No. 99-2509

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

CHERYL A. GILE,

Plaintiff-Appellee,

v.

UNITED AIRLINES, INC.,

Defendant-Appellant.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

Judge Rebecca Pallmeyer
Case No. 94 C 1692

BRIEF OF AMICI CURIAE IN SUPPORT OF PLAINTIFF-APPELLANT

EQUIP FOR EQUALITY, INC.
MENTAL HEALTH ASSOCIATION IN ILLINOIS
MENTAL HEALTH CONSUMER EDUCATION CONSORTIUM, INC.
NATIONAL ALLIANCE FOR THE MENTALLY ILL
NATIONAL ALLIANCE FOR THE MENTALLY ILL- ILLINOIS CHAPTER
NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS
NATIONAL MENTAL HEALTH ASSOCIATION

IN SUPPORT OF AFFIRMANCE

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DISCLOSURE STATEMENT
(formerly known as Certificate of Interest)

Appellate Court No: 99-2509

Short Caption: Cheryl A. Gile v. United Airlines, Inc.

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Equip for Equality, Inc., Mental Health Association in Illinois, Mental Health Consumer Education Consortium, Inc., NAMI, NAMI of Illinois, NAPAS, National Mental Health Association.

(2) If such party or amicus is a corporation:

i) Its parent corporation, if any; and

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STATEMENT OF INTEREST OF AMICI CURIAE

Amici are a broad range of organizations which advocate on behalf of, and provide services to, people with psychiatric disabilities. Individuals with psychiatric disabilities are often the subject of discrimination in the workplace because of unwarranted fear and stereotypes by employers. It is critical that the protections of the Americans with Disabilities Act ("ADA"), including the right to reasonable accommodations, be enforced in a manner that ensures that people with psychiatric disabilities are able to fully participate in the American workforce.

Please see the appendix for a complete statement of interest of each *amicus.*

STATEMENT OF THE CASE

Cheryl Gile, an employee with depression, sued United Airlines under the ADA for failing to provide her with a reasonable accommodation. Specifically, she sought reassignment to the day or afternoon shift after her disability made her unable to work on the night shift. At trial, the District Court instructed the jury to consider Gile's disability in the absence of mitigating measures such as medication. United argues that this Court should reverse the jury verdict because of the Supreme Court's recent rulings, which held that the use of medication should be considered in evaluating disability. We leave it to Gile's brief to provide a detailed description of the evidence presented at trial concerning Gile's particular limitations despite her use of medication. In this brief, *amici* write to inform the Court about how the Supreme Court's cases apply to people with mental illness. Specifically, we will review the three "prongs" of the definition of the disability and the manner in which people with psychiatric disabilities are covered by the ADA even with the use of mitigating measures. Next, we will summarize the

extensive psychiatric literature which establishes that individuals with mental illness who take medication often still have impairments which substantially limit major life activities. As the literature shows, psychiatric disabilities are by nature cyclical and intermittent. They are often substantially limiting at sufficient intervals so as to constitute a disability. We will then explain how an individual may also retain residual limitations despite the medication. Finally, we will set forth how the mitigating measure itself may cause side effects that are substantially limiting.

ARGUMENT

I. The United States Supreme Court's Decisions Do Not Preclude Employees Who Use Mitigating Measures From ADA Coverage.

For purposes of protection under the ADA, an individual must have a "disability," which is defined as:

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

These three "prongs" provide ADA coverage to individuals with a present disability ("actual disability" prong), a record or history of having an actual disability (the "record" prong) as well as to those whom others erroneously regard as having a disability (the "regarded as" prong).

In a recent trio of cases, *Sutton v. United Air Lines*, ___ U.S. ___, 119 S.Ct. 2139 (1999); *Murphy v. United Parcel Service,* ___ U.S. ___, 119 S.Ct. 2133 (1999); and *Albertsons, Inc. v. Kirkingberg,* ___ U.S. ___, 119 S.Ct. 2162 (1999), the United States Supreme Court held that in determining whether a person with an impairment is "substantially limited" in a major life activity, and therefore has an actual disability under the ADA, the effects of any mitigating

measure utilized by the individual must be taken into account.

Because of the possible application of the Supreme Court's mitigating measures decisions to the case at bar, *amici* believe it is critical to analyze these decisions to determine their implications for employees with psychiatric impairments. In reviewing the Supreme Court's analysis, each of the three prongs of the definition of "disability" will be discussed separately.

A. The First Prong: Actual Disability (A Physical Or Mental Impairment That Substantially Limits One Or More Major Life Activities)

In *Sutton v. United Airlines,* plaintiffs were twin sisters each with severe myopia, whose vision could be, and was, corrected to 20/20 with eyeglasses. The Supreme Court held that plaintiffs were not covered under the first prong of the ADA's definition of disability (i.e. actual disability) because they were not "substantially limited" in the major life activity of working when they were wearing glasses. In reaching this holding, the Court ruled that an ADA plaintiff's impairment is to be evaluated in its mitigated state when assessing whether the impairment substantially limits a major life activity. *Sutton,* 119 S.Ct. at 2149. However, the Court expressly held that "[t]he use or nonuse of a corrective device does not determine whether an individual is disabled; that determination depends on whether the limitations an individual actually faces are in fact substantially limiting." *Id.* Use of a mitigating measure, therefore, is not an automatic disqualifier from ADA coverage.

The Court discussed how people who used particular mitigating measures, such as prosthetic limbs or wheelchairs, would be disabled even though they used such mitigating measures because the substantial limitation on their ability to walk or run continued with the mitigating measure. The Court then addressed individuals who use medication to mitigate the

symptoms of their disabilities, concluding that "[t]he same may be true of individuals who take medicine to lessen the symptoms of an impairment so that they can function but nevertheless remain substantially limited." *Id.* Thus, the Court recognized that unlike the disabling conditions in *Sutton,* which were completely corrected by the use of eyeglasses, many disabilities are more complex and their limiting impact may not be completely mitigated by the measures used to treat or address them. Psychiatric impairments, we submit, may frequently fall into this category.

In one of the first decisions following the Supreme Court's mitigating measures opinions, the Third Circuit Court of Appeals recognized that a plaintiff with a psychiatric disability who takes mitigating measures may still proceed with an ADA claim under the "actual disability" prong. *Taylor v. Phoenixville School District,* 1999 WL 649376 (3rd Cir. 8/18/99). In *Taylor,* a school secretary with bipolar disorder filed suit under Title I of the ADA after the school failed to provide her with a reasonable accommodation. The defendant argued that the plaintiff did not have an actual disability because she took medication for her psychiatric condition. The plaintiff asserted, however, that the medication had not entirely controlled her symptoms, leaving her still substantially limited in her ability to think. The Third Circuit noted that briefing for defendant's motion for summary judgment had occurred prior to the Supreme Court's mitigating measures decisions, and Third Circuit precedent at that time stated that disability should be evaluated without regard to mitigating measures. Nevertheless, the Third Circuit held that plaintiff had presented sufficient evidence to defeat summary judgment. *Id.* at slip op. 8-9.

The Supreme Court in *Sutton* also recognized that the side effects experienced by a person who uses a mitigating measure can themselves be substantially limiting and therefore be sufficient for the person to meet the definition of actual disability. *Sutton, supra* at 2147. The

Court cited several medical sources including an article discussing the adverse side effects of some psychiatric medications. *Id.* The Third Circuit's recent decision in *Taylor* is also instructive on how the side effects of psychiatric medications can be substantially limiting. In *Taylor,* the court held that the side effects of lithium, such as impaired concentration and memory problems, "bear directly on [the major life activity of] thinking." *Taylor, supra* slip op. at 8-9. *See also, McAlindin v. County of San Diego,* 1999 WL 717728 (9th Cir. 9/16/99) (plaintiff's declaration that he was substantially limited despite the medications he took for anxiety disorders required reversal of district court's order of summary judgment)

B. The Second Prong: A Record Of Disability

None of the Supreme Court's opinions in the mitigating measures decisions discussed the second "prong" of the definition of disability, i.e. record of disability. Individuals who are unable to demonstrate that they have a present substantial limitation of a major life activity because of the use of mitigating measures may nevertheless be covered under the record of disability prong.[1]

The Supreme Court did discuss record of disability in *School Board of Nassau County v. Arline,* 480 U.S. 273 (1987).[2] The plaintiff in *Arline* was a school teacher who was terminated

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[1] The intent of the record of impairment provision is to ensure that people are not discriminated against because of a history of disability. Equal Employment Opportunity Comm'n, *Interpretive Guidance on Title I of the Americans with Disabilities Act,* 29 C.F.R. 1630.2(k) (1991).

[2] Although *Arline* was decided under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, prior to the enactment of the ADA, cases interpreting the Rehabilitation Act are useful for ADA analysis. When enacting the ADA, Congress adopted the definition of disability from the Rehabilitation Act. By doing so, Congress intended that the relevant case law developed under the Rehabilitation Act be applicable to the interpretation of the term disability as used in the ADA. *(See* S. Rep. No. 116, 101st Cong., 1st Sess. 21 (1989); H.R. Rep. No. 485 part 2,

from her job solely because of her susceptibility to tuberculosis. The Court held that plaintiff's hospitalization for tuberculosis prior to the termination was "more than sufficient" to establish that she had a "record of impairment" that substantially limited one or more of her major life activities." *Id.* at 281. It is clear from that decision that present mitigation can have no effect on whether an individual has a record of disability. Indeed, only where a mitigating measure has been sufficient to render an impairment not substantially limiting for the entire history of the impairment may an employer escape liability by claiming that an individual fails to have a record of disability based upon such measures. In post-*Sutton* cases, plaintiffs have been able to demonstrate that even though they are not currently substantially limited in a major life activity with the use of a mitigating measure, they are still covered by the ADA because they had an impairment that was once substantially limiting. *See Stensrud v. Szabo Contracting Company, Inc.*, 1999 WL 592110 (N.D. Ill. 8/2/99) (plaintiff with arthritis who was not currently substantially limited in a major life activity demonstrated that he had a record of disability).

People with psychiatric disabilities frequently experience severe and substantially limiting symptoms before they undergo a mitigating measure like medication or therapy. In fact, even as they begin to use a mitigating measure, such individuals may experience substantially limiting symptoms as they find the appropriate dosage or treatment for their specific needs. Where these past experiences constitute substantial limitations of major life activities, they will satisfy the second prong of the ADA's definition of "disability."

C. The Third Prong: Being Regarded As Having A Disability

In analyzing the third prong of the ADA's definition of disability, the Supreme Court in

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101st Cong., 2d Sess. 50 (1990); H.R. Rep. No. 485 part 3, 101st Cong., 2d Sess. 27 (1990))

Sutton held that there are two ways in which individuals may regarded as having a disability :

> (1) a covered entity mistakenly believes that a person has a physical impairment that substantially limits one or more major life activities, or (2) a covered entity mistakenly believes that an actual, nonlimiting impairment substantially limits one or more major life activities. In both cases, it is necessary that a covered entity entertain misperceptions about the individual. *Sutton, supra* at 2149-2150.

In its analysis, the Court relied on its previous decision in *Arline.* In *Arline,* the Court recognized the importance of misperception in the discrimination that Congress was attempting to eradicate:

> By amending the definition of 'handicapped individual' to include not only those who are actually physically impaired, but also those who are regarded as impaired and who, as a result, are substantially limited in a major life activity, Congress acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from the actual impairment. *Arline, supra* at 284.[3]

Cases decided since the Supreme Court's mitigating measures cases have reaffirmed that plaintiffs who are not covered under the first prong of the definition of disability because of the use of mitigating measures, may still be covered under the "regarded as" prong. *See, Haiman v. Fox Lake,* 1999 WL 476973 (N.D. Ill. 7/7/99) (summary judgment denied where genuine issue of fact remained as to whether plaintiff with heart condition who used mitigating measures was regarded as having a physical impairment that substantially limited her ability to work); *Stensrud, supra* (plaintiff with arthritis who was not currently substantially limited in a major life activity presented sufficient evidence to support a claim that the defendant regarded him as substantially limited).

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[3] In *Vande Zande v. Wisconsin Dep't of Admin.,* 44 F.3d 538, 541 (7th Cir. 1995), this Court compared the regarded as prong to other types of illegal discrimination and observed that "[m]any such impairments are not in fact disabling but are believed to be so, and the people having them may be denied employment or otherwise shunned as a consequence. Such people, objectively capable of performing as well as the unimpaired, are analogous to capable workers discriminated against because of their skin color or some other irrational, irrelevant characteristic."

II. The Complexity Of Treating Psychiatric Disabilities Often Makes It Difficult To Mitigate Their Limiting Effects.

Psychiatric disabilities are complex disorders and their treatment is correspondingly complex. In contrast to the treatment of a vision impairment, where the simple step of an accurate eyeglass prescription may mitigate the impairment entirely, treatment of mental illness often entails continuous adjustments and imperfect solutions. Variations among individuals with mental illnesses, as well as the episodic nature of these illnesses, make effective treatment difficult. As a result, many individuals with mental illness continue to experience limitations even while receiving treatment, such as medication or therapy, for their illness.[4] In determining whether an individual is a person with a disability, courts must take care not to presume that an individual who takes medication to treat a psychiatric disability is no longer substantially limited in major life activities.

A. Variation Among Individuals With Mental Illness

The tremendous variation among individuals with mental illnesses makes it difficult to treat these disorders effectively. Unlike visual and many other physical impairments, mental illnesses may cause different types of limitations and take different courses from one individual

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[4] *See, e.g.,* Ann E. Moran et al., *The Journey of Sylvia Frumkin: A Case Study for Policymakers*, 35 HOSP. & COMMUNITY PSYCHIATRY 887 (1984) (describing life of woman with mental illness who intermittently experienced severe limitations over many years despite treatment through medication and therapy in various settings). *See also* Trisha Suppes, *New Horizons in Management and Treatment of Bipolar Disorder*, 6 J. CALIFORNIA ALLIANCE FOR THE MENTALLY ILL, Issue No. 2, 1995, at 14, 15 (for a substantial minority of patients with bipolar disorder, typical antipsychotic medications may prevent acute episodes but do not eliminate mood swings, poor concentration, episodes of hypomania and depression, and continued difficulty functioning); Michael Gitlin, *Bipolar Disorders: Clinical Complexities, Current Challenges*, 6 J. CALIFORNIA ALLIANCE FOR THE MENTALLY ILL, Issue 2, 1995, at 7, 9 (even as a greater number of effective medications have become available, the relapse rate among individuals undergoing treatment for bipolar disorder has increased).

to the next.[5] In addition, response to treatment may vary among individuals with the same diagnosis, and some individuals may fail to respond to any available treatments.[6] The Congressional Office of Technology Assessment concluded that "[w]hile . . . effective treatments are available for many mental disorders, they are not a panacea. Medications are not effective for everyone, and some of the most disabling symptoms of mental disorders may resist their effects."[7] The heterogeneity of mental illness, even among individuals with the same diagnosis, requires individualized treatment planning and continued assessment of an individual's status on an ongoing basis.[8] Due to the difficulty of predicting which drugs will prove most effective for

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[5] Equal Employment Opportunity Comm'n, *Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities* 5 (March 1997); Am. Bar Ass'n Comm'n on Mental & Physical Disability Law, MENTAL DISABILITIES AND THE AMERICANS WITH DISABILITIES ACT 57 (2d ed. 1997); Laura Lee Hall, *Making the ADA Work for People with Psychiatric Disabilities, in* MENTAL DISORDER, WORK DISABILITY, AND THE LAW 241, 255 (Richard J. Bonnie & John Monahan eds., 1997); Gerd Huber, *The Heterogeneous Course of Schizophrenia*, 28 SCHIZOPHRENIA RES. 177 (1997).

[6] John P. O'Reardon & Jay D. Amsterdam, *Treatment-Resistant Depression: Progress and Limitations,* 28 PSYCHIATRIC ANNALS 633, 633-37 (1998) (describing possible reasons for failure to respond to antidepressant treatment); Maurizio Fava & Junko Kaji, *Continuation and Maintenance Treatments of Major Depressive Disorder*, 24 PSYCHIATRIC ANNALS 281, 282 (1994) (responsiveness to acute antidepressant treatment can vary across different subgroups of individuals with depression); Am. Bar Ass'n Comm'n on Mental & Physical Disability Law, Nat'l Mental Health Ass'n, THE ADA AND PEOPLE WITH MENTAL ILLNESS: A RESOURCE MANUAL FOR EMPLOYERS 13 (1993) (each person's reactions to a prescribed medication dosage will vary depending on various factors); 20 C.F.R. Pt. 404, Subpt. P, App. 1, § 12.00 H (present day treatment of mental impairments enables some but not all individuals to function in workplace at a level close to that before onset of the disorder).

[7] Office of Technology Assessment, PSYCHIATRIC DISABILITIES, EMPLOYMENT, AND THE AMERICANS WITH DISABILITIES ACT 59 (1994).

[8] *See, e.g.,* Courtenay M. Harding & James H. Zahniser, *Empirical correction of seven myths about schizophrenia with implications for treatment*, 90 ACTA PSYCHIATRICA SCANDINAVICA 140, 141 (1994).

whom, trial and error methods of treatment are often used, where a series of medications are prescribed in varying dosages until an appropriate regimen is determined.[9]

B. Episodic Nature Of Mental Illness

Effective treatment of mental illness is also difficult because of the episodic, or cyclical, nature of most serious mental illnesses. That is, symptoms do not permanently abate when an individual begins receiving treatment, but instead wax and wane, reappearing from time to time when the individual has relapses or recurrences of the illness.[10] "Most mental illnesses do not follow an orderly path of onset, course and outcome. Rather, the disorder comes and goes; it may take several forms; it can move from periods of stability to setbacks, or recurrences, and back again."[11]

Episodic illnesses often elude effective treatment for several reasons. First, the erratic nature of these illnesses makes it difficult to determine what treatment will work best. The symptoms and the efficacy of treatment cannot simply be examined at a single point in time, but must be continually assessed as the illness progresses and changes over time.[12] Second, recurrent

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[9] Irvin D. Rutman, *How Psychiatric Disability Expresses Itself as a Barrier to Employment,* 17 PSYCHOSOCIAL REHABILITATION J., Jan. 1994, at 15, 19.

[10] *Id.* at 18 (severe mental illness is typically manifested episodically, with periods of relative lucidity and calm alternating with acute phases); MENTAL DISABILITIES AND THE AMERICANS WITH DISABILITIES ACT, *supra* note 5, at 57 (describing "irregular and episodic nature" of mental illnesses); Equal Employment Opportunity Comm'n, *Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities* at 9 (psychiatric disabilities may take the form of chronic episodic conditions that are substantially limiting when active or are likely to recur in substantially limiting forms).

[11] Rutman, *supra* note 9, at 18.

[12] *See* 20 C.F.R. Pt. 404, Subpt. P, App. 1, § 12.00E; Harding & Zahniser, *supra* note 8, at 141.

episodes may be triggered by factors that medication cannot control, such as psychological and psychosocial stressors.[13] Third, medication regimens are often discontinued after remission of symptoms or recovery, and relapses or recurrences of symptoms frequently occur after discontinuation.[14] Antidepressant medications, for example, are typically prescribed only for a period of months rather than years.[15] Determining when to prescribe medication to prevent the possibility of recurrent episodes, and for how long, are difficult and complex issues.[16]

Fourth, optimal dosages of medications may often be difficult or impossible to maintain on a long term basis due to side effects caused by the medications. The benefits of the medication must be balanced against negative side effects, often leading clinicians to reduce dosages, discontinue use of a particular medication, and/or switch to an alternative medication.[17]

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[13] Michael Gitlin, *supra* note 4, at 9.

[14] *See, e.g.,* Fava & Kaji, *supra* note 6, at 281 (high rates of relapse and recurrence of depression after discontinuation of continuation treatment and maintenance treatment); Suppes, *supra* note 4, at 15 (high rates of recurrence of bipolar episodes after discontinuation of maintenance treatment); Robert M.A. Hirschfeld, *Guidelines for the Long-Term Treatment of Depression*, 55 J. CLINICAL PSYCHIATRY, suppl. 12, Dec. 1994, at 61, 61 (high rate of recurrence of depression may result from treatment being withdrawn too soon).

[15] Rutman, *supra* note 9, at 19.

[16] Gitlin, *supra* note 4, at 7; Fava & Kaji, *supra* note 6, at 282; Hirschfeld, *supra* note 14, at 68.

[17] *See, e.g.,* J. Craig Nelson, *Safety and Tolerability of the New Antidepressants,* 58 J. CLINICAL PSYCHIATRY, suppl 6, 1997, at 26, 29 (discussing rates of discontinuation of various medications due to adverse side effects); Raphael J. Leo, *Movement Disorders Associated With the Serotonin Selective Reuptake Inhibitors*, 57 J. CLINICAL PSYCHIATRY 449, 453 (1996) (dose reduction associated with improvement of certain adverse side effects, but most individuals with these side effects have done best with drug cessation or use of an alternate antidepressant); Susan L. McElroy et al., *Minimizing and Managing Antidepressant Side Effects*, 56 J. CLINICAL PSYCHIATRY, suppl 2, 1995, at 49, 49 (side effects deter clinicians from prescribing adequate antidepressant doses, which can lead to poor outcomes in reducing symptoms and recurrences);

As a result, individuals may experience difficult adjustment periods whenever changes are made in their medication regimens.[18] Thus, finding an effective medication that will not only alleviate current symptoms of mental illness, but also prevent future recurrences, is a complicated task.

Gile's experience is consistent with these general observations about the difficulty of controlling the symptoms of mental illness through medication. During the period from the onset of her mental illness through the time that this lawsuit was filed, her symptoms of depression and anxiety were alleviated for brief periods of time, and actually worsened despite treatment through both medication and therapy.[19]

III. A Person With A Psychiatric Disability May Have Residual Limitations That Substantially Limit Major Life Activities.

Even among individuals who respond successfully to medication for a psychiatric disability, many still experience significant residual symptoms.[20] What is generally considered a successful response to treatment for depression, for example, is a clinically and statistically

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Fava & Kaji, *supra* note 6, at 283 (when dosage of particular medication was reduced in patients with adverse side effects, those effects decreased, but remission of symptoms was not sustained). *See also* Moran et al., *supra* note 4 (describing difficulty of balancing side effects and benefits of drugs for woman with chronic mental illness; medications were often withdrawn or lowered when she experienced side effects, often leading to a recurrence of symptoms). *See infra* pp. 13-14 for a description of side effects caused by medications used to treat psychiatric disabilities.

[18] THE ADA AND PEOPLE WITH MENTAL ILLNESS, *supra* note 6, at 13 (individuals go through adjustment periods after starting medication, changing dosages, and stopping medication).

[19] *See* Plaintiff's Brief at 12.

[20] John P. O'Reardon & Jay D. Amsterdam, *Treatment-Resistant Depression: Progress and Limitations,* 28 PSYCHIATRIC ANNALS 633, 633 (1998).

significant reduction of symptoms, not full remission of symptoms or recovery.[21] Many fewer individuals actually achieve full remission of symptoms through medication than respond to the medication.[22] The failure to achieve remission or recovery may be due to an individual's resistance to the treatment or simply to inadequate dosages or duration of medication.[23]

Moreover, medications often alleviate only certain types of symptoms, while other types are not affected. "[S]ome of the most disabling symptoms of mental disorders may resist their effects."[24] For example, psychotropic medications may control certain primary manifestations of a mental illness, such as hallucinations, but may have no effect on functional limitations -- such as impaired concentration and impaired ability to maintain interpersonal relationships -- caused by the illness.[25] Thus, residual limitations that substantially limit major life activities may remain even when medication does improve an individual's condition.

IV. The Side Effects of Medication May Substantially Limit Major Life Activities.

Many individuals undergoing treatment for mental illness experience debilitating side

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[21] *Id.* at 634.

[22] *Id.* at 633-34 (approximately 70% of patients respond to treatment, while only about 30% achieve remission of symptoms).

[23] *Id.* at 635-37.

[24] Hall, *supra* note 5, at 256; *see also* Office of Technology Assessment, *supra* note 7, at 59.

[25] 20 C.F.R. Pt. 404, Subpt. P, App. 1, § 12.00G (psychotropic medications may control primary manifestations but have no impact on functional limitations); Suppes, *supra* note 4, at 15 (antipsychotic medications may eliminate acute episodes but not poor concentration, mood swings, and other functional limitations); Hall, *supra* note 2, at 256 (medication has little direct impact on such functional issues as interpersonal relationships); Office of Technology Assessment, *supra* note 7, at 59 (same).

effects as a result of the medications prescribed. Side effects that may result from medications prescribed for mental illness include: drowsiness, fatigue, lethargy, insomnia, weight gain, blurred vision, aggravation of glaucoma, anxiety, agitation, hypotension, hypertension, nausea, vomiting, dyspepsia, constipation, fecal impaction, palpitations, diarrhea, urinary retention or hesitancy, sexual dysfunction, headaches, dry mouth, tachycardia, high or low blood pressure, arrythmia, lightheadedness, and panic attacks.[26] Side effects from medications also commonly include mobility impairments --such as tremors, muscle rigidity, muscle spasm, shuffling or otherwise impaired gait, jaw tightness, tongue protrusion, involuntary movements of facial muscles, limbs or trunk, loss of coordination, swelling of limbs, and restlessness (akathisia),[27] and cognitive impairments -- such as impairments of short-term memory, concentration, and attention, as well as confusion, disorientation, and delirium.[28] This list of side effects is by no means exclusive. These adverse side effects may, by themselves or in combination with the limiting effects of the mental illness itself, substantially limit an individual in major life activities.[29]

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[26] *See generally* Nelson, *supra* note 17, McElroy, *supra* note 17; *see also* Alan Frazer, *Antidepressants*, 58 J. CLINICAL PSYCHIATRY, suppl. 6, 1997, at 9, 15-17; Rutman, *supra* note 9, at 19; Office of Technology Assessment, *supra* note 7, at 59; Hall, *supra* note 5, at 256, Fava & Kaji, *supra* note 6, at 283.

[27] *See, e.g.,* Leo, *supra* note 17; Rutman, *supra* note 9, at 19.

[28] *See, e.g.,* McElroy, *supra* note 17, at 54.

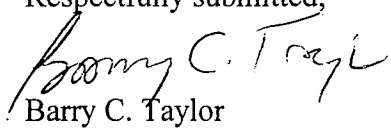
[29] *See* Office of Technology Assessment, *supra* note 7, at 59 (side effects of medication may be "quite annoying" or "outright disabling").

CONCLUSION

The Supreme Court's mitigating measures cases have refined, not repealed, the actual disability prong. People who use mitigating measures will be covered by the ADA if they can demonstrate that they are still substantially limited in their mitigated state or if the side effects of the mitigating measure are themselves substantially limiting. Additionally, many people who use mitigating measures who are not currently substantially limited in a major life activity may still be covered under the second and/or third prong of the definition of disability.

In considering United's argument that Gile's use of medication removed her from the protections of the ADA, this Court should recognize the complexity of treating psychiatric impairments and the many ways individuals with psychiatric disabilities may be substantially limited in major life activities even while taking medication.

Respectfully submitted,



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APPENDIX

Equip for Equality, Inc.

Equip for Equality, Inc. founded in 1985, is a private, not-for-profit organization and is the federal designated protection and advocacy system for people with disabilities for the State of Illinois. Equip for Equality's mission is to advance the human and civil rights of people with physical and mental disabilities in Illinois, including individuals with psychiatric disabilities. Equip for Equality believes that people with disabilities should be afforded the same access to benefits of society as are granted to persons without disabilities, and is committed to securing that access through self-advocacy assistance, legal services, education and public policy advocacy. Each year, Equip for Equality serves approximately 2,500 people with disabilities and is experienced in addressing the barriers and related legal issues facing people with disabilities, including barriers in employment.

Mental Health Association in Illinois (MHAI)

The Mental Health Association in Illinois (MHAI) is the oldest mental health advocacy organization in Illinois. A not-for-profit affiliate of the National Mental Health Association, MHAI provides services to persons with mental illness such as advice and referral, screens several thousands of persons for depression each year, provides violence prevention training to children and adolescents, engages in educational campaigns designed to reduce the stigma associated with mental illness and advocates in the Illinois legislature, the United States Congress and elsewhere, for increases in the resources available for the prevention and treatment of mental illness and for increased protections

for the rights of persons with mental illness. Because MHAI believes that employment discrimination against persons with mental illness is widespread, wasteful of human potential and economically inefficient, MHAI supports the vigorous enforcement of laws, such as the Americans with Disabilities Act, designed to protect persons with mental illness from discrimination in employment.

Mental Health Consumer Education Consortium, Inc.

The Mental Consumer Education Consortium, Inc. (MHCEC) is a non-profit organization that is committed to unite individuals and groups for effective leadership in the mental health system of Illinois. Its goal is to promote every person's right to access to appropriate and effective mental health services. MHCEC advocates for consumers and helps consumers advocate for themselves and other consumers in a variety of areas including employment.

National Alliance for the Mentally Ill (NAMI)

The National Alliance for the Mentally Ill (NAMI) is the nation's leading grassroots advocacy organization solely dedicated to improving the lives of persons with severe mental illnesses. NAMI has more than 200,000 members and 1,200 state and local affiliates in all fifty states, the District of Columbia, Puerto Rico and Canada. NAMI's efforts focus on support to persons with severe mental illnesses and their families; advocacy for nondiscriminatory and equitable federal, state and private-sector policies; research into the causes, symptoms and treatments for brain disorders; and education to eliminate the pervasive stigma towards severe mental illnesses.

National Alliance for the Mentally Ill – Illinois Chapter (NAMI Illinois)

NAMI Illinois is one of Illinois' largest mental health advocacy organizations. Made up of over 35 local affiliates, NAMI Illinois' mission is dedicated to eradicating mental illness and improving the lives of the mentally ill and their families. Through education and advocacy at the local and state level, NAMI Illinois provides support to consumers and family members whose lives have been touched by mental illness. NAMI Illinois' membership of over 5,000 is made up of family members, consumers, professionals and those who believe in our mission.

National Association of Protection and Advocacy Systems (NAPAS)

NAPAS is a voluntary membership association which facilitates coordination among the Protection and Advocacy Systems ("P&As") in every state, and represents their interests before Congress and the executive branch of government. The agency has long been recognized as a key player in the disability rights movement, helping to develop significant disability coalitions and policies on the national level. In 1986, following congressional hearing and investigations which substantiated numerous reports of abuse and neglect in state psychiatric hospitals, former Senator Weicker introduced the bill which eventually became the Protection and Advocacy for Individuals with Mental Illness Act of 1986, 42 U.S.C. 10801 et seq. (The Program's regulations are published at 42 C.F.R. Part 51.) Congress recognized that existing state systems responsible for protecting the rights of this population varied widely and were frequently

inadequate. As a result of this support, the P&As have done and continue to do significant work on behalf of individuals with mental illness.

National Mental Health Association

The National Mental Health Association is a national organization with over 340 affiliates dedicated to promoting mental health, preventing mental disorders, and achieving victory over mental illness, as well as respect, dignity and opportunities for persons with disabilities.

No. 99-2509

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

CHERYL A. GILE, Plaintiff-Appellee,	)	
v.	)	Appeal from the United States District Court for the Northern District of Illinois
UNITED AIRLINES, INC., Defendant-Appellant.	)	Judge Rebecca Pallmeyer Case No. 94 C 1692

CERTIFICATE OF SERVICE

Pursuant to 25(d) of the Federal Rules of Appellate Procedure, the undersigned hereby certifies that he served the Brief of Amici Curiae in support of Plaintiff-Appellee upon the parties of record, by enclosing three true and correct copies of same in separate envelopes addressed as follows:

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and depositing same with first class postage fully prepaid in the United States mail at Chicago, Illinois on this 30th day of September, 1999.

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