet the requirement of the definition of disability. This is primarily because the definition of disability was predicated on the medical model, that the disability is a medical condition individualised for that disabled person. The concept of the medical model²⁸⁷ has shown that disabled people are often isolated, segregated and discriminated against. The ideal approach would be to base the definition of disability on the social model,²⁸⁸ the focus being on a society that has created the barriers – the difference between the two models is that the medical model cannot be rectified or amended to address the fundamental flaws of definition of disability, but the social model can be amended and changed through society itself and can continue to be changed through the passage of time. The research has also looked at other international laws²⁸⁹

²⁸⁴ Hansard 22/5/94, 813

²⁸⁵ Section 1 of the DDA 1995

²⁸⁶ See Appendix 2

²⁸⁷ See Chapter 2

²⁸⁸ See Chapter 2

²⁸⁹ See Appendix 1

The Australian approach²⁹⁰ proves that Civil Rights based disability discrimination legislation can work in Commonwealth systems like ours. The American approach²⁹¹ has shown that their legislation is the quickest, fairest and most effective methods ensuring disabled people have a right to employment and education. It also persuades society to open its doors to disabled people and to include these people in the community. If society is responsible for excluding disabled people then ending that exclusion can only be achieved through social and political changes. By not introducing Civil Rights legislation or adopting other examples of international laws such as the Australian or American legislation, the British Government has ignored this responsibility and challenge, however pressure from campaigners have forced the Government to consider the present DDA 1995 definition of disability as it is fundamentally flawed.

7.2 The Way Forward

Due to pressure from campaigners and the inability of the Government to change the definition of disability under the DDA 1995 – because the definition was based on a medical model.²⁹² The Government worked with the DRC and has now introduced new amendments to the disability legislation.

²⁹⁰ See Appendix 1

²⁹¹ See Appendix 1

²⁹² See Chapter 3

The DDA 2005 came into force in December 2006, and made some significant changes to the DDA 1995, such as:

- Increased responsibilities on Local Authorities.
- Protection for people who have HIV, Multiple Sclerosis and cancer from the date of diagnosis.
- Removal of the requirement that a "mental illness" be "clinically well-recognised".

The present Government has now tried to rectify the DDA 1995 definition of disability after pressure from disabled movement groups. The social model which is the preferred model adopted by disability groups is modelled on the concept that it is society that creates the 'barriers' against disabled people and is now more widely accepted. The present Government accepts this concept to the extent that it has now amended the DDA 1995 in the direction of the social model. The current trend shows that disability awareness in the UK are now moving disability laws from the medical model towards the social model. The implementation of the DDA 2005 holds much promise in overcoming the limitations of the individual complaints approach taken under the DDA 1995. The new approach under the DDA 2005 does not allow for individuals to make complaints of discrimination, but rather acts like a prevention of discrimination in the first place, thus avoiding the need to litigate. This may show some positive outcomes, such as implementing policies, services, setting targets and performance measures that are monitored by Inspecting bodies such as Disability Rights Commission who will monitor delivery. The main

amendments made to the DDA 1995 by the DDA 2005²⁹³ place a duty on all public authorities²⁹⁴ when carrying out their functions to have due regard to the needs of disabled people and to consider the following:

- Promote equality of opportunity between disabled persons and other persons;
- Eliminate discrimination that is unlawful under Disability Discrimination Legislation;
- Eliminate harassment of disabled persons that is related to their disabilities;
- Promote positive attitudes towards disabled persons;
- Encourage participation by disabled persons in public life; Take steps to take account of disabled persons' disabilities, even when that involves treating disabled persons more favourably than other persons.²⁹⁵

The Disability Rights Commission, in its "The Duty to Promote Disability Equality: Statutory Code of Practice"²⁹⁶ quotes a report, "Improving the Life Chances of Disabled People", in which the Government set out its vision of disability equality such that:

²⁹³ S49A DDA 2005

²⁹⁴ Disability Rights Commission The Duty to Promote Disability Equality, Statutory Code of Practice

²⁹⁵ Op Cit footnote 294

²⁹⁶ Op Cit footnote 294

“By 2025 disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society.”²⁹⁷

The Disability Rights Commission went on to state:

“That disabled people do not have the same opportunities or choices as non-disabled people. Nor do they enjoy equal respect or full inclusion in society on an equal basis. The poverty, disadvantage and social exclusion experienced by many disabled people are not the inevitable result of their impairments or medical conditions, but rather stems from attitudinal and environmental barriers.”²⁹⁸

The new amended legislation is now based on ‘the social model of disability’ and hopefully provides a basis for the successful implementation of the duty to promote disability equality.

There has been increased protection for people who have HIV, Multiple Sclerosis and Cancer from the date of diagnosis. The DDA 1995 Act already contained special provisions in relation to progressive conditions; where someone has a progressive condition, he/she was treated as having an impairment which had a *substantial* adverse effect from the moment any impairment resulting from that condition first had *some* effect on the person's

²⁹⁷ Op Cit footnote 294

²⁹⁸ Op Cit footnote 294

ability to carry out normal day-to-day activities. However under the DDA 2005: protection for people who have HIV, multiple sclerosis and all types of cancer will now be extended, so that from the date of diagnosis they will be deemed to be disabled. People who have been diagnosed with one of these three conditions will therefore be deemed to have a disability even if they have no symptoms that effect their day-to-day activities.. Other progressive conditions will continue to be dealt with as previously under the DDA 1995.

The Government had considered excluding certain cancers such as skin cancer that would not attract protection from the point of diagnosis but decided not to do so. Therefore, even nominally "minor" cancers will be protected from the date of diagnosis. The rational for the changes is that HIV, Multiple Sclerosis and Cancer all attract considerable stigma and have a personal impact from the point of diagnosis, for example an employer may dismiss a person because he knows that person will need time off work for treatment/medical check-ups and therefore it is felt that sufferers should be protected from that date.

There is the removal of the requirement that a "mental illness" be "clinically well-recognised"²⁹⁹. The position under the DDA 1995 was that in order to satisfy the definition of disabled within the DDA 1995, it was necessary for an individual to demonstrate that a mental impairment is a "clinically well-recognised" disease,³⁰⁰ as well as showing it had a substantial and long-term

²⁹⁹ Mental Health Chapter 5

³⁰⁰ See Appendix 4

adverse affect on his/her ability to carry out normal day-to-day activities. Therefore if, for example, a person was signed off work by a GP suffering from depression which, for example, he/she stated was caused by work related stress, that person needed to show that he/she was suffering from a "clinically well-recognised" condition to gain protection under the DDA 1995. As with all clinical conditions, there are guidelines³⁰¹ for doctors to consider when diagnosing a patient with clinical depression. The requirements therefore meant that mental conditions must have fulfilled certain specific guidelines, and thus fit into a recognised clinical condition, in order to be classified as a 'disability' for protection under the DDA 1995. This has in the past provided employers with a certain level of comfort that mental conditions, which can by their nature appear nebulous and hard to substantiate, must fit a specified clinical basis before sufferers can claim the protections of the DDA 1995.

Changes under the DDA 2005 requirement that a "mental illness" be "clinically well-recognised"³⁰² will be removed, bringing the definition of a mental impairment into line under the definition of disability with the requirements to prove a physical disability. The rationale for this amendment results from lobbying by the Disability Rights Commission and mental health groups such as Mind, who have argued that there are a variety of barriers to formal diagnosis of mental health conditions – for example, reluctance by sufferers themselves to receive a diagnosis that is perceived as a label leading to

³⁰¹ See Chapter 5

³⁰² See Appendix 4

stigma. It has been argued by these groups that this has meant that significant numbers of people suffering from acute mental health conditions that have not been formally diagnosed were unfairly denied protection under the DDA 1995. This amendment is likely to make it easier for individuals to succeed in disability discrimination claims in relation to mental illnesses such as depression. While evidential issues as to whether a mental condition amounts to a disability are likely to become more difficult with this change, employers can take comfort from the fact that a mental impairment must still have a substantial, adverse effect on the individual's ability to carry out normal day-to-day activities and must have lasted, or be likely to last, for 12 months or more. Whilst Claimants may try to argue that less specific diagnoses, such as anxiety and stress, are 'disabilities', if these are claimed over a particular incident and can be shown to be short-term, they will still not qualify as a disability.

Personality disorders are another potential effect of this change to the law and could be in relation to dismissals as a result of 'personality' problems. In the recent case of *Perkins v St Georges Health Care NHS Trust*³⁰³ the Court of Appeal confirmed that a dismissal for unacceptable behaviour flowing from an employee's personality could be fair. Could Mr Perkins, under the new provisions of the DDA 2005 of defining a mental health impairment have claimed that he had a 'personality disorder', and therefore should have had protection on grounds of having a disability? A 'personality disorder' is generally diagnosed where a person is rigid and tends to respond

³⁰³ ICR 617 CA 12/10/05 IRLR 934 See Appendix 3 (37)

inappropriately to problems, to the point where relationships with family, friends and employers are adversely affected. Difficulties arise because these symptoms are exacerbated forms of personality traits that most people exhibit to some extent – so where along the line does a normal personality become eccentric, and thence a 'personality disorder'? Even the medical profession itself seems unsure, with some sectors refusing to classify personality disorders as mental illnesses. The change to the DDA 1995 removing the requirement that a mental condition be clinically well-recognised does appear to open the door for Claimants who have been dismissed due to personality issues, to argue that reasonable adjustments should have been made due to their 'personality disorder'. Case law will determine exactly how the Courts interpret the new provisions relating to mental conditions, and it seems likely we will see some interesting cases in this area.

The Disability Rights Commission recognises that whilst many people have positive attitudes towards disabled people, some people express pity, fear, lack of respect and sometimes even contempt. These attitudes are often hurtful and can lead to discrimination and also place unnecessary restrictions on disabled people. The Disability Rights Commission state, that for many disabled people the environmental barriers play an even more important role in restricting opportunities than attitudes. They go on to explain that although these barriers can be unintentional, this does not make their impact upon disabled people any less significant. When buildings, services and employment practices are designed in ways that fail to take into account the particular circumstances of disabled people, this excludes and disadvantages

them. The same applies when budgets are set out for a programme without considering the additional needs of disabled people.

These issues have been addressed by the new DDA 2005, which amends the DDA 1995. The Duty to Promote Disability Equality addresses the duties of public authorities to tackle disability discrimination in a practical way, by introducing policies that actively promote opportunities and so prevent discrimination taking place and having to resort to litigation. The rationale behind the new amendments is that Public Authorities can also make a huge contribution towards equal opportunities for disabled people. They are able to do this by addressing the way in which they run their own services and employ people, and by exerting their influence in the community, for example the way in which they regulate the activities of others by granting licenses and/or planning permission, by providing education in schools and colleges, by inspecting the performance of these and other organisations. All these functions of public authorities are subject to the duty to promote disability equality.

The new Act states that public authorities are required to have due regard to the need to take steps to take account of disabled peoples disabilities, even when that involves treating the disabled person more favourably than able bodied people. This underlines that equality of opportunity cannot be achieved simply by treating disabled and able bodied people alike.

An example of this is where a disabled student may need special car parking space as he/she is unable to use public transport. Able bodied people may also want a parking space, but they will not have the same degree of disadvantage if they do not have one. The disabled student will be prevented from attending the course at college if they do not have a parking space, the able bodied person will simply be inconvenienced. Therefore, more favourable treatment is necessary to provide equality to that disabled person to access the course at college.

This principle has always been recognised in the Act, particularly through the duty to provide reasonable adjustments. The educational establishment in this example will have a duty under the new legislation to provide such a parking space if, in all the circumstances, it is a `reasonable` adjustment to make. So, instead of a disabled person asking for a reasonable adjustment to be made, public authorities will now have to ensure there are now sufficient disabled parking spaces in their car parks. This clearly is a more positive step to take because public authorities are now have to be pro-active in their decisions to ensure disabled people are treated fairly and not excluded. No longer will a disabled person have to ask for a reasonable adjustment to be made – it will be expected that disabled people will be able to access services and provisions within society.

It clearly shows that the trend is moving from the medical model to a social model and that the Government are accepting the social model more favourably than the medical model and trying to tackle the social exclusion

that is faced by many disabled people as a result of attitudes and barriers being placed against them in society.

It is hoped that this is a major move forward to combating social exclusion by implementing the Duty to Promote Disability Equality.³⁰⁴ Public Authorities, under specific duties, have to involve disabled people. The specific duties require a Public Authority to involve disabled people who appear to the authority to have an interest in the way it carries out its functions in the development of the Disability Equality Scheme. Additionally, the Disability Equality Scheme must include a statement of the way in which disabled people have been involved in its development. These requirements reflect the fact that public authorities will not be able to identify and prioritise equality initiatives effectively unless they consider the views of disabled people. It was predominantly able-bodied researchers who helped to draft the DDA 1995 Section 1 definition of disability and probably part of the reason why the definition of disability is so ineffective – the original drafting of the DDA 1995 had no input from disabled people. The new Statutory Codes state that disabled people should be involved in all key aspects of the development of the scheme such as identifying the barriers faced by disabled people and highlighting unsatisfactory outcomes; setting priorities for action plans, and assisting planning activity.

³⁰⁴ Op Cit footnote 294

The new amendments to the DDA 1995 will hopefully make major changes within society for disabled people. Public Authorities³⁰⁵ such as local authorities, hospitals, universities and schools will be expected to implement the new statutory duty, thus making major changes to provide equality among disabled people. It means finally that the UK is now moving towards accepting the social model and rejecting the medical model and that the medical model was too narrow a definition of disability. This time, disabled people will be able to voice their views and opinions on how best to accommodate disabled people within society; disabled people are of course the group best able to do this because of the personal experiences of being disabled.

The overriding importance of the social model of disability is that it no longer sees disabled people as having something wrong with them – it rejects the individual pathology model. This means that when disabled people are no longer able to perform certain tasks the reasons are seen as poor design of buildings and unrealistic expectations of other people, unsuitable housing or work environments. Hopefully, in the future this will be addressed by the legislation just passed and the Duty to Promote Disability Equality will make a real difference to the lives of disabled people.

The aim of the new duty imposed on public authorities is for them to make more substantial changes and therefore hopefully have a greater impact on the lives of disabled people rather than for example, litigate against a

³⁰⁵ See Appendix 7

company or an employer for disability discrimination. The purpose of the new duty is to avoid such litigation in the first place, thus giving public authorities the responsibility of implementing major changes to protect disabled people.

Although the new legislation does not create any new individual rights for disabled people, it does provide restitution when a disabled person has been subjected to discrimination. The duty provides a framework for public authorities to carry out their functions more effectively and tackle discrimination and its causes in a proactive way. The duty therefore reinforces the pre-existing duties under the DDA 1995.

In my view the new amended DDA 2005 may hold much promise in overcoming the limitations and restrictions of the DDA 1995 definition of disability. However, the new duties under DDA 2005 have not led some public bodies to review their practices and implement reforms in the way Parliament intended. Implementation of the disability equality duty has demonstrated that the positive duty can become an exercise in procedure and a high amount of paperwork, rather than in institutional change. It merely becomes a paper exercise according to the consultation paper³⁰⁶ on the proposed disability duty, the general view of the disability duty is that it is "overly bureaucratic, process-driven and resource intensive"³⁰⁷.

³⁰⁶ Equal Opportunities Review (EOR 154) July 2006

³⁰⁷ Ibid footnote 291

At the time of writing the conclusion of this dissertation there now appears to be a fundamental flaw to the implementation of the new duty on public authorities. As a Disability Rights Solicitor and a member of the Liverpool Disability Steering Group I have encountered difficulties in accessing disability equality both for clients and people that I represent within the network of the Steering Groups. I submit two scenarios, which highlight the difficulties.

The first offender, involved, is the Legal Services Commission who are deemed to be a Public Authority. A client who is in the latter stages of MS cannot walk and wishes to make an application for LSC funding (Legal Aid) to challenge the failure of Social Services to implement a care package for his needs. An application is made for LSC funding and the decision made by the LSC is that the client has to access the initial Legal Help and Assistance³⁰⁸ at the nearest Citizens Advice Bureau or Law Centre rather than grant the client a full LSC Funding Certificate. Bearing in mind the client cannot walk to his nearest CAB/Law Centre to access legal advice. This was challenged by myself³⁰⁹ and the Appeal was submitted before the LSC Area Committee, challenging this decision and citing the new duty under the DDA 2005. The LSC to this end granted full LSC funding and the client is now in receipt of LSC funding. To date it is known that the LSC still expect disabled people to

³⁰⁸ Legal Help and Assistance is the old form of the Green Form Scheme which offers initial legal help and advice at an initial stage. All CAB's and Law Centres and some law firms offer this initial advice, but if a client chooses to instruct a law firm which does not offer this initial advice, they will be expected to obtain the initial advice elsewhere and be expected to travel to their nearest CAB/LAW Centre to access advice.

³⁰⁹ See Appendix 8

access their nearest CAB/Law Centre to obtain advice under the Legal Help and Assistance Scheme³¹⁰ at their nearest Citizens Advice Bureau or Law Centre.

The second scenario is highlighted by the findings of the Liverpool Disability Steering Group membership³¹¹. To date there are numerous public bodies in Liverpool that have not fulfilled their obligations under the new duty.³¹² The Steering Group contacted the DRC who are the monitoring body of the new duty under the DDA 2005 and the group were duly informed by an advisor at the DRC that they are endeavouring to do their best, but they still have approximately 50,000 bodies to check. Meanwhile, although the new legislation has been passed there still are public bodies who have not even completed their final draft to their Equality Policy, such as Liverpool City Council.

In my opinion a new duty on public bodies to promote disability equality should be action-based and goal-oriented but should allow those bodies greater autonomy in how they deliver equality. The reason is that a public body must pay due regard to the need to eliminate unlawful discrimination and promote equality of opportunity. The goal, therefore, is equality of opportunity whilst the duty is to pay due regard. I argue that both the goal and the duty are potentially problematic under the DDA 2005. "Equal opportunity" is too

³¹⁰ Ibid

³¹¹ Liverpool Disability Network

³¹² DDA 2005

vague a definition and too limited to function as a workable target. The duty to pay "due regard" merely requires a body to consider the need to promote equality, not to take any action. This viewpoint is also supported by both Sandra Fredman and Sarah Spencer in the article in "Equality: Towards an Outcome-Focused Duty"³¹³ They propose that the new duty should specify the equality goals, moving beyond equality of opportunity, and specify a clearer duty, moving beyond due regard. They propose a goal-oriented, action-based and progressive duty. They quoted equality of opportunity is a broad concept:

"Equality of opportunity is a broader concept than the formal version of equality, which requires only that similarly situated people be treated equally. Recognising that the same treatment might perpetuate disadvantage by failing to address existing discrimination and disadvantage, equality of opportunity aims to equalise the starting point. However, equality of opportunity can have a range of applications."³¹⁴

They further question this "equality of opportunity" with the query about the "responsibility gaps" where a public body cannot be responsible for aspects of disability discrimination over which it has no control. For example, a public employer might need to draw the attention of transport authorities to the needs to address transport difficulties that affect the ability of potential employees to get to work. Therefore clearer guidelines are required for

³¹³ Fredman S. et al: "Equality: towards an outcome-focused duty" EOR 156 September 2006

³¹⁴ Ibid

policymakers to ensure that the DDA 2005 works because of its impact across public sectors.

Although the new amended DDA 2005 may have opened doors to excluded groups, in my view this does not mean that they have the resources to progress through the doors, for example, many public authorities when challenged about their failure to implement their new "Duty to Promote Equality Policy" they simply state that it will be completed when they receive finances from their new financial year budget.

My view on the new amendment is that there are some positive outcomes such as removing the requirement that a mental impairment should be clinically well-recognised be removed, and that HIV MS and cancer sufferers be deemed as disabled from the point of diagnosis are positive moves. However, having encountered difficulties with the new amended DDA 2005 both in a professional and personal capacity, I feel that there is still very little difference between the DDA 1995 and the DDA 2005 with regards to accessing justice for disabled people. All that the new duty under the DDA 2005 has done is to put the responsibility on public authorities to make new policies and regulations to combat discrimination – but if public authorities cannot even implement their new "Duty to Promote Equality Amongst Disabled People Statement" I am not convinced that the new amended legislation will make any real difference to the lives of disabled people, but with the passage of time will tell whether it has been successful or not.

Hence, this research has highlighted important issues and made several criticisms of its findings around Section 1 of the DDA 1995 and the DDA 2005 in its failure to protect disabled people. This document aims to contribute to the raising of awareness in society of the discrimination and exclusion disabled people face because of their disabilities. A failure to address these issues surrounding the flawed definition of disability faced by disabled people only further contributes to their continuing exclusion. The way ahead is for disabled people, researchers and the Government to work together to construct a more appropriate definition of disability within the legislation, borrowing from other legislation such as the ADA³¹⁵ to protect those disabled people who deserve to be protected.

Although the Government has not taken the ADA approach they have decided to take the social model approach³¹⁶ and this hopefully will address some difficulties disabled people face in society. It is too early to establish whether the new “Duty To Promote Disability Equality” will have any real impact on the lives of disabled people because there is currently, at the time of writing this dissertation, there is no case law to support or criticise the amendments to the DDA 2005.

³¹⁵ See Appendix 1

³¹⁶ DDA 1995 as amended DDA 2005 Duty To Promote Equality Among Disabled People Statutory Code

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9. Appendices

**Appendix 1 – Comparison of the British , American and Australian
Disability Laws.**

9.1 APPENDIX ONE -UK, USA, AND AUSTRALIA

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	BRITAIN	AMERICA	AUSTRALIA
Definition	Section 1 of the DDA 1995 provides that "(s)ubject to the provisions of Schedule 1, a person has a disability for the purposes of this Act if he/she has a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities.	AMERICANS WITH DISABILITIES ACT 1990 a physical or mental impairment that substantially limits one or more of their major life activitiesor a record of having such an impairment; or (that they are)...regarded as having such an impairment	AUSTRALIAN DISABILITY DISCRIMINATION ACT 1992 total or partial loss of the person's bodily or mental functions; or total or partial loss of a part of the body; or the presence in the body of organisms causing....or ...capable of causing disease or illness; or the malfunction, malformation or disfigurement of a part of the person's body; or a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction; or a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour
Exclusions	Definition of disability does not cover addiction to or dependency on alcohol, nicotine, or any other (non prescribed) substances ³⁰⁰ although the result of such addictions (cirrhosis, emphysema, lung cancer, psychosis) are covered by the DDA 1995	Definition of disability excludes current illegal drug users and current alcoholics, it's provisions do protect non-using addicts ³⁰¹	
Evidence required	In the cases of Cook -v Kitchen Range Foods, Thorpe -v- The Royal Hospitals NHS Trust and Alexander -v- Driving Standards Agency ³⁰² The Claimants in these cases would not be defined as disabled under Section 1 of the DDA 1995.	In the cases of Cook -v Kitchen Range foods, Thorpe -v- The Royal Hospitals NHS Trust and Alexander -v- Driving Standards Agency ³⁰³ The ADA's definition of disability would extend to the Claimant and therefore protect them from discrimination.	In the cases of Cook -v Kitchen Range Foods, Thorpe -v- The Royal Hospitals NHS Trust and Alexander -v- Driving Standards Agency ³⁰⁴ The ADD definition of disability would extend to the Claimant and therefore protect them from discrimination

³⁰⁰ Para 10 of the Guidance
³⁰¹ ADA Section 104 (C) (4)
³⁰² Op Cit footnote 91
³⁰³ Op Cit footnote 92
³⁰⁴ Op Cit footnote 93

<p>Conclusions</p>	<p>The DDA 1995 definition is based on functional limitation caused by the disability itself, however, it ignores or fails to understand the importance of social exclusion caused by disability. Furthermore, the DDA 1995 limits the protected class to those whose impairment causes a substantial effect, but is flawed by a failure to include those who are perceived or regarded as having such an impairment.</p>	<p>The ADA defines disability more widely to include physical and mental impairments as well as being regarded as having an impairment. Evidence suggests the ADA is gradually beginning to improve the lives of disabled in American while avoiding most of the problems anticipated by its opponents. The ADA has not led to a flood of litigation and its legal provisions have proved relatively uncomplicated to enforce. While the Act has cost money, these costs have been dispersed between Government companies and consumers and have been offset by many increased business opportunities and significant savings to state, welfare and social security budgets.</p>	<p>The ADD definition follows closely the recommendations of the HREOC's (Human Rights & Equal Opportunities Commission) Draft Position Paper. It is interesting to note that the HREOC in that document expressly rejected the definition of disability set out in the Americans with Disabilities Act 1990.</p> <p>The HREOC argued that the requirement that a person's impairment substantially limits major life activities is a source of unnecessary legal difficulties or complexities. In particular, it saw such a definition as posing difficulties for people whose condition has disabling effects only intermittently rather than continuously or whose condition is controlled by medication and/or other treatments (for example many people with epilepsy, some forms of mental illness or asthma).</p> <p>This would have also applied to the DDA 1995 where difficulties have occurred in determining whether a person is still deemed to be disabled with the effect of medical treatment.</p>
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A Civil Rights Issue?

The USA and Australia have adopted an anti-discrimination and/or Human Rights approach in which employment practices are part of an overall policy of law, recognising the rights of disabled people and seeking to address discrimination against them. Britain and most members of the European Union practice a more restricted approach in which specific Government Departments attempt to ensure that disabled people achieve full economic

and social participation by making incremental changes in their policies. In Britain it is argued that the lack of a written constitution or a Human Rights culture is inappropriate for this country and there was much resistance from the Government to allow a Civil Rights constitution being implemented.³⁰⁵ The British Government is also opposed to a harmonisation of European Social policy and its record of promoting the rights of disabled people is significantly worse than many of its European partners.³⁰⁶ Our Government often complains that comprehensive anti-discrimination legislation for disabled people is impractical or would not work in this country's legal system. In fact it could be argued it is those countries whose legal systems which are closest to ours which have pioneered anti-discrimination legislation such as Australia who have civil rights based anti-discrimination legislation for disabled people.

The Australian Approach

Australia's definition of disability is contained in the Australian Disability Discrimination Act 1992 (ADD).³⁰⁷

The Australian ADD is administered through the Human Rights and Equal Opportunities Commission through the Disability Discrimination Commission. The Disability Discrimination Commissioner investigates allegations, encourages conciliation, conducts inquiries, can make declarations on whether discrimination has taken place and orders prohibiting continuing discrimination. An Order can be endorsed through the Federal Court and may declare the Respondent should pay damages by way of compensation.

³⁰⁵ Bames 1991 Liberty 62 - 92

³⁰⁶ Employment Dept., 1993

³⁰⁷ See Appendix 1

The Australian definition of "disability" requires **"no limitation of activities"** as in the case of the Americans with Disabilities Act 1990 or **"effect on"** the disabled person's "ability to carry out daily activities" unlike the DDA 1995 definition of disability which is based on the medical conditions. The Australian Act offers the disabled person protection if they can prove they have a disability regardless of whether or not they can carry out daily activities or have to prove that their disability has a substantial impact on their major life activities; all that a disabled person needs to prove is that they have a partial loss of a bodily or mental function and they will gain the protection under the Australian and American legislation.

The definition of disability in the Australian Disability Discrimination Act 1992 follows closely the recommendations of the Human Rights & Equal Opportunities Commission (HREOC) Draft Position Paper. It is interesting to note that the HREOC, in that document expressly rejected the definition of disability set out in the American's With Disabilities Act 1990. The HREOC argued that the requirement that a person's impairment substantially limits major life activities is a source of unnecessary legal difficulties or complexities. In particular, it saw such a definition as posing difficulties for people whose condition has disabling effects only intermittently rather than continuously or whose condition is controlled by medication and/or other treatments (for example many people with epilepsy, some forms of mental illness or asthma).³⁰⁸

³⁰⁸ Op Cit footnote 45

The USA Approach

The most comprehensive legal protection against discrimination of disabled people can be found in the United States and is achieved by the Americans With Disabilities Act 1990 (ADA). This Act came into force in 1992. The ADA specifically prohibits discrimination against disabled people and guarantees equality of opportunity for people with disability in employment, public services (including transport) private sector services and accommodations (access) and telecommunications. It has been argued that progress achieved by the American disabilities movement is partly due to the country's strong civil rights culture and the campaigning activities of many ex-service personnel disabled during the Vietnam War.

President Bush, who signed the ADA 1990 commented

"When you add together state, local and private funds it costs about £200 billion annually to support Americans With Disabilities, in effect to keep them dependent."³⁰⁹

The ADA defines disability more widely to include anybody who has a physical or mental impairment irrespective of the degree of how the impairments affect them, which unlike Britain's definition under Section 1³¹⁰. Research³¹¹ in the US has shown that anti-discrimination legislation is largely cost effective. It also suggests the ADA is gradually beginning to improve the lives of disabled

³⁰⁹ George Bush, The White House, 26/7/90, in Liberty. Access Denied, p9

³¹⁰ Op Cit footnote 1

³¹¹ Scott V. 1994, Lessons From America, RADAR See Appendix 1 Table under title Conclusions for America

people in the USA while avoiding most of the problems anticipated by its opponents. The ADA has not led to a flood of litigation and its legal provisions have proved relatively uncomplicated to enforce. While the Act has cost money, these costs have been dispersed between Government, companies and consumers and have been offset by many increased business opportunities and significant savings to state, welfare and social security budgets. In this way the legislators moved away from a strictly medical formulation whilst the meaning of redefinition of disability remains restricted to functional limitation. The category of people protected by the ADA is further widened to include people having a record of an impairment and people who have been misclassified as having a substantially limiting impairment. The ADA's definition of a disabled person includes anyone with a physical or intellectual impairment which substantially limits a major life activity, or has a record of such an impairment, or is regarded as having such an impairment. It also protects carers and people who have a known association or relationship with someone who is disabled and so affords considerably wider protection than the DDA 1995.

Having discussed briefly the background of Australian and the USA international law it is necessary to discuss the background of how the British disability legislation was created, why it was created and whether it meets the requirements of protecting disabled people.

Appendix 2 - Demonstration of Cases Brought Under Part II of the DDA

1995

Type of Disability	Total Number of Cases at Hearing	Number of Cases Successful at Hearing	Number of Cases Unsuccessful at Hearing
Mental Impairment			
Depression, Bad Nerves or Anxiety	167	30 (18.0%)	137 (82.0%)
Mental Illness, Phobia, Panic or Other Nervous Disorders	47	12 (25.5%)	35 (74.5%)
Specific Learning Difficulties i.e. Dyslexia	31	8 (25.8%)	23 (74.2%)
Type of Disability			
Physical Impairment			
Disabilities connected with back or neck	188	37 (19.7%)	151 (80.3%)
Disabilities connected with the arms or hands	146	24 (16.4%)	122 (83.6%)
Disabilities connected with the legs or feet	141	30 (21.3%)	111 (78.7%)
Visual impairment	54	15 (27.8%)	39 (72.2%)
Auditory impairment	57	17 (29.8%)	40 (70.2%)
Heart, blood pressure or circulation problems	53	14 (26.4%)	39 (73.6%)

Diabetes	46	18 (39.1%)	28 (60.9%)
Epilepsy	51	14 (27.5%)	37 (72.5%)
Chest or breathing problems egg. asthma or bronchitis	47	13 (27.7%)	34 (72.3%)
Stomach, liver, kidney or digestive problems	32	9 (28.1%)	23 (71.9%)

Cases brought under Part II of the DDA 1995³²⁹

³²⁹ Disability Rights Commission (DRC) The Social Exclusion Consultation Paper 2003

Appendix 3 - Employment Case Law

(1) Foster v Hampshire Fire and Rescue Services (1998). The EAT upheld a decision that a woman who suffered from both asthma and migraine was not disabled, on the grounds that although she suffered from a physical impairment which had a long-term adverse effect on her mobility, that effect was not "substantial" taking into account all the evidence. She suffered from asthma attacks about two to three times a year and when these took place she was unable to walk or breathe properly. She also suffered from about eight or nine migraines attacks a year during which she had to lie in a darkened room.

(2) Foord v J A Johnson & Sons ET Case No S/200300/97. A shop assistant in a bakery refused to work extra hours to cover for a colleague who was on holiday because she would suffer from pains in her legs and feet by standing too long. She was then dismissed. She went to see a doctor who diagnosed her to have fallen arches which meant that she was unable to stand on her feet for long periods of time. It was held by the Tribunal that the Claimant did not have a physical impairment. She was able to cope with her normal working hours of 8.00am to 2.00pm six days a week and had only experienced difficulties on one occasion when she worked an extra 2 hours. It was not serious enough to indicate that she had a disability.

(3) (a) Ekpe v Commissioner of the Metropolis Police 2000 ICR 1984 EAT
The Claimant who suffered from a muscle wasting condition of her right hand was unable to do a number of daily activities. In the winter months she also

suffered a lot of pain, to the extent that she had difficulty opening doors with her right hand.

(3) (b) *Ekpe v Commissioner of the Metropolis Police* 2000 ICR 1984 EAT

The Claimant, in relation to gender focused activities such as applying make up and nail varnish for example which are performed by females rather than by males, the Tribunal held that putting make up on or putting rollers in hair were not normal day-to-day activities, because they were carried out almost exclusively by women. However, the EAT said that this was plainly wrong because it would exclude anything done by women rather than men, or vice-versa as not being normal.

(4) *Cook v Kitchen Range Foods* 36 EORDCLD pg 4 The Claimant was able to carry normal weights and to stand for periods of up to two hours, with the effect that his back injury could not be said to have affected his normal day-to-day activities.

(5) *Thorpe v Royal Hospitals NHS Trust*. 36 EORDCLD pgs 11-12 This decision must have been particularly baffling for the unsuccessful, Claimant. The Tribunal found the Claimant could not be regarded as disabled because: "she lives a full life, largely unaffected by her disability due to the good sight in her left eye and due undoubtedly to her determination not to let her partial sightedness prevent a normal life".

(6) Alexander v Driving Standards Agency³⁶ EORDCLD pg 4. The Claimant, a driving test examiner, was diagnosed as having had two epileptic fits. These had both occurred at night and the chances of day time recurrences were "extremely small". She could not accordingly be regarded as suffering from a recurring illness. Further, the effects of each fit having lasted less than twenty-four hours, her condition could not be regarded as "long term"

The Claimant advised the DVLA who suspended her driving licence and as a consequence her employer then suspended her from duties. The Claimant then made a claim for disability discrimination and the Employment Tribunal found that her epilepsy did not fall within the definition of a disability. The Employment Tribunal established that she had only had two epileptic seizures, both of which recurred during the night while she was asleep. The Employment Tribunal then went on to say that the chances of the Claimant having a seizure during the day were rated as extremely small by medical advisers and that the Tribunal thought it unlikely that any substantial adverse effect that the Claimant had experienced in the past would recur. It followed therefore that the effect of the impairment was not long-term. The Employment Tribunal added that the only effects of seizure on a day-to-day activity were the side effects which could last up to twenty-four hours. These included a severe headache, memory loss, and speech impediment. In the Tribunal's decision these effects at the time were not substantial and as a consequence the Claimant lost her claim for disability discrimination.

(7) (a) Goodwin v The Patent Office 1999. The EAT took the view that there was no need to specify what constitutes day-to-day activities on the basis that

while it is difficult to define, it is easily recognised. The EAT went on to say that when looking at day-to-day activities it should focus on normal daily activities and not on particular circumstances which could be considered as a subjective test. The EAT went on to quote in this case that: "the fact that a person cannot demonstrate a special skill such as playing the piano is not relevant as it is not a normal day-to-day activity even if the individual concerned is a musician. Similarly, if a person has organised his/her home in such a way as to accommodate a disability, the fact that a person is able to manage is not to be used when considering these issues. If a person is unable to perform any normal daily activities that person will then be considered to have an impairment." The EAT also stressed "the fact that a person with an impairment is able to carry out daily activities is not a relevant consideration and Tribunals will err if they focus on the thing a person can do instead of the thing that they cannot do".

7 (b) Goodwin v the Patent Office IRLR 4 EAT. In this case the Claimant, a paranoid schizophrenic, was employed by the Patent Office as a patent examiner, but in the time he was employed he was not on proper medication during his eight months of employment. He was dismissed following complaints from other work colleagues about his odd behaviour and he brought a complaint of disability discrimination against his employers. A Tribunal in this case heard evidence from a doctor that the Claimant had a mental illness and his symptoms included imagining that other people could access his thoughts and mind and thereby putting a paranoid interpretation on the words and actions of other people. His auditory hallucinations caused him

often to leave his office or his place of employment and therefore impaired the Claimant's ability to stay in concentration for any period of time. The Tribunal had overlooked the detailed reasons for the Claimant's dismissal the employers had set out in their response notice to the Claimant's Application Notice that there were various related incidents of the Claimant's behaviour towards work colleagues.

(8) Leonard v South Derbyshire Chamber of Commerce 2001 IRLR 19 EAT The Claimant suffered from clinical depression. The Claimant tired easily and slept for long periods. When debating these issues the Tribunal found that the Claimant's tiredness affected her mobility in terms of the distances she could walk and drive. Additionally, her manual dexterity and her physical co-ordination were affected because of her tiredness. Her vision tended to blur and she could not maintain concentration and she suffered some memory loss.

(9) Hudson v the Post Office. ET Case No 3100773/98 The Claimant was a driver and when his employers discovered he had poor sight in his left eye they removed him from his driving position as a result of his poor eyesight. The Tribunal held that the Claimant did not come under the definition of disability because he was still able to carry out normal day-to-day activities since he could rely on the sight in his good eye.

(10) Quinlan v B & Q 1997 EAT Case No 1386/97 The Claimant underwent heart surgery and was unable to lift heavy bags. As a result the Claimant was

dismissed. The Tribunal found that that although the Claimant was unable to lift heavy bags he was able to lift everyday objects. It was therefore established that the claimant was not disabled within the definition of the DDA 1995. The Tribunal also went on to state that "Para C 18 of the Guidance states that it would be reasonable to regard as having a substantial adverse effect an inability to pick up objects of moderate weight and the inability to carry a moderately loaded tray steadily. It would not be reasonable to regard as having a substantial adverse effect, an inability to carry heavy luggage without assistance and the inability to move heavy objects without a mechanical aid."

(11) *Coco Cola Enterprises Ltd v Shergill* EAT Case No 0003/02. The EAT accepted that a person who suffered from an impairment of mobility that prevented him or her from taking part in any "normal endeavours at fitness" would probably be disabled. The EAT went on to state that the fact a person could not keep fit by playing a particular sport or game did not make that sport or game a normal a day-to-day activity. It followed that even if the Tribunal's findings that goal keeping, playing snooker and cycling were normal endeavours at fitness was correct it was to be disregarded because of the terms of the Guidance. The EAT considered the Tribunal's view that the Claimant's inability to engage in certain fitness activities demonstrated in a more extreme way, that the restrictions his impairment placed on his everyday life of how long he was able to drive or able to sit. The EAT took the view that the Tribunal could have investigated the restrictions on his mobility to determine whether or not the Claimant was disabled. Since the Tribunal

had failed to make any findings of fact with regard to the Claimant's difficulties in driving and sitting, it was impossible to decide whether he was disabled or not. As a result of this the EAT allowed the Appeal and ordered the case to be heard at a different Tribunal to determine the issue of whether the Claimant suffered from a disability, which was later held that he did suffer from a disability.

(12) Greenwood v British Airways plc. 1999ICR 060 EAT The Claimant, a senior cargo assistant was off work because of nervous tension between October 1993 and March 1994 during which time he underwent counselling. When he returned to work the Claimant continued to experience flashbacks that caused him to be depressed and the depression made it difficult for him to concentrate. Between December 1996 and March 1997 the Claimant was off sick on four occasions. In May 1997 the Claimant saw the Company Doctor who reported the Claimant's treatment had been successful and the Claimant was fit and well. That month the Claimant applied for an internally advertised promotion but was informed at the end of June that he had not been successful because he was viewed as unreliable because of his previous sickness record. In August 1997 the Claimant went off sick with depression. He presented a claim of disability discrimination and at the time of the Tribunal Hearing in March 1998 was still absent from work.

At the hearing the Tribunal noted that as at the date of the alleged discriminatory act - June 1997 the Claimant's condition had ceased to have any effect and his depression was not likely to recur. The Tribunal concluded that the Claimant was not disabled within the meaning of the Act because the

condition was not long-term. On Appeal the EAT overturned the Tribunal's decision, its view being that even if it could be said that the Claimant did not have a current disability within the meaning of Section 1 the Claimant had nevertheless made out a case that he had had a disability in the past which was covered by Section 2. The Tribunal had failed to take into account the fact that the adverse effect of the Claimant's depression recurred and he was therefore to be regarded as having had a past disability by virtue of Para 5 (2) Schedule 2.

(13) *Farrell v Hammersmith Hospital NHS Trust and ors*¹. ET Case No 2200918/97 The Claimant suffered from bouts of depression in 1994. She became ill again with depression in January 1996 and her condition deteriorated in summer 1996 after she became pregnant. She was dismissed in December 1996 as a result of having time off work and on the grounds of capability. The Employment Tribunal dismissed the Claimant's claim of disability discrimination because on this occasion her illness had lasted for less than twelve months and there was no evidence that it was likely to re-occur. Additionally there was no evidence that she was unable to carry out normal day-to-day activities.

(14) *Butler v Eastleigh Housing Association Ltd.*, ET Case No3101121/97

ET Case No: 3101121/97. The Claimant a finance manager became depressed following incidents at work during which he took exception to remarks made to him by a colleague in front of other staff. The GP diagnosed the Claimant as having reactive depression and he continued to be affected

by work related stress. As a consequence he was signed off sick for two weeks. He was eventually dismissed in January 1997. However, a couple of months later he applied for another post and secured this position. He initially started the job on a part-time basis and later on a full-time basis. The Claimant brought a case against his former employers on the grounds of disability discrimination. The Employment Tribunal held that at the time of his dismissal the Claimant was suffering from some depression which started about October 1996, but the effects were not long lasting, as in less than two months from his dismissal he had also started another job. Therefore, accordingly he was found not to be disabled for the purpose of the DDA 1995.

(15) Jobling v Corporate Medical Management Ltd., ET Case No 703101/2001. The Claimant suffered from depression between November 1988 and February 1989 and was prescribed medication which she continued to take for some time thereafter. The Claimant was dismissed from her job and she submitted a claim of disability discrimination. Her claim failed on the grounds that she did not have a continuing depressive illness after February 1989 despite her continued use of medication after that date. The Employment Tribunal accepted medical evidence that her continuing use of medication was "almost a placebo affect" and the EAT saw no reason to interfere with the Employment Tribunal's original decision

(16) Aves v Bournemouth International Airport Ltd., ET Case No: 3101789/98. The Claimant was diagnosed as HIV positive in February 1998. At the end of 1996 he suffered severe fatigue and tiredness which was relieved by anti-

retroviral therapy. The Employment Tribunal held that the Claimant was a disabled person for the purpose of DDA 1995 **once** his ability to carry out normal day-to-day activities was affected.

(17) Cox v Careeragent Ltd., t/a Bell Toyota Ltd., ET Case No: 1700896/98.

The Claimant was dismissed soon after telling his employers that he had been diagnosed as having a malignant tumour on his jaw. The Employment Tribunal found that the main reason for the Claimant's dismissal was that the employers expected the Claimant to have a substantial amount of time off work for treatment. Although the Claimant was not suffering from a substantial adverse effect, the condition was progressive and he had some pain which was sufficient for the Employment Tribunal to find that he was disabled under the Act.

(18) O'Donnell v Ministry of Defence ET Case No: 3101421/97. The Claimant

applied for a job with the MOD and was refused a job based on a medical which showed that he suffered from Ankylosing Spondylitis. This was an incurable condition causing some pain and stiffness of the back. However, the Claimant had learned to cope with this condition. The condition which he suffered from tends to affect male adults and was generally progressive until the age of forty when it levelled out. At the time the Claimant applied for the job he was thirty-nine. The Claimant made a claim against the MOD on the grounds of disability discrimination. The Employment Tribunal found that the Claimant's condition was not progressive since the medical evidence showed that the majority of pathological changes relating to his condition had probably

already occurred. Even if the Employment Tribunal were wrong about that, they did not think that Ankylosing Spondylitis was likely to result in the Claimant having an impairment which had a substantial adverse effect on his ability to carry out normal day-to-day activities.

(19) Mowatt-Brown v University of Surrey 2002 IRLR 235 EAT. The EAT emphasised this point stating that the question to be asked is whether on the balance of probabilities the Claimant has established that the condition in his case is likely to have substantial adverse effects. It is not enough simply to establish that he has a progressive condition and that it has or has had an effect on his ability to carry out normal day-to-day activities. The Claimant must go to show that it is more likely than not that at some stage in the future he will have an impairment which will have a substantial adverse effect on his ability to carry out normal day-to-day activities. The EAT stated that how a Claimant does this is up to him. The EAT made it clear that in the *Mowatt-Brown* case the Employment Tribunal may well have to rely on medical evidence to determine whether a condition is likely to deteriorate and whether it is likely to have a substantial adverse effect on a person's ability to carry out normal day-to-day activities.

(20) (a) Vicary v British Telecommunications 1999 IRLR 680 EAT. The Claimant suffered from an upper arm condition which caused her to lose strength in her arms. The Tribunal found that she was unable to do the following, prepare vegetables, cut up meat or roast potatoes, carry pans full of water, manually open jars, tins or packets, carry baskets of washing, read

without resting the book on the arm of the chair, do heavy shopping, do any DIY tasks, file her nails, tong her hair, iron, shake quilts, groom animals, polish furniture, knit, sew, cut with scissors, hold a briefcase, suitcase or handbag with handles or carry a chair or a moderately loaded tray.

(20) (b)) Vicary v British Telecommunications 1999 ITLR 680 EAT. In reaching their conclusion the Tribunal referred to evidence from the Respondent's regional medical officer. That doctor had a special qualification in Occupational Health and had attended seminars on the DDA 1995. It was her opinion that the Claimant's disability was not substantial within the meaning of the DDA 1995. The EAT held that the Tribunal's decision was perverse for a number of reasons, one of which was the Tribunal had misdirected themselves in respect of the medical evidence doctor. The EAT held that the Tribunal should have had regard to the doctor's attendance at DDA 1995 seminars and that was irrelevant. Furthermore, the EAT ruled that it was not for a witness to determine whether or not the disability was substantial and whether or not an activity was a normal day-to-day activity for the purposes of the DDA 1995, these were matters solely for the Tribunal to decide. In this case the Tribunal had in effect delegated the responsibility of the decision to the company doctor. On the facts the EAT felt bound to conclude the Claimant suffered from a disability within the meaning of the Act

(21) Kapadia v London Borough of Lambeth 2000 IRLR 14 EAT The Claimant suffered from reactive depression, complained of an inability to sleep, loss of

appetite, mood swings, lack of motivation and increasing difficulty in absorbing and organising information and communicating with other people.

(22) Morgan v University of Sheffield EAT0322/00. The Claimant was physically assaulted by her female supervisor whilst at work. She was offered alternative jobs within the University but none were such that her employers could not guarantee the Claimant would not encounter the supervisor if she continued to work for the University, so she resigned. The Claimant made a claim at the Tribunal, her claim form did not mention disability or the DDA 1995. When the Claimant instructed Solicitors, they applied for the Claim Form to be amended to include "discrimination under the Disability Discrimination Act."

The Tribunal did not allow the claim and the claim was heard on appeal by Mr Justice Lindsay at the Employment Appeal Tribunal. The Claimant lost her claim and this matter is regarded as a landmark case with regard to mental illness. The transcript of the proceedings is attached as Appendix 6

(23) Walton v Mascot 2000 ET Case No 2305250/00 It was decided that the Claimant's diabetes was aggravated by his stressful working conditions.

(24) Taylor v The Planning Inspectorate ET Case No 5302523/00. The potential employer withdrew a conditional offer of employment when a medical report revealed that the Claimant suffered irritable bowel syndrome, migraine and stress. It was established that all these conditions were interrelated and exacerbated in her previous job as a result of having a difficult working

relationship with her line manager. It was established in her previous two years in her former place of work, she had taken a large amount of sick leave. The doctor who examined her stated in his report that he had serious doubts about the Claimant's ability to give a full effective service in the post because of her propensity to react badly to stressful conditions. The doctor stated in his report that this could well lead to further sickness absences. The Claimant made an application to the Tribunal on the grounds that she had been discriminated because of her disabilities, however, before the Tribunal the parties accepted that stress was not a clinically recognised condition that can constitute disability within the meaning of Section 1 although irritable bowel syndrome and migraines can be defined as disabilities.

(25) *Delamaine v Abbey National plc ET Case No 2305204 /97*. The part-time cashier was subjected to a robbery which resulted in her receiving counselling to help her to cope with the stress resulting from the robbery in her work place. Between the time periods of October 1995 to March 1996, a total of seven months, she was prescribed sedatives by her GP and continued to work until May 1996 when she left her work place in a distressed state. After a period of long term sickness absences she eventually resigned in August 1997. The Tribunal in this case took the view that the post-traumatic stress disorder she suffered from could amount to a clinically well recognised illness and they found that the Claimant suffered quite severely between May and December 1996. Unfortunately, her claim failed since her condition had gradually improved and the Tribunal held that from April 1997 she was no longer suffering from a substantial adverse effect.

(26) Abadeh v British Telecommunications plc 2001 EAT ICR 156. The Claimant, a telephone operator employed by BT, received a sudden blast of high-pitched noise through the left earphone of his headset. The incident caused the Claimant to suffer permanent hearing loss, Tinnitus and post-traumatic stress disorder

(27) Jones v The Selcare Trust ET Case 2404641/97. The Claimant discovered a lump in her breast in May 1996 which was diagnosed as a Fibroadenoma in April 1997. This was removed the following month. There was some evidence linking her drug use with both the malignancy and the Fibroadenoma. As there were problems at work the Claimant did not return to her previous job. The only alternative employment offered her by her employers was unacceptable because the journey was impossible. At the time of the Claimant's dismissal in May 1997 she had been absent from work with severe depression since the previous July. The Tribunal held that the Claimant was disabled.

(28) Ward v Signs by Morrell Ltd., 1997 ET Case No 2106342/97. The Claimant complained that he was dismissed on 19th August 1997 because he had suffered from depression for the previous 12 months. His depression was caused by matrimonial difficulties and problems at work which resulted in him not sleeping well. He was prescribed Prozac which he relied on. The Claimant complained of a lack of concentration and being generally forgetful especially when cooking for example, not remembering how long the potatoes had been

boiling. The Claimant enjoyed playing football but lost the enthusiasm to get into the team. At a preliminary hearing the Employment Tribunal held the Claimant was disabled as his depression amounted to a mental impairment which had a substantial long term effect on his normal day-to-day activities.

(29) Cockhill v The Insolvency Service 1999 ET Case No 2200168/908. The Claimant suffered from clinical depression between 1990 and 1994 at which time the depression ceased. The Claimant reported that in June 1997 he was not offered a post by the employers because of his previous depression. At a preliminary hearing the Employment Tribunal held that the Claimant suffered from a disability within the meaning of the DDA 1995 and as the disability had lasted for more than 12 months and on the evidence it could well recur.

(30) Cassidy v Benefits Agency 1997 ET Case No 1900624/97. The Claimant suffered from depression. The Employment Tribunal dismissed her claim that her depression was a disability under the DDA 1995. The evidence showed the Claimant had difficulty coping with the stress and strains of life but not to the extent that she was incapable of coping. The Claimant suffered from bouts of depression – feeling low – but this did not amount to a depressive illness.

(31) Cruickshank v VAW Motorcast Ltd., 2002 IRLR 24 EAT. The Claimant's asthma was triggered by his exposure to fumes at work. His condition improved when he was away from work. A Tribunal's decision that his dismissal did not amount to disability discrimination was overturned on appeal by the EAT. The EAT held that an employer in these circumstances could not

avoid his obligations under the Act by relying on the fact that if the employee was dismissed his/her condition would improve to the extent that the impairment would no longer have a substantial long-term effect. The employer must seek to make reasonable adjustments and should not dismiss unless he is justified in doing so.

(32) *Holmes v Bolton Metropolitan Borough Council 1998 ET Case No 2403516/98* in which the Tribunal held that the Claimant had dyslexia and was disabled within the meaning of Section 1. The medical report from a Clinical Psychologist showed that the Claimant was within the average range of general intelligence, but that he had severe difficulties in tests involving reading, spelling and writing. The Claimant had no difficulties in non-verbal reasoning, verbal fluency and semantic fluency and reports also stated that people with dyslexia often scored in a normal range in the tests. The Consultant also stated that the Claimant could be expected to understand and to carry out tasks that did not require literary skills, but he would have difficulty in completing tasks concerning reading, writing and arithmetic. The Tribunal found that the Claimant had difficulties in carrying out normal day-to-day activities that required literacy skills and that the effects were substantial.

(33) *Gittens v Oxford Radcliffe NHS Trust EAT 1200*. The EAT upheld a decision that a nurse with bulimia nervosa (an eating condition) was not entitled to protection under the DDA 1995. The NHS Trust would not employ the Claimant because of her condition, but nevertheless argued that she was not disabled because her ability to carry out day-to-day activities was not

substantially impaired. It was accepted that her condition meant that the Claimant regularly brought herself to vomit and self-harm. She was prescribed anti-depressants and went to a Positive Thinking Group. Medical evidence also showed that the Claimant had an impaired memory and lacked the ability to concentrate. The report also showed that her perception of the risk of physical danger was also affected. Nevertheless, the Tribunal held that the Claimant's condition did not affect her day-to-day activities and the EAT upheld this decision thereby declaring her as not being disabled because she was able to carry out day-to-day activities and they were not substantially impaired.

(34) *Blackledge v London General Transport Services* 2000 EAT 1073/00.

The Claimant claimed he was suffering from a post-traumatic stress disorder because in the 1970's and 1980's he had served in the Armed Forces as a soldier during which time he witnessed shootings and death. Getting on with his job or his day-to-day life. The Claimant described to the Tribunal as an example of the problems he experienced, an occasion when he had been driving his bus and heard a pneumatic drill which reminded him of a machine-gun fire. He explained for a few seconds he froze but thereafter he was able to carry on driving his bus. As a consequence of these experiences he had flash-backs and intrusive memories of the violence he had witnessed, although these did not prevent him from doing his job.

(35) Shaughnessy v The Lord Advocate ET S/401513/99 2000 A lawyer with a stammer was turned down for a job and complained under the DDA 1995. The claim failed on the grounds that the stammer did not have a "substantial" effect. It was acknowledged that all the other requirements for the stammer to be a disability were met. The evidence as summarised in the judgment was broadly as follows.

The Claimant was a highly intelligent individual who was in regular employment and had achieved a degree of success in the field of litigation. The Tribunal had no difficulty understanding him and communicating with him. These processes were undoubtedly slowed down but the problems soon melted into the background and they had fewer communication problems with him than with many Claimants and qualified representatives. The Claimant had developed various self-help techniques, including avoiding particular words or phrases. He had specific problems in numerous situations, including introducing himself in company which he found impossible, delegating tasks to colleagues which he therefore often found easier to do himself, and in emotionally charged litigation. In his ordinary day-to-day activities the stutter affected him in a number of ways, including avoiding the telephone where possible, limiting social contact outside the family, and in various other ways. There was evidence in medical reports that in this case the emotional consequences were more severe than the physical symptoms, which were mild or moderate. His stammer presented as primarily a covert or interiorised one in that it may not be obvious to everyone he meets. It might though take

him longer to get his message across at times and what he said may sound convoluted. The effect of his stammer on his ability to perform normal day-to-day activities had a much greater impact because of how he managed his life to avoid difficult speaking situations, resulting in a "moderate" disability.

The Tribunal quoted the Guidance in Para C 19 as to what it would be reasonable to regard as having a substantial adverse effect and what not. It considered that the Claimant fell somewhere in between the two positions, so that the Guidance was only of limited assistance.

It seemed to the Tribunal in this case that the only argument between the parties was in relation to the use of the word "substantial" to describe the Claimant's condition; every other aspect of the test being satisfied. To the Claimant, the stammer and its consequences were substantial. The reports referred to it variously as mild or moderate.

The Tribunal concluded that the physical condition by itself was not substantial, given how he had addressed the Tribunal. It accepted, however, that on occasions, in emotional or stressful circumstances, his self-help mechanisms could break down (for an experienced practitioner an Employment Tribunal should not be stressful). In examining the Claimant's reaction to his condition, the Tribunal held that it had to look at what the Claimant **does**:

"As far as possible, he simply avoids or evades situations where he can get into difficulties. In this respect he is no different from someone who is extremely shy, for example; or someone who has a facial disfigurement. Most of the time, he has the option to avoid the situation, and take these options. Inevitably there are going to be some situations which cannot be avoided, but from the evidence, these are few and far between."

Clearly the Claimant did not regard his condition as "minor or trivial", but an observer might well do so. Taking a commonsense view the Claimant did not have a "limitation going beyond the normal differences of ability which might exist among people (Guidance Para A1) The Tribunal had considerable sympathy for the Claimant but could not consider him a disabled person within the DDA 1995.

(36) Power v Panasonic UK Ltd., IRLR 151 EAT. The Claimant appealed to the EAT. In considering whether the Tribunal had erred in law in its conclusion. The EAT decided that the Claimant did not have a disability within the meaning of the DDA 1995 1995. The EAT found that the Regulations and Guidance were different but not in conflict. The EAT stated that the cause of the impairment in issue was not material when deciding whether a person is disabled within the meaning of the DDA 1995 1995. The EAT stated that the Tribunal should have considered whether the alleged disability fell within the definition contained in the Act and then moved on to consider whether it was excluded by the Regulations. The EAT found that the Tribunal had erred in law in failing to consider whether, at the material time, depression had a

substantial and long term adverse effect on the Claimant's ability to carry out her normal day-to-day activities.

The employer argued that although there were errors in the Tribunal's conclusions, these had not tainted its decision. The EAT rejected this submission, stating that the Tribunal's use of the phrase 'core issue' indicated that it had wrongly focused on the cause of the Claimant's impairment rather than on whether she was disabled within the meaning of the Act. Therefore, the decision could not stand.

(37) *Perkins & St George's Health Care Trust 2006 IRLR 934*. The Claimant was a Director of Finance. The Trust had concerns over his personality and style of management and asked him to resign. After he raised a grievance the Claimant was invited to a disciplinary meeting where it was alleged that he was not a team player, did not contribute to problem solving, and had a negative and disabled approach to difficult tasks. The Claimant countered by making allegations of bullying, dishonesty and a lack of integrity on the part of senior colleagues. The Claimant was summarily dismissed.

The Court of Appeal held whilst the dismissal was procedurally unfair, the Tribunal had been entitled to make a 100% reduction to the compensation awarded to the Claimant. The reduction was on the basis that the Claimant's conduct at the disciplinary hearing was such that it destroyed any possibility of him working with senior colleagues in the future.

The facts in this case were partly extreme and the Tribunal had been heavily influenced by the Claimant's behaviour at the hearing. While personality itself cannot be grounds for dismissal if an employee's personality manifests itself in such a way as to lead to a breakdown in trust and confidence then the dismissal could be potentially fair by reason of condur or "some other substantial reason.

Appendix 4 - ICD-10 Codes and DSM-IV Codes

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ICD-10

Chapter V codes for Mental Disorders:

- F00- F09 **Organic, including symptomatic, mental disorders.**
- F10- F19 **Mental and behavioral disorders due to psychoactive substance abuse.**
- F20- F29 **Schizophrenia, schizotypal and delusional disorders.**
- F30- F39 **Mood (affective) disorders.**
- F40- F48 **Neurotic, stress-related and somatoform disorders.**
- F50- F59 **Behavioral syndromes associated with physiological disturbances and physical factors**
- F60- F69 **Disorders of adult personality and behavior**
- F70- F79 **Mental retardation**
- F80- F89 **Disorders of psychological development**
- F90- F98 **Behavioral emotional disorders with onset usually occurring in childhood or adolescence**

ICD-10 codes consist of a single letter followed by 3 or more digits, with a decimal point between the second and third (e.g K35.1, "Acute Appendicitis with peritoneal abscess"). As there are many thousands of variations at the 4 character level - where all three digits are used - it is common practice to summarize at the 3 character level (e.g. K35, "Acute appendicitis", which includes peritoneal abscess and all other forms of the condition).

The diagnoses are presented in code order (i.e. rather than by the diagnosis name). The list of ICD-10 chapters below

should help you locate the particular diagnosis you require from these tables:

Codes:

A and B	Certain infectious and parasitic diseases.
C00 to D48	Neoplasms.
D50 to D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism.
E	Endocrine, nutritional and metabolic diseases.
F	Mental and behavioral disorders.
G	Diseases of the nervous system.
H00 to H59	Diseases of the eye and adnexa.
H60 to H95	Diseases of the ear and mastoid process.
I	Diseases of the circulatory system.
J	Diseases of the respiratory system.
K	Diseases of the digestive system.
L	Diseases of the skin and subcutaneous tissue.
M	Diseases of the musculoskeletal system and connective tissue.
N	Diseases of the genitourinary system.
O	Pregnancy, childbirth and the puerperium.
P	Certain conditions originating in the perinatal period.
Q	Congenital malformations, deformations and chromosomal abnormalities.
R	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified.
S and T	Injury, poisoning and certain other consequences of external causes.
U	This letter is currently left vacant.
V, W, X and Y	External causes of morbidity and mortality.
Z	Factors influencing health status and contact with health services.

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- Disorders Diagnostic Criteria (DSM-IV™ Made Easy).
- Free Testing.
- DSM-IV Diagnoses and Codes - Alphabetical
- DSM-IV Diagnoses and Codes - Numerical
- e.g.

- **Axis I:**
Clinical Disorders, most V-Codes, and conditions that need Clinical attention.
Diagnosis Flow Charts.
- **Axis II:**
Personality Disorders and Mental Retardation.
- **Axis III:**
General Medical Conditions.
- **Axis IV:**
Psychosocial and Environmental Problems.
- **Axis V:**
Global Assessment of Functioning Scale.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard classification of mental disorders used by mental health professionals in the United States. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). DSM-IV has been designed for use across settings, inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care, and with community populations and by psychiatrists, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals. It is also a necessary tool for collecting and communicating accurate public health statistics. The DSM consists of three major components: the diagnostic classification, the diagnostic criteria sets, and the descriptive text.

The diagnostic classification is the list of the mental disorders that are officially part of the DSM system. "Making a DSM diagnosis" consists of selecting those disorders from the classification that best reflect the signs and symptoms that are afflicting the individual being evaluated. Associated

with each diagnostic label is a diagnostic code, which is typically used by institutions and agencies for data collection and billing purposes. These diagnostic codes are derived from the coding system used by all health care professionals in the United States, known as the ICD-9-CM.

For each disorder included in the DSM, a set of diagnostic criteria that indicate what symptoms must be present (and for how long) in order to qualify for a diagnosis (called inclusion criteria) as well as those symptoms that must not be present (called exclusion criteria) in order for an individual to qualify for a particular diagnosis. Many users of the DSM find these diagnostic criteria particularly useful because they provide a compact encapsulated description of each disorder. Furthermore, use of diagnostic criteria has been shown to increase diagnostic reliability (i.e., likelihood that different users will assign the same diagnosis). However, it is important to remember that these criteria are meant to be used as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion.

Finally, the third component of the DSM is the descriptive text that accompanies each disorder. The text of DSM-IV systematically describes each disorder under the following headings: "Diagnostic Features"; "Subtypes and/or Specifiers"; "Recording Procedures"; "Associated Features and Disorders"; "Specific Culture, Age, and Gender Features"; "Prevalence"; "Course"; "Familial Pattern"; and "Differential Diagnosis."

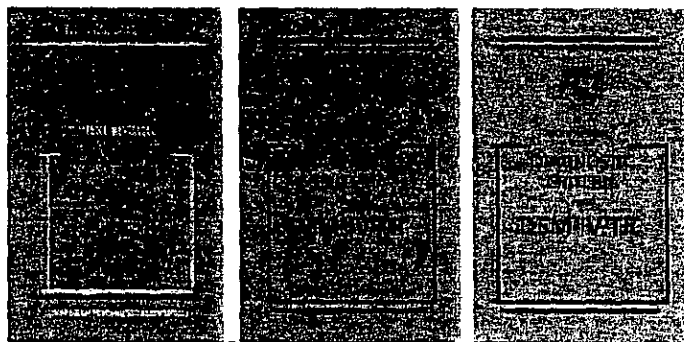
DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition), published in 1994 was the last major revision of the DSM. It was the culmination of a six-year effort that involved over 1000 individuals and numerous professional organizations. Much of the effort involved conducting a comprehensive review of the literature to establish a firm empirical basis for making modifications. Numerous changes were made to the classification (i.e., disorders were added, deleted, and reorganized), to the diagnostic criteria sets, and to the descriptive text based on a careful consideration of the available research about the various mental disorders.

In anticipation of the fact that the next major revision of the DSM (i.e., DSM-V) will not appear until 2010 or later (i.e., at least 16 years after DSM-IV), a text revision of the DSM-IV called DSM-IV-TR was published in July 2000. The primary goal of the DSM-IV-TR was to maintain the currency of the DSM-IV text, which reflected the empirical literature up to 1992. Thus, most of the major changes in DSM-IV-TR were confined to the descriptive text. Changes were made to a handful of criteria sets in order to correct errors identified in DSM-IV. In addition, some of the

with each diagnostic label is a diagnostic code, which is typically used by institutions and agencies for data collection and billing purposes. These diagnostic codes are derived from the coding system used by all health care professionals in the United States, known as the ICD-9-CM.

For each disorder included in the DSM, a set of diagnostic criteria that indicate what symptoms must be present (and for how long) in order to qualify for a diagnosis (called inclusion criteria) as well as those symptoms that must not be present (called exclusion criteria) in order for an individual to qualify for a particular diagnosis. Many users of the DSM find these diagnostic criteria particularly useful because they provide a compact encapsulated description of each disorder. Furthermore, use of diagnostic criteria has been shown to increase diagnostic reliability (i.e., likelihood that different users will assign the same diagnosis).

diagnostic codes were changed to reflect updates to the ICD-9-CM coding system adopted by the US Government.



Lookup DSM III-R / DSM IV Codes
 ICD-9-CM Coding System.

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Appendix 5 - Information re: NOAH

NOAH (The National Organisation for Albinism and Hypopigmentation) www.albinism.org/publications/social.html. The Americans With Disabilities Act defined disability with respect to an individual as "a physical or mental impairment that substantially limits one or more of the major life activities of such an individual; a record of such an impairment or being regarded as having such an impairment". Since Albinism involves a visual impairment some people consider it as a disability. One definition of handicap is "the obstacles of a person encountered in the pursuit of goals in real life, no matter what their source". Thus a person with a disability may or may not be handicapped in pursuing the life they want to live. The identification of albinism as a disability is complicated by the concept of legal blindness. In the United States a person is legally blind if his/her vision cannot be corrected with glasses or contacts to better than 20/200 in his/her better eye. By this standard some with albinism fit the legal category of visual impairment and some do not. Yet, in spite of varying visual acuity, many of the problems experienced by those with albinism remain similar.

**Appendix 6 - Transcript of Landmark Case - Mrs S Morgan v
Staffordshire University EAT0322/00**

Rita Hardaker

From: COLIN OLIVER [nilloc66@fiscali.co.uk]
Sent: 26 November 2006 18:27
To: Rita Hardaker
Subject: EAT03220011122001.doc Morgan Case Law
Attachments: header.htm

Appeal No. EAT/0322/00

EMPLOYMENT APPEAL TRIBUNAL
58 VICTORIA EMBANKMENT, LONDON EC4Y 0DS

At the Tribunal
On 24 October 2001
Judgment delivered on 11 December 2001

Before

THE HONOURABLE MR JUSTICE LINDSAY (PRESIDENT)

MR P DAWSON OBE

MR J R RIVERS

MRS SAMANTHA MORGAN

APPELLANT

STAFFORDSHIRE UNIVERSITY

RESPONDENT

Transcript of Proceedings

JUDGMENT

Revised 19 December 2001

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Lay Representative

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B3 2PP

MR JUSTICE LINDSAY (PRESIDENT)

1. We have before us an appeal from the Employment Tribunal at Shrewsbury under the Chairmanship of Mr D.P. Thompson. The Tribunal held that the Applicant below, Mrs Samantha Morgan, was not disabled within the meaning of **section 1 of the Disability Discrimination Act 1995**. Whilst others of the necessary components of disability within that Act ("the DDA") were proven, the Tribunal, albeit with some reluctance, concluded that Mrs Morgan did not have a mental impairment, the only impairment she was claiming to have. Mrs Morgan appeals.

2. On 22nd March 1999 Mrs Morgan had lodged an IT1 identifying her complaint as "Constructive Dismissal". She had been employed by the Respondent in the catering facility. She had been assaulted, whilst at work, by her female supervisor but had later been offered alternative jobs within the University's employ but which were such that the employer could not guarantee that she would not again encounter that supervisor, who continued to work for the University. She accepted none of the alternatives offered and resigned. She said:-

"I consider that my employer forced me to this position by its failure to recognise, in dealing with my Supervisor, the mental effect of her assault on me and the totally unreasonable expectation that I could continue to work for her."

Although her IT1 mentioned the stress and anxiety which the assault had caused her and her going off sick on that account, she had for a time returned to work before resigning. She identified a Senior Regional Officer of her Union as representing her. Her IT1 does not mention any disability or the DDA.

3. On 7th April 1999 the University lodged its IT3. Mrs Morgan, some time after the assault, had been examined by the University's Occupational Physician. He had reported that he could not see Mrs Morgan being able to work alongside the Supervisor (or with the colleagues, 7 in all, who had supported that Supervisor by writing a letter of support for her during her disciplinary process). He had suggested that Mrs Morgan should be given a rôle in which she would not come into contact with any of those people. Hence the University offered alternative jobs to Mrs Morgan, but none had been accepted by her. The University averred that it had taken all reasonable steps to meet the situation and that there was accordingly no breach of any express or implied term of contract which could amount to justification for Mrs Morgan's regarding herself as dismissed on account of the University's breach. The IT3 did not mention disability or the DDA.

4. By May 1999 Solicitors had taken over conduct of Ms Morgan's case and on 8th June 1999 they wrote to the Tribunal indicating in words the amendment which they wished to make to Mrs Morgan's claim, they having earlier raised the question of amendment, as it would seem, only generally. The amendment sought, however, was remarkably unspecific. It was to insert as a head of complaint: "Discrimination contrary to the Disability Discrimination Act" and, in amplification, a paragraph as follows:-

"I also believe that my employer failed to make reasonable adjustments to my working conditions contrary to section 6 of the DDA, in that they failed to accept my request to be transferred from my work place and/or failed to adjust my working arrangements so as to enable me to carry out my employment, contrary to the provisions of the Act."

5. On 15th July 1999, at a first preliminary hearing, the Employment Tribunal gave leave to Mrs Morgan to incorporate a claim under the DDA within her IT1. However, although the University's representative at the hearing indicated that the DDA claim would be resisted, no more explicit form of words was then put to the Tribunal as the proposed amendment than had appeared in Mrs Morgan's Solicitors' letter. No one would wish Employment Tribunals to encumber themselves with unnecessary formality but it is difficult to resist the thought that had Mrs Morgan's advisers been required to spell out in writing exactly what disability she was claiming to have and also, perhaps, when it could be expected to have come to the University's attention that adjustments were needed on account of that disability, that would have focused the attention of her advisers on what evidence they would need to produce to substantiate the claim against the opposition which they were told the DDA claim would meet. Alternatively, a requirement that Mrs Morgan should specify her disability might have led to a recognition that she would not be able to do so and might, in turn, have provoked an abandonment or compromise of the DDA issues which had been added by the amendment. As it was, the Employment Tribunal at their first preliminary hearing accepted from Mrs Morgan's advisers that the amendment she was permitted would be clarified by way of Further and Better Particulars, though we have seen no order on the point, nor can any time limit for their service be seen to have been prescribed.

6. On 23rd August 1999 the University wrote to the Tribunal to say that it wished to amend its IT3 to add a denial of discrimination under the DDA and indicating that it denied that Mrs Morgan was then or had been disabled within the meaning of that Act. It also denied that it had failed to make adjustments contrary to section 6 of the DDA. The University set out its proposed amendment

to its IT3 verbatim: it included an indication that the University would be adducing evidence from its own Occupational Health Physician that the alternative jobs offered to Mrs Morgan had been suitable to meet her medical needs. The letter stated that the University had not received any Further and Better Particulars from Mrs Morgan's advisers.

7. On 9th December the Tribunal at Shrewsbury had before it a second preliminary hearing, to decide whether Mrs Morgan was a disabled person within **section 1 of the DDA**. When and in what terms the Tribunal had earlier specified the question to be heard and whether, before the hearing, any more clear specification by Mrs Morgan's Solicitors of her alleged disability had emerged in particulars is not a matter on which the parties before us were able to help us. However, no medical practitioner gave evidence on Mrs Morgan's behalf, either orally or by way of any report directed to the requirements of the DDA, although copies of a good many of her medical notes, going back as far as 1985, were produced by her for the Tribunal's scrutiny. Nor was any medical evidence called by the University. Only Mrs Morgan gave evidence.

8. Mrs Morgan was represented below by Counsel, who indicated that it was a mental rather than a physical impairment that was being asserted. That being so, Mrs Morgan needed to satisfy **para 1 (1) of Schedule 1 of the DDA** which provides:-

"1. (1) Mental impairment includes an impairment resulting from or consisting of a mental illness only if the illness is a clinically well-recognised illness."

9. Section 3 of the DDA enables the Secretary of State to give guidance about matters to be taken into account on a number of issues likely to arise in disability discrimination cases, guidance which tribunals in some cases are obliged to take into account. Whilst the nature of mental impairment is not, in terms, one of the issues so described, the guidance issued by the Secretary of State on 25th July 1996 (after he had laid a draft of it before Parliament) included, as paras 12-15:-

"12. Physical or mental impairment includes sensory impairments, such as those affecting sight or hearing.

13. Mental impairment includes a wide range of impairments relating to mental functioning, including what are often known as learning disabilities (formerly known as "mental handicap"). However, the Act states that it does not include any impairment resulting from or consisting of a mental illness unless that illness is a clinically well-recognised illness (Sch 1, para 1).

14. A clinically well-recognised illness is a mental illness which is recognised by a respected body of medical opinion. It is very likely that this would include those specifically mentioned in publications such as the World Health Organisation's International Classification of Diseases.

15. The Act states that mental impairment does not have the special meaning used in the Mental Health Act 1983 or the Mental Health (Scotland) Act 1984, although this does not preclude a mental impairment within the meaning of that legislation from coming within the definition in the Disability Discrimination Act (s. 68)."

Whilst it may be debated whether a Tribunal is bound to accept the guidance there given, it plainly cannot be wrong to accept it. Accordingly in general there will be 3 or possibly 4 routes to establishing the existence of "mental impairment" within the DDA namely:-

- (i) proof of a mental illness specifically mentioned as such in the World Health Organisation's International Classification of Diseases ("WHOICD");
- (ii) proof of a mental illness specifically mentioned as such in a publication "such as" that classification, presumably therefore referring to some other classification of very wide professional acceptance;
- (iii) proof by other means of a medical illness recognised by a respected body of medical opinion.

A fourth route, which exists as a matter of construction but may not exist in medical terms, derives from the use of the word "includes" in **para 1 (1), Schedule 1** to the Act. If, as a matter of medical opinion and possibility, there may exist a state recognisable as mental impairment yet which neither results from nor consists of a mental illness, then such state could be accepted as a mental impairment within the Act because the statutory definition is inclusive only rather than purporting to exclude anything not expressly described by it. This fourth category is likely to be rarely if ever invoked and could be expected to require substantial and very specific medical evidence to support its existence.

10. It is against that legislative background that the Tribunal had to determine whether Mrs Morgan was at any relevant time a disabled person. As for whether whatever she was suffering from had "a substantial and long-term adverse effect on [her] ability to carry out normal day-to-day activities", those being other necessary ingredients before a finding of disability can be made within **section 1 (1) of the DDA**, the Tribunal held that if there had been mental impairment they would have held those other components to have been present. Thus the crucial issue was whether she had adequately shown she had a mental impairment within the Act.

11. The Tribunal set out the evidence derived from Mrs Morgan's medical notes relating to periods after she had been assaulted by the Supervisor on 16th February 1998. They said:-

3. On 25 February 1998 the applicant went to see her doctor and he recorded: "Feeling depressed, can't sleep anxious".

4. On 14 April the applicant again visited her doctor and he recorded: "Bad still. Long

discussion. Long term anxiety/depression. Needs counselling - agrees this time she will attend. Re-arrange."

5. On 28 April 1998 the doctor records: "Very low. Court case pending re. assault by her supervisor at work."

6. On 28 April 1998 the doctor signed the applicant off work for two weeks and his diagnosis was "nervous debility". There followed two further sick notes. One is dated 12 May 1998 for four weeks' diagnosing "anxiety" and another dated 9 June 1998 for five weeks also diagnosing "anxiety".

7. The applicant was away ill from work until her resignation on 28 December 1998.

8. On 5 June 1998 the doctor records the applicant as "Improving. Having counselling."

9. On 20 August the applicant was described by Doctor P Willdig, the respondent's consultant in occupational medicine, in a letter of that date to Lynne Mellor, human resources manager as follows:

"On relating the above series of events to me today, Mrs Morgan became obviously agitated and extremely tearful. She is obviously stressed and anxious by the sequence of events."

10. On 18 May 1999 her general practitioner describes the applicant as: "Feeling low. Not sleeping following last year's "assault" incident at work, still has problems although she resigned in Dec 1998. Has counselling ... helpful to a certain extent."

12. Then the Tribunal referred to matters derived from the medical notes relating to dates before the assault, as follows:-

"11. The Tribunal's attention was drawn to a letter from the Salisbury General Infirmary dated 12 September 1985 where it stated:-

"This young lady was seen in A & E in a hysterical state and D as "acute stress reaction ... I suspect she is depressed and needs continuing care."

12. The Tribunal's attention was also drawn to a general practitioner's note dated 18 October 1990 where it indicates that the applicant was suffering from "mild depression."

13. Then the Tribunal summarised the oral evidence which Mrs Morgan had given in their paragraph 14, as follows:-

"14. The applicant gave evidence that her life was adversely affected from the date of the assault until she went on holiday in August 1999. She stated that before the incident she would mop the kitchen floor and vacuum her carpets every single morning. After the incident she only reluctantly did this on a Sunday with moral pressure from her husband. She would often get the vacuum out in the morning, do virtually nothing all day, and put it away in the evening without using it. She would mix up the children's sandwiches and sometimes fail to give them the correct sandwiches or any sandwiches at all, and sometimes only gave them a drink. She sometime omitted to include a spoon so that they could eat their yoghurt. She had problems with making up their sandwiches about three times out of five every week. She would walk the children to school and her head would be full of thoughts about the incident at work, she failed to listen to what her children were saying and talking to her about, and she would take an extraordinary long time to cross the road. She hardly ever slept. Before the incident she used to read books from the library every month and afterwards she did not read at all. She used to do some embroidery before the incident but did not do so afterwards. Prior to the incident she used to enjoy going out with her family at the weekend, including visiting National Trust properties, shopping and having picnics etc.. After the incident she was just not interested in going out anywhere at all with the family at weekends. There were a couple of times when she had a panic attack, once in a public house and once in Woolworths where she just had to leave the premises and go home for no apparent reason. Although she was prescribed medication on one occasion by the doctor, for most of the period she was not on any medication. She had counselling. She had problems with the physical relationship with her husband. She wished to embark on an NVQ course. She started, but she had to give it up. She could not concentrate. Normally she would have enjoyed doing it."

14. The Tribunal then referred itself to a number of leading and relevant authorities. They

turned to consider whether Mrs Morgan's state fell within any specific description mentioned in the WHOICD. They were thus looking at what we have called route (i) in para 9 above. They said:-

"There was certain doubt in the Tribunal's mind. There was no medical report as such before the Tribunal. It relies on the evidence of the applicant and in general terms the general practitioner's notes. We will not repeat the evidence that has been found in this regard which is set out earlier in this decision. We were particularly troubled by the absence of any firm indication on the evidence before us that the applicant may or may not have been suffering from a clinically well recognised illness. It was clear that the applicant was suffering from anxiety and stress, sometimes variously described as nervous debility or depression. The Tribunal were really left to their own devices to see if it might be possible to fit in the applicant's symptoms with those matters set out that we have earlier described in the International Classification of Diseases. The applicant has been helped throughout by her trade union, then solicitors, and Counsel at the actual hearing. However, try as we might the Tribunal were unable to be satisfied on the evidence that they heard and the documents that they saw that the applicant was indeed suffering from a mental impairment as described in the Act. There was no doubt that she was suffering from stress and anxiety and was depressed and this certainly had an effect on her life as is obvious from this decision."

15. Neither the whole nor even the whole of the material parts of the WHOICD was put before the Tribunal below but only the first sheet and two pages of parts (little, if anything, more than indices) relating to "Mood [affective] disorders F30-F39" and "Neurotic, stress related and somatoform disorders F40-F48". Those extracts merely subdivide the headings into sub-headings and further into sub-sub-headings but attempt no description of the symptoms to be expected with each. Thus, for example (though we cannot say this was necessarily the most relevant of the sub-headings), under F43 one finds:-

"F43	Reaction to severe stress, and adjustment disorders
F43.0	Acute stress reaction
F43.1	Post-traumatic stress disorder
F43.2	Adjustment disorders
.20	Brief depressive reaction
.21	Prolonged depressive reaction
.22	Mixed anxiety and depressive reaction
.23	With predominant disturbance of other emotions
.24	With predominant disturbance of conduct
.25	With mixed disturbance of emotions and conduct
.28	With other specified predominant symptoms
F43.8	Other reactions to severe stress."

There was nothing before the Tribunal by way of informed medical diagnosis which plainly or in terms ascribed Mrs Morgan to any of the headings in the WHOICD or which even told the Tribunal what could be expected to be found by way of symptoms or manifestation of any of the listed mental and behavioural disorders. After referring to para 14 of the Secretary of State's guidance (*supra*) the Tribunal concluded:-

"There was just no evidence or assistance from the applicant, or those representing her, to assist

the Tribunal in reaching a conclusion that the applicant was suffering from a mental illness which is recognised by a respective [sic] body of medical opinion. Accordingly, the Tribunal have somewhat reluctantly come to the conclusion that the applicant is not disabled as she did not have a mental impairment within the meaning of the Act."

16. On 24th January 2000 the Tribunal sent its decision to the parties and on 6th March 2000 Mrs Morgan lodged her Notice of Appeal. Mrs Morgan is no longer represented by Solicitors or Counsel but her husband, Mr B.J. Morgan, as her lay representative, put in a skeleton argument and appeared before us on her behalf. Mr Kibling appeared for the University.

17. Mrs Morgan drew our attention to some of the medical notes that had been put to the Tribunal, some of which were summarised by the Tribunal in the passages we have cited. These included notes as to an Accident & Emergency incident in September 1985 when 4 tablets of valium were prescribed and "Underlying depression" and "I suspect she is depressed and needs continuing care" was noted. However, by 3rd February 1987 a Professor of Psychiatry was reporting "no substantial evidence of depressive illness" and by 31st March 1987 that "It was gratifying that there was such substantial improvement in her mental state". The Professor reported "No frank evidence of a major depression neurosis" in May 1987. Mrs Morgan was unfortunately frequently in need of medical care for a great range of physical discomforts or conditions over the years and by October 1997 a doctor reports "on-going recurring episodes of depression" consisting of "losing her temper, irritability and guilty feelings" that led to 5 counselling sessions. By March 1999, Mrs Morgan having made a claim to the Criminal Injuries Compensation Board ("CICB") in relation to the Supervisor's assault, there was a note of her having been "Of low mood pending Court case" and that it was "not known" if the assault had contributed to "an exacerbation of pre-existing long-standing anxiety/depression problem for which she has attended counselling in past. No obvious suggestion of this except G.P. Note of 28.4.98". Her G.P.'s clinical notes noted her speaking in September 1997 of problems then making her depressed, to her starting drinking and, in April 1995, of "long-term anxiety/depression" and, as the CICB note referred to, to her being "very low" with the Court case as to the Supervisor's assault pending. All these medical notes were before the Tribunal and, as we have said, some were specifically referred to in the passage from the decision cited above. On many of the noted occasions medication was prescribed but not in all cases and there was no one to tell the Tribunal what, if anything, could be inferred from the substances and amounts described or the periods over which they were prescribed.

18. Mr Morgan not unreasonably argues that it would be remarkable if an illness could be long-term, have a substantial effect on day-to-day activities, receive clinical treatment consisting of medication, time off work and counselling and NOT be a clinically well-recognised mental illness. However, that argument, first of all, assumes illness; secondly, in the absence of an informed explanation as to the medication, that reference to it adds little; thirdly, as to time off work, it fails to distinguish between physical and mental and short-term and long-term causes for absence from work and, fourthly, as to counselling, it fails to deal with whether or not the counselling was successful in eradicating the (assumed) illness. Moreover, it is more an argument that Mrs Morgan's condition, had only it been more fully explained than it was at the hearing, could have been properly recognised as an illness and as a clinically well-recognised one or as one specifically mentioned in the WHOICD than an argument that such was the conclusion which the Tribunal should have arrived at on the exiguous material put before the Tribunal at the time.

19. That Mrs Morgan could perhaps have satisfied the Tribunal that she had at some material time suffered from a clinically well-recognised illness is evident from a letter she obtained from Dr David Loughney on 2nd October 2001. It speaks of her suffering from "clinical depression" and that her mild depression of the past had been made worse by the assault. Even so, doubt remains because the WHOICD suggests the need (for example, under "Generalized Anxiety Disorder") for primary symptoms to be expected most days and usually for months and (for "Post-Traumatic Stress Disorder") "there must be repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagining or dreams. Conspicuous emotional detachment, numbing of feeling are often present but are not essential for the diagnosis". If what is being attempted is a claim to fall within a WHOICD category then "clinical depression" without more is insufficient. The work has no such simple category. That apart, we say only that Mrs Morgan could perhaps have satisfied the Tribunal as to her having "a clinically well-recognised illness" as it is conspicuous that although, in her letter to him, Mrs Morgan indicates to Dr Loughney that she had to be very pedantic about that particular wording, Dr Loughney, by mistake or design (we know not which), fails to answer in those required terms. However, an inescapable shortcoming in Dr Loughney's letter is, of course, its date, over 8 months after the hearing at the Tribunal and longer still after the relevant events. Further, as Dr Loughney seems to have provided the letter only a few days after being asked to do so, there is no reason to think that it or something like it would not have been available at the hearing.

20. Dr Loughney's letter cannot therefore be relied upon in the search for some error of law on the Tribunal's part. We have to limit our view of the evidence to that adduced at the hearing as it could and should have appeared to the Tribunal at the hearing. 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, still less as its proof as at some particular time. Even G.P.s, we suspect, sometimes use such terms without having a technical meaning in mind and none of the notes, without further explanation, can be read as intending to indicate the presence of a classified or classifiable mental illness, either after the exacerbating events of the assault proceedings were over or at all. Indeed, the notes of the Professor of Psychiatry, possibly the most authoritative although speaking of a distant time, suggests its absence. There was no evidence from any doctor to explain what he had meant at the time his note was made, nor to assert that Mrs Morgan was at any time mentally impaired within the Act. Without our here setting out further extracts from the WHOICD, we notice that the work shews at many parts of its classification that specific symptoms, often required to be manifest over a minimum specified periods or with a minimum specified frequency, are required if a claimant relies upon falling within it. For Mrs Morgan to have pointed, as happened below, to the occasional references in the medical notes and then to the indices in the WHOICD, without any informed medical evidence beyond those notes, was to invite failure. We cannot say that the Tribunal's conclusion on that evidence was in error of law. We must therefore dismiss the appeal, but we do not do so without making some general observations.

(1) Advisers to parties claiming mental impairment must bear in mind that the onus on a claimant under the DDA is on him to prove that impairment on the conventional balance of probabilities.

(2) There is no good ground for expecting the Tribunal members (or Employment Appeal Tribunal members) to have anything more than a layman's rudimentary familiarity with psychiatric classification. Things therefore need to be spelled out. What it is that needs to be spelled out depends upon which of the 3 or 4 routes we described earlier in our paragraph 9 is attempted. It is unwise for claimants not clearly to identify in good time before the hearing exactly what is the impairment they say is relevant and for respondents to indicate whether impairment is an issue and

why it is. It is equally unwise for Tribunals not to insist that both sides should do so. Only if that is done can the parties be clear as to what has to be proved or rebutted, in medical terms, at the hearing.

(3) As the WHOICD does not use such terms without qualification and there is no general acceptance of such loose terms, it is not the case that some loose description such as "anxiety", "stress" or "depression" of itself will suffice unless there is credible and informed evidence that in the particular circumstances so loose a description nonetheless identifies a clinically well-recognised illness. In any case where a dispute as to such impairment is likely, the well-advised claimant will thus equip himself, if he can, with a writing from a suitably qualified medical practitioner that indicates the grounds upon which the practitioner has become able to speak as to the claimant's condition and which in terms clearly diagnoses either an illness specified in the WHOICD (saying which) or, alternatively, diagnoses some other clinically well-recognised mental illness or the result thereof, identifying it specifically and (in this alternative case) giving his grounds for asserting that, despite its absence from the WHOICD (if such is the case), it is nonetheless to be accepted as a clinically well-recognised illness or as the result of one.

(4) Where the WHOICD classification is relied on then, in any case where dispute is likely, the medical deponent should depose to the presence or absence of the symptoms identified in its diagnostic guidelines. When a dispute is likely a bare statement that does no more than identifying the illness is unlikely to dispel doubt nor focus expert evidence on what will prove to be the area in dispute.

(5) This summary we give is not to be taken to require a full Consultant Psychiatrist's report in every case. There will be many cases where the illness is sufficiently marked for the claimant's G.P. by letter to prove it in terms which satisfy the DDA. Whilst the question of what are or are not "day-to-day activities" within the DDA is not a matter for medical evidence - **Vicary -v- British Telecommunication plc** [1999] IRLR 680 EAT, the existence or not of a mental impairment is very much a matter for qualified and informed medical opinion. Whoever deposes, it will be prudent for the specific requirements of the Act to be drawn to the deponent's attention.

(6) If it becomes clear, despite a G.P.'s letter or other initially available indication, that impairment is to be disputed on technical medical grounds then thought will need to be given to further expert evidence, as to which see **de Keyser -v- Wilson** [2001] IRLR 324 at p 330.

(7) There will be many cases, particularly if the failure to make adjustments is in issue, where the medical evidence will need to cover not merely a description of the mental illness but when, over what periods and how it can be expected to have manifested itself, either generally or to the employer in the course of the claimant's employment. Thus claimants' advisers, before seeking medical evidence, must consider also whether it will be enough to prove a present impairment and whether, instead or in addition, they will need to prove it at some earlier time or times and to prove how it could, earlier or at present, have been expected to have manifested itself.

(8) The dangers of the Tribunal forming a view on "mental impairment" from the way the claimant gives evidence on the day cannot be over-stated. Aside from the risk of undetected, or suspected but non-existent, play-acting by the claimant and that the date of the hearing itself will seldom be a date as at which the presence of the impairment will need to be proved or disproved, Tribunal members will need to remind themselves that few mental illnesses are such that their symptoms are obvious all the time and that they have no training or, as is likely, expertise, in the detection of real or simulated psychiatric disorders.

(9) The Tribunals are not inquisitorial bodies charged with a duty to see to the procurement of adequate medical evidence - see **Rugamer -v- Sony Music Entertainment UK Ltd. [2001] IRLR 644 at para 47**. But that is not to say that the Tribunal does not have its normal discretion to consider adjournment in an appropriate case, which may be more than usually likely to be found where a claimant is not only in person but (whether to the extent of disability or not) suffers some mental weakness.

21. No doubt as more cases are contested on "impairment" these general guidelines will require refinement but, to revert to our immediate task, we dismiss the appeal.

**Appendix 7 - Public Authorities subject to the specific duties as set out
in The Disability Discrimination (Public Authorities) (Statutory Duties)
Regulations 2005 SI No 2966**

Appendix A: Public authorities subject to the specific duties

As set out in The Disability Discrimination (Public Authorities)(Statutory Duties) Regulations 2005 SI No. 2966.

SCHEDULE 1

Regulation 2

PART I

The Adult Learning Inspectorate

The Advisory, Conciliation and Arbitration Service

Any of the naval, military or air forces of the Crown (except in relation to employment in the armed forces)

The Arts Council of England

The Arts Council of Wales

The Audit Commission for Local Authorities and the National Health Service in England and Wales

The Arts and Humanities Research Council

An Assembly subsidiary as defined by section 99(4) of the Government of Wales Act 1998(1)

The Big Lottery Fund

The Biotechnology & Biological Sciences Research Council

A body corporate established pursuant to an order under section 67 of the Local Government Act 1985(2)(transfer of functions to successors of residuary bodies, etc)

The British Broadcasting Corporation, in respect of its public functions

The British Council

The British Educational Communications and Technology Agency (BECTA)

The British Library

(1) 1998 c.38.

(2) 1985 c.51.

The British Museum

The British Tourist Authority

The British Transport Police

The British Waterways Board

The Central Police Training and Development Authority (CENTREX)

The Channel Four Television Corporation, in respect of its public functions

The Chief Constable for the Ministry of Defence Police appointed by the Secretary of State under section 1(3) of the Ministry of Defence Police Act 1987⁽³⁾

A chief constable of a police force maintained under section 2 of the Police Act 1996⁽⁴⁾

The Children and Family Court Advisory and Support Service

The Children's Commissioner for Wales

The Commission for Healthcare Audit and Inspection

The Commission for Patient and Public Involvement in Health

The Commission for Racial Equality

The Commission for Social Care Inspection

The Commissioner of Police for the City of London

The Commissioner of Police of the Metropolis

The Common Council of the City of London, in its capacity as a local authority or port health authority

The Common Council of the City of London, in its capacity as a police authority

In England, a county council, a London borough council or a district council

In Wales, a county council or a county borough council

The Council of the Isles of Scilly

The Council for the Central Laboratory of the Research Councils

⁽³⁾ 1987 c.4.
⁽⁴⁾ 1996 c.16.

The Countryside Council for Wales
The Criminal Injuries Compensation Authority
The Director-General of the National Crime Squad
The Disability Rights Commission
The Economic & Social Research Council
The Electoral Commission
English Heritage
English Nature
English Partnerships
The Engineering & Physical Sciences Research Council
The Environment Agency
The Equal Opportunities Commission
Estyn
The Financial Services Authority
A fire authority constituted by a combination scheme under section 5 or 6 of the Fire Services Act 1947(5)
The General Dental Council
The General Medical Council
The General Social Care Council
The General Teaching Council for England
The Greater London Authority
A Health Authority established under section 8 of the National Health Service Act 1977(6)
The Health and Safety Commission
The Health and Safety Executive
The Heritage Lottery Fund
The Higher Education Funding Council for England
The Higher Education Funding Council for Wales

(5) 1947 c.41. Sections 5 and 6 were repeated, in relation to England and Wales, by the Fire and Rescue Services Act 2004 (c.21), but a scheme in force immediately before the repeat of those sections is given continued effect.
(6) 1977 c.49.

The Historic Royal Palaces Trust

The Horniman Museum

A housing action trust established under Part 3 of the Housing Act 1988(7)

The Housing Corporation

The Human Fertilisation and Embryology Authority

The Imperial War Museum

The Independent Police Complaints Commission

The Independent Regulator on NHS Foundation Trusts

The Independent Review Service

The Information Commissioner

A joint authority established under Part 4 of the Local Government Act 1985 (police, fire services, civil defence and transport)

A joint authority established under section 21 of the Local Government Act 1992(8)

The Law Society of England and Wales

The Learning and Skills Council for England

The Legal Services Commission

A Local Health Board established under section 16BA of the National Health Service Act 1977

A local probation board established under section 4 of the Criminal Justice and Court Services Act 2000(9)

The London Development Agency

The London Fire and Emergency Planning Authority

The Medical Research Council

The Metropolitan Police Authority established under section 5B of the Police Act 1996

A Minister of the Crown or government department

The Museum of London

The Museum of Science and Industry in Manchester

(7) 1988 c.50.

The Museums, Libraries and Archives Council

The National Assembly for Wales

The National Audit Office

The National College for School Leadership

The National Consumer Council

The National Forest Company

The National Gallery

A National Health Service trust established under section 5 of the National Health Service and Community Care Act 1990(10)

The National Library of Wales

The National Lottery Commission

The National Maritime Museum

The National Museum for Science and Industry

A National Park Authority established by an order under section 63 of the Environment Act 1995(11)

The National Portrait Gallery

The Natural Environment Research Council

The Natural History Museum

The Nursing and Midwifery Council

Ofcom

The Particle Physics & Astronomy Research Council

A Passenger Transport Executive for a passenger transport area in England and Wales within the meaning of Part 2 of the Transport Act 1968(12)

A police authority established under section 3 of the Police Act 1996

A primary care trust established under section 16A of the National Health Service Act 1977

The Qualifications and Curriculum Authority (QCA)

A regional development agency established under the Regional Development Agencies Act 1998(13) (other than the London Development Agency)

Remploy Limited

Royal Mail Group

The Science Museum

The Scottish Parliamentary Corporate Body

The Security Industry Authority

The Service Authority for the National Crime Squad

The Service Authority for the National Criminal Intelligence Service, otherwise than in respect of its Scottish functions within the meaning given by section L2 of Part II of Schedule 5 to the Scotland Act 1998(14)

Sianel Pedwar Cymru (Welsh Fourth Channel Authority), in respect of its public functions

Sir John Soane's Museum

The Social Fund Commissioner of the Independent Review Service

A special health authority established under section 11 of the National Health Service Act 1977

The Sports Council for Wales

Sport England

The Standards Board for England

A Strategic Health Authority established under section 8 of the National Health Service Act 1977

Student Loans Company Ltd.

The Sub-Treasurer of the Inner Temple or the Under-Treasurer of the Middle Temple, in his capacity as a local authority

The Tate Gallery

The Training and Development Agency for Schools

Transport for London

UK Film Council

UK Sport

The UK Sports Council

The Victoria and Albert Museum

The Wallace Collection

PART II

The governing body of a secondary school, in England, within the meaning of section 5(2) of the Education Act 1996(15) and any such school as may be determined by the Secretary of State to be treated as a secondary school under section 5(4) of that Act

The proprietor of a City Technology College, City College for Technology of the Arts, or an Academy

The governing body of an institution within the further education sector within the meaning of section 91(3) of the Further and Higher Education Act 1992(16)

The governing body of an institution within the higher education sector within the meaning of section 91(5) of the Further and Higher Education Act 1992

A local education authority

PART III

The governing body of a primary school, in England, within the meaning of section 5(1) of the Education Act 1996, and any such school as may be determined by the Secretary of State to be treated as a primary school under section 5(4) of that Act

The governing body of a community special school or a foundation special school, in England, within the meaning of section 20 of the School Standards and Framework Act 1998(17)

A local authority with respect to the pupil referral units it establishes and maintains, by virtue of section 19 of the Education Act 1996

PART IV

The governing body of an educational establishment maintained by a local education authority, in Wales

Appendix 8 - Legal Services Commission Appeal on Behalf of a Claimant



LEGAL SERVICES COMMISSION

North Western Region

2nd Floor, Lee House, 90 Great Bridgewater St,
Manchester M1 5JW DX:14343

Tel:0161 244 5000 Fax:0161 244 5196/7



TP04

Our Case Reference Number :

Date : 19/09/2006

Your Ref : ..

Dear Sirs

I have received your application for public funding.

Your request for an emergency certificate has been refused. The reason for this is it is considered that the emergency can be met by the client acting in person with the assistance of a solicitor under Legal Help or Help at Court if appropriate.

Your application for a full certificate is now being considered and I will write to you shortly.

The applicant has received a copy of this letter.

Yours faithfully

Regional Director

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MOOD-G

24139771

APPLICATION FOR REVIEW

The applicant wishes to make an Application for a Review on the following grounds:

- 1. The Legal Services Commission should be aware that their comment in their letter dated 19th September 2006 "the assistance of a solicitor under Legal Help or Help at Court if appropriate" is discriminatory under the Disability Discrimination Act 1995 Part III in which you have imposed an unfair procedure rule on the Applicant and thereby will be deemed to be treating him less favourably because of his disability. Your comment would also be unlawful under the Duty to Promote Equality for Disabled People due to be in force in December 2006 as a Public Authority.**
- 2. The provisions of Legal Help and Assistance does not apply to litigation cases such as this case as it is a Judicial Review matter against a Local Authority. Furthermore, Legal Help and Assistance and Representation at Court only represents clients in the County Court and not in a High Court matter.**

FACTUAL BACKGROUND

- 3. The Applicant suffers from severe MS and severe depression. He is unable to walk very far and relies on local shops to deliver him food such as take-aways. The Applicant is desperate need of care via carers because he cannot bathe, cook, dress or toilet himself properly.**

Upon visiting the client at his home on 7th September 2006 it was apparent to his legal representative that the Applicant was unable to walk or to attend to his personal hygiene and personal care needs. The representative noticed that there was several weeks of post behind the front door which were unopened. In addition to this it was also noticed that the house was very unclean and smelt of strong urine and it appeared that the Applicant was sleeping rough downstairs on the couch. It also appeared that the Applicant was undernourished and very unkempt in his appearance.

- 4. The Applicant's legal representative, (who at the time worked at F.A.I.R. Limited in Liverpool, but who is now working at Pannone LLP in Manchester) made a telephone referral via the Care Line in Liverpool on behalf of the Applicant in July of this year. A further telephone call was also made by the Applicant to the Care Line the same month and subsequently in August of 2006 a further**

telephone call was made by the Applicant only to be advised that he was on a waiting list for a number of weeks. The legal representative, since joining Pannone LLP have made two further telephone calls to the Care Line on 15th and 18th September. A third attempt has been made to contact the Care Line today 20th September and was put on hold for 25 minutes and then the line disconnected.

- 5. In accordance with the CPR Rules the Pre-Action Protocol was dispensed with on Counsel's Advice that this matter was extremely urgent based on the client's unmet needs.**

- 6. The Legal Services Commission have stated in their letter dated 19th September 2006 "that this emergency can be met by the client acting in person with the assistance of a solicitor under Legal Help or Help at Court". It is submitted that due to the client's mobility issues he is unable to access legal services as he is unable to leave his home. Furthermore, this case was referred by the Glaxo Centre in Liverpool (a help/advise centre for people with various medical issues) to the legal representative who visited him at home to take instructions.**