Implications of the Americans With Disabilities Act of 1990 for Elderly Persons

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Key Word: aging

Because the prevalence of disability increases proportionately with age, the expanding population of older adults is potentially the largest single group to benefit from the Americans With Disabilities Act of 1990 (ADA) (Public Law 101-336). One fourth of elderly persons have functional disabilities acquired through age-related chronic and acute conditions. The ADA guarantees older adults with disabilities equality in the workplace and the community. It also enhances their opportunities to continue living independently as long as possible. Applications of the ADA for elderly persons with functional impairments include providing opportunities to continue working in a job suited to their abilities, eliminating structural or programmatic barriers to full inclusion, and providing accommodations for sensory losses. Occupational therapists also have certain responsibilities and opportunities in supporting the rights of elderly persons with functional impairments under the ADA. These responsibilities include providing rehabilitation to promote community reintegration, consulting with employers and service providers on the unique needs of the elderly, and advocating on behalf of and in association with older Americans.

The Americans with Disabilities Act of 1990 (ADA) (Public Law 101-336), supports the ability of older persons with disabilities to live independently. The severity as well as prevalence of activity limitations increases proportionately with age (Pope & Tarlov, 1991). The median age of the United States population is increasing and, consequently, the proportion of persons with disabilities is increasing (Dawson, Hendershot, & Fulton, 1987). Although the ADA was not expressly written with elderly persons in mind, its provisions will help all older persons, whether or not they are technically categorized as disabled. The spirit and the letter of the ADA emphasize providing support for persons to remain integrated in their communities.

Even though the ADA is a civil rights law aimed at achieving full participation in society for persons with disabilities, it does not guarantee that opportunities are made available. Occupational therapists are challenged to identify new roles, settings, and approaches to implementing the ADA or assisting others in complying with it. Therapists who provide ADA consultation or work with older adults should therefore understand the provisions of the ADA that can make a major difference in the lives of these older adults. Proactive therapists will help to ensure that the opportunities guaranteed by the ADA include the unique needs of older Americans. Because many provisions and potential applications of the law remain untested in the courts, our strong advocacy will help ensure that the provisions of the ADA are fully implemented for the older person (Batavia, Dejong, Eckenhoff, & Materson, 1990).

The goals, intentions, and purposes of the ADA are especially compatible with the philosophy of occupational therapy, which is based on the belief that engaging in purposeful activity is central to human life (Bowman, 1992). Occupational therapists are able to draw on their knowledge of persons and their environment, as well as their assets and limitations, to identify alternative strategies to enhance occupational performance (Christiansen, 1991).

In this article we examine the demographic characteristics and unique needs of middle-aged persons and the elderly. We describe Titles I, II, III, and IV of the ADA in reference to their effect on rehabilitation of the elderly and their capacity to create opportunities for greater independence.

Demographic Imperatives

Aging and Functional Disabilities

Nearly three out of four persons with a substantial functional limitation are older than 49 years of age, and nearly half are older than 64 years of age (Dawson et al., 1987). Conditions most frequently experienced by middle-aged and older adults are chronic and degenerative (most commonly, musculoskeletal, cardiovascular, respiratory, and

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metabolic) (Vetter, Lewis, & Ford, 1990). Disabilities result from the interaction of normal aging with these age-related conditions, and from injuries. Among elderly persons, cognitive impairment is common.

Functional limitations progress from an inability to perform the activities necessary for independent living and socializing outside the home to the eventual loss of self-care skills. Three fourths of elderly persons with functional impairments report difficulty with heavy household tasks; half have problems going to the grocery store and to other destinations beyond walking distance. This progression suggests that an initial limitation in the range of activities involving acquisition of goods and services outside the home may often lead to loss of the ability to live independently (Macken, 1986).

The effect of changes in functional ability are particularly dramatic for disabled elderly persons who live alone. This group comprises more than 30% of the elderly population, the largest number being women 85 years of age and older (Kasper, 1988; Macken, 1986). Despite numerous obstacles, most older persons prefer to age in place, such as in their own homes or retirement communities, for as long as possible. ADA-mandated services and accommodations, which enable elderly persons with disabilities to remain in the community, can benefit elderly persons without disabilities and society as well. Generally, community living is less expensive than institutionalization because persons are able to support themselves with personal resources, thus reserving the use of public funds for nursing homes and other health services (Macken, 1986).

Aging of the Work Force

Longer life expectancy means a greater retiree-to-worker ratio and a greater number of unemployed people dependent on a shrinking work force (Noel, 1990). Labor economists predict a continuing decline in the number of younger workers. By the year 1995, it is projected that the number of 18- to 24-year-olds in the labor market will shrink by 2 million (Mitchell, Levine, & Pozzenbon, 1988). Although there are currently 4.9 persons of working age (21 to 64 years) in our population for each person over 65 years old, there will be only 2.8 such persons by the year 2025 (Crystal, 1988). Consequently, the forced and voluntary retirement patterns of older workers will need to be reevaluated to prevent unnecessary future work force reductions. Rehabilitation professionals recognize the importance of treatment goals for older adults that promote a return to productive life roles and work, when appropriate. However, the Rehabilitation Services Administration (RSA) reported that only a fraction of older persons with disabilities who could benefit from vocationally oriented rehabilitation actually receive it (Kemp & Kleinpazt, 1985; Morrison & Magel, 1984; Matheson, 1990).

For many older persons, meaningful employment provides more than an income; it enhances the quality of life and the self-respect that comes with independence and personal autonomy (Burkhauser & Hirvonen, 1989). The need to work does not diminish as one grows older, as evidenced by the number of older persons who do volunteer work. Thirty-four percent of people aged 65 to 74 years who live alone and 43% of older couples do volunteer work (Department of Health and Human Services, 1991).

Ageist attitudes and a lack of knowledge of the aging process among physicians and health professionals may contribute to an erroneous belief that chronic illness is a normal consequence of aging (Brody & Ruff, 1986). Lowered expectations of an older person’s ability to benefit from rehabilitation may cause physicians and therapists to question whether rehabilitation is worth the time, money, and effort. Studies of age bias in the setting of treatment goals have found that rehabilitation professionals set less aggressive patient goals for older persons and question their vocational rehabilitation potential. Bartak, Kbitek, Shaver, Blood, and Shepard (1986) found that when therapists responded to a description of a hypothetical older patient, they were significantly less aggressive in their treatment goal setting than when responding to a description of a hypothetical younger patient. For example, the treatment goal of returning to work (full-time) was included for 96% of the younger patients but for only 44% of the older patients. The issue of age bias must be addressed in all health care professions, rehabilitation in particular. Older patients may internalize the therapist’s judgment of their capabilities and thus prevent themselves from realizing their full rehabilitation potential (Becker & Kaufman, 1988).

As the U.S. population ages, with attendant increases in chronic illness, disability, and institutionalization, remedies will be sought that can both lessen the social cost and improve the quality of life of elderly persons. Each of the five titles of the ADA provides a means by which older persons can more fully participate in a productive and independent life. Some of the roles an occupational therapist may play in implementing the ADA for older persons include providing education concerning rights and opportunities, creating accommodations for disabilities, modifying programs and services to maximize inclusion, and decreasing environmental barriers to full access and participation.

Title I: Employment

Title I of the ADA prohibits discrimination against disabled persons in the workplace. Employment practices such as hiring, continued employment, promotions, and return to work are also covered under the ADA (Verville, 1990). It requires reasonable accommodations such as architectural modification, job restructuring, and flexible work times suited to the needs of the disabled worker.
Older workers are disproportionately designated as disabled. Two thirds of Social Security Disability Insurance recipients are older than age 50 (Morrison & Magel, 1984). Although only 26% of the American work force is 45 years of age or older, those older workers experience 71% of the disabilities that last 5 months or longer (Matheson, 1990). However, it is a decreasing ability to perform job functions, not on-the-job injuries, that is the major cause of early retirement. Work injuries do not increase with age and are actually proportionally higher for workers in the 20- to 34-year-old group. Hester, Decelles, and Hood (1986) reported that only 20% of disabled workers in the 55- to 64-year cohort enter the disability support system because of injury, whereas 41% enter because of a progressive impairment.

The factors that lead to early retirement (and disability retirement) are frequently related to the type of functions that a job requires. Burtless (1987) analyzed the Longitudinal Retirement History Survey (LRHS) data of male workers in more physically demanding jobs versus less physically demanding jobs and found that in the age range of 58 to 72 years, 7% fewer blue-collar workers than white-collar workers are employed full-time (and 3.6% fewer part-time). The blue-collar differential increases in the 62 to 64 years age bracket. Burtless (1987) concluded that professional, managerial, clerical, and sales occupations have the greatest career longevity, men in crafts and service occupations retire at an intermediate age and farmers and laborers tend to leave the work force at the youngest age. Blue-collar workers are more affected by physical work limitations and poor health and leave the labor force far more frequently than do white-collar workers. Many such workers could remain productive if given the opportunity to work part-time, have flexible schedules, or transfer to less strenuous or different responsibilities (Crystal, 1988).

**Occupational Disability**

The progressive occupational impairment experienced by older workers that most frequently leads to disability or early retirement or both was defined by Matheson as “a gradual decrease in ability to perform substantial gainful activity” (1990, p. 1). Older American workers (55 years of age and older) experience a disproportionately high rate of progressive impairments that are severe enough to cause functional limitation leading to occupational disability. Matheson (1990) described the “routes” through which progressive occupational disability occurs:

1. Impairment that is aggravated by the cumulative effect of job tasks beyond the functional limitations of the older worker (especially with impairments due to upper extremity continuous trauma). Composed of a wide variety of arthritic problems, in addition to damage to periarticular tissues, impairment is primarily caused by a mismatch between the older worker’s functional capability and the job’s demands.
2. Impairment that worsens because of gradual physical deconditioning through the inactivity of the older worker.
3. Functional limitations that increase because of inappropriate adaptation. For example, impairment in one hand leads to overuse of the other hand to such a degree that a new impairment is developed that leads to occupational disability.

Awareness of these routes through which occupational disability occurs will allow for the early identification of workers with progressive impairments that result in permanent disability and early retirement. Work site changes mandated by the ADA, such as providing job analysis and matching the job to the worker as the capacities of the worker change during the aging process, will allow cumulative trauma disorders to be anticipated and prevented.

**Forced and Early Retirement**

Matching the job and the work site to the worker will both prevent injury and allow for the return of disabled workers to employment. Occupational therapists with knowledge of aging, cumulative trauma, physical and job performance analysis, and work site modifications can assist employers in making workplace accommodations enabling older workers to stay on the job. As work site policy and procedural changes are being planned, ADA information provided to employers should include considerations that promote the continued employment of the older worker.

Older workers with disabilities are more likely to believe that they are expected to retire (Kemp & Kleinplatz, 1985; Mitchell, 1988). This decision is often irreversible even if they later reconsider it. Many disabled older workers are fearful of jeopardizing their benefits if they do return to work and fail to maintain expected job performance. The opportunity to return to work part-time, to a modified job task, or to a different job may greatly reduce the number of people forced into early retirement.

Older persons with acquired, age-related disabilities, such as stroke and heart conditions, often experience the same difficulties in returning to work or continuing employment as do older persons with on-the-job injuries. For example, in a comparison of the occupational status of stroke survivors in the United States and Sweden, Fugl-Meyer (1980) revealed that whereas 40% of the Swedes returned to some form of employment (including part-time work), none in the United States group returned to any form of work. The scarcity of part-time positions and shorter rehabilitation periods in the United States are believed to account for this difference.
Older employees are often pressured into early retirement because of an assumed decline in competence. By performing a job analysis to determine the essential functions of a job, employers can more adequately determine an older person's ability to perform job-related functions (Maffeo, 1990). If there is a functional decline, the ADA requires employers to determine whether other employment options are available to older employees.

A National Health Interview Survey (Kovar & LaCroix, 1987) studied the work-related activities of the noninstitutionalized population in the 55- to 74-year-old age group, and described their ability to perform activities that are common to a variety of occupations. The items studied were mobility, endurance for confined movement, lower and upper body strength, freedom of movement, and fine motor skills. Overall, 58% of the subjects who were workers had no difficulty with any of the 10 work-related activities (Kovar & LaCroix, 1987).

Evaluating the requirements of a job often leads to the realization that many valuable workers are physically or psychologically unsuited to many specific jobs. As McFarland (1973) pointed out, few persons are physically suited to pilot airplanes, work on docks, tend blast furnaces, and do heavy construction work in adverse weather. Conversely, most persons with some limitations have capacities that can and should be used in gainful employment. Required, at any age, are adequate methods for matching the physical and psychological requirements of a job with the physical and psychological capacities of the worker (McFarland, 1973). Every worker needs assurances that job requirements will not exceed his or her physiological and psychological capabilities. The enforcement of such assurances, supported by ADA mandates, can increase efficiency and reduce the potential for work injury. Even though the current trend is for earlier voluntary and involuntary retirement, work is an economic necessity for many older people, especially for those who live alone. Seventeen percent of single men and 15% of single women older than 65 years of age continue to work. These figures are nearly 50% higher than those for married persons over 65 (Kasper, 1988).

ADA requirements of workplace adaptation, writing functional job descriptions, and matching the job to the worker should also reduce premature retirements among persons who have had a stroke, heart attack, or cancer. When an employee reaches the age of 40, he or she may also be covered by provisions of the Age Discrimination in Employment Act of 1967 (Public Law 90–202) and subsequent amendments (commonly known as the ADEA). This act protects older workers from discrimination with respect to hiring, dismissal, or reclassification in any manner that adversely affects their status as employees. The older employee with a disability who has a complaint of discrimination can seek a legal remedy under either the ADA or ADEA, depending on which is most favorable to the situation.

Of particular importance to older Americans, the ADA designates that the term disabled covers illnesses, even after recovery; chronic diseases; and terminal conditions. Many workers with chronic diseases such as asthma and heart disease avoid informing their employers of their condition for fear of job discrimination. Under the ADA, as long as an illness does not prevent an employee from doing his or her job, any discrimination due to health condition is unlawful.

The ADA also requires that the workplace allow for management of diseases. For example, companies must provide persons with diabetes with appropriate places and times for blood glucose monitoring, insulin injections, and dietary adherence. The rate of absenteeism for workers with diabetes is no higher than for the rest of the work force; however, many have trouble finding and keeping a job. Most jobs can be performed by persons with diabetes if they are given time to manage their disease. Persons with cardiovascular disease and asthma need to be allowed time to follow dietary requirements or the opportunity to retreat from stressful situations.

Occupational therapists are a primary source of education for the accommodation of chronically and terminally ill workers. For example, many employers assume that persons with cancer will be unable to perform their jobs, yet persons newly diagnosed with a terminal illness can often go on working for many years.

It is important to demonstrate to employers that what is beneficial for the worker with a chronic illness is also beneficial for the entire work force and cost-effective in the long term. More effective management of these persons in the workplace can lead to lower health care costs for both the company and the worker who has the disease.

The ADA also protects relatives and caregivers of disabled persons from discrimination. These provisions are especially pertinent to caregivers of older disabled family members. Caregivers are due all the same rights and protections provided to disabled workers, that is, freedom from discrimination in hiring, promotion, and dismissal. Although still untested in the courts, reasonable accommodation of caregiver responsibilities may include flexible work scheduling, time off, and adaption of the home for a combination of work duties and caregiving duties.

Title II: Public Services

Under Title II, all public bus and rail services must make accommodations that will enable persons with disabilities to use their services. The enforcement dates of the sections of this title go into effect gradually from August 25, 1990 to July 2010. Title II expands the transportation options beyond the current paratransit systems, vans that run on demand to take passengers wherever they need to go. Because the ADA requires public trans-
portation authorities to provide paratransit services to disabled persons living near fixed routes, there is concern that older riders without disabilities who use paratransit systems may lose their places on the vans to make room for those classified as disabled under the ADA (American Association of Retired Persons [AARP], 1992–1993). If this happens, care must be taken to ensure that older persons know how to use public transportation and feel safe doing so.

Transportation is essential to the older person's quality of life. Especially in the United States, losing the ability to drive can be a serious handicap. A lack of access to public transportation can prevent persons from using ambulatory health care services. Studies cited by Wan (1987) show that approximately 7% of noninstitutionalized elderly persons with severe impairments would benefit from ambulatory health care services but were not receiving them. Under Title III, terminals for public transportation will be required to provide several forms of accommodation for disabilities commonly experienced by older persons, such as decreased endurance, sensory impairments, and mobility impairments. In the role of consultant, the occupational therapist can recommend reasonable accommodations that will provide greater safety and access for older persons with disabilities. These may include enlarged lettering on schedules and maps, low vision aids for reading small print, visual images of audio messages, wheelchair accessible entry and loading areas, visual and texture contrasts for stairs and walkways, illuminated handrails on stairways, reduced glare lighting, raised buttons and grab bars for elevators and lifts, telephones with volume control, and training for drivers and employees concerning the needs of the older passenger (Kershaw & Boda, 1989).

Occupational therapists can be instrumental in assuring that transportation centers, stations, and vehicles meet the needs of older persons with disabilities, by participating in the planning and design process in partnership with older consumers with disabilities. Title II has specific uniform regulations covering transport provided by public entities. Occupational therapists can provide transportation systems with insight into the needs of elderly travelers as well as technical information concerning the regulatory requirements of Title II.

Education of the older consumer is of primary importance in the realization of the rights protected by each of the Titles. Occupational therapists can educate and train older persons to use public transportation with confidence.

**Title III: Public Accommodations**

Title III affects all entities whose operations involve commerce. The statute enumerates 12 categories of public accommodations: (a) hotels, places of lodging; (b) restaurants; (c) movies, theaters; (d) auditoriums, places of public gathering; (e) stores; (f) banks, health care service providers, hospitals, pharmacies; (g) terminals for public transportation; (h) museums, libraries; (i) parks, zoos; (j) schools; (k) senior centers, social service centers; and (l) places of recreation. Those entities are required to make readily achievable accommodations for persons with disabilities. Title III ensures that older patrons with functional limitations have equal access to goods and services through the modification of structural or programmatic barriers or customized service practices. As of January 1992, more than 5 million private institutions that had no previous experience with this type of regulation were required to provide access and services to all persons with disabilities, regardless of age (Flannery, 1991). The combination of Titles II and III can enhance the current lifestyles of many elderly persons with disabilities. Title II will allow them to reach their destinations and Title III will enable them to participate fully once they arrive.

Title III also mandates access as well as accommodation for communication. The person with disabilities must be given the opportunity to see, hear, and understand what is going on. Insight and understanding of the functional deficits in older adults enables the occupational therapist to recommend design considerations or adaptations to accommodate for sensory limitations. Sensory changes increase as persons grow older and are usually compounded by the simultaneous occurrence of physical and cognitive changes. Age-related auditory deficits include a decreased ability to hear sounds in general and high-frequency sounds in particular. Distinguishing pertinent sounds from background noise is also more difficult for persons with even mild age-related hearing loss. Environmental accommodations that can enhance hearing make use of various acoustical materials, such as carpeting, draperies, and wall hangings (Christenson, 1990).

Age-related visual impairments often include a decreased ability to see objects clearly and to judge distances accurately. Occupational therapists providing consultation in low vision and visual impairment may recommend environmental modifications and accommodations that address lighting, including transitional lighting and color contrasts in halls or stairways, as well as treatments that increase illumination and reduce glare. Color contrasts and tactile cues can be used to identify important items (i.e., fire extinguishers), to direct traffic, or to enhance perception of the depth, size, or distance of objects.

Decreased endurance is frequently overlooked in the design of environments and accommodations for the older person. For many, the opportunity to sit and rest is an essential part of performing an activity. Consulting occupational therapists may assist in identifying the optimal location of benches, chairs, and raised platforms in public facilities, such as shopping malls, where walking and standing is required. In addition to architectural and technological accommodations, occupational therapists
can help businesses become more attuned to the older customer by suggesting informal courtesy measures, such as having employees available to assist patrons with reaching and carrying (Allen, 1990). Other services that businesses can provide at little or no cost include clipboards, so that wheelchair or cane users can more easily sign checks or credit slips; wheelchair or motorized scooter loan services; special assistance for persons with cognitive impairments; and brochures printed to identify the locations of rest areas, phones with amplifiers, and accessible restrooms. What exactly the ADA will mean to homebound persons is still in question, as the lines continue to be drawn on how far businesses must go to serve these persons.

It is difficult to determine which of the various assisted living programs providing long-term care for elderly persons fall under the purview of the ADA without looking at some of the nonhousing aspects of a housing facility's operation. The ADA is fairly straightforward in its coverage of some of these operations, including a housing project's employment practices, the commercial establishments it houses on its campus, and the services and facilities it opens to the public. However, most of these facilities with mixed uses are covered (fully or partially) by other federal disability statutes.

Title III of the ADA is the fourth major piece of federal legislation that deals with disability rights relating to housing and related services used by elderly persons. The first, the Architectural Barriers Act of 1968 (Public Law 90–480), and the 1973 Section 504 of the Rehabilitation Act (Public Law 93–112) require programs and buildings that receive federal funds to be accessible. The Fair Housing Act, as amended in 1988 (Public Law 100–420), established accessibility requirements for all housing with four or more units. The Fair Housing Act includes a provision that limits the ability of residential facilities to screen prospective residents. Under this law, landlords are prohibited from asking prospective residents whether they are capable of living independently because the question tends to screen out people with disabilities. This provision has led to problems for providers of assisted living programs for elderly persons. Continuing Care Retirement Communities (CCRCs) are currently struggling with this stipulation because entrance fees, space, and services have been based on the actuarial assumption that a resident will enter the CCRC in a relatively healthy condition and live independently for a number of years before requiring higher levels of care. CCRCs complain that the inability to screen applicants to achieve a balance of independent and frail residents threatens the institution’s financial solvency. Housing specifically covered by or exempted from the Fair Housing Act is excluded from the provisions of the ADA. Some of the nonhousing aspects of a facility’s operation will likely be covered by the ADA in most cases. Therefore CCRCs, like many residential programs, are covered by both the FHA and ADA (AARP, 1992–1993). Providers of assisted living programs would prefer to be covered only by the ADA as a medical service, but a recent ruling by the Department of Housing and Urban Development (HUD) confirmed that retirement communities are covered by the Fair Housing Act Amendments. Facilities viewed as medical service centers under the ADA are allowed to screen to assess the health of prospective residents to determine whether services offered in the facility are appropriate to the person. Similar screenings are allowed by medical facilities, such as hospitals and nursing homes.

The issue of whether nursing facilities are subject to Title III of the ADA depends on how they are characterized. However, when the totality of the services they provide and people they assist is considered, it becomes clear that Title III is applicable to most nursing facilities, thus they are required to provide accommodations for disabled residents and to eliminate programmatic and structural barriers.

The argument that the ADA applies to nursing facilities finds its greatest support in the preamble to the regulations implementing Title III regarding length of stay. In general, the ADA covers short-term residential stays, whereas Fair Housing covers long-term residences. If a facility allows, but does not have, separate units for both residential and short-term stays, it is subject to the ADA and the FHA. Because nursing facilities usually have a mix of residents and provide social services, it is generally held that accommodations must be made for residents under the ADA (AARP, 1992).

Title III states that public accommodations may not impose eligibility criteria that exclude persons with disabilities. For example, a common practice in long-term care facilities is the segregation of elderly persons according to their disabilities and use of mobility devices. Elderly residents have also been arbitrarily assigned to senior centers, apartments, assisted living quarters, or nursing facilities without regard to their abilities. Such discrimination violates Title III of the ADA, which guarantees older persons with disabilities “full and equal enjoyment” of programs in the most integrated setting appropriate to their needs. Older persons with disabilities are entitled to participate in all activities to the same extent as persons without disabilities, even if they cannot achieve the same result. Separate programs or benefits designed specifically for older persons with disabilities are also prohibited, unless they are deemed necessary to allow them the opportunity to participate. A public accommodation cannot impose eligibility criteria that directly exclude or screen out persons with disabilities, unless the criteria are necessary for the provision of goods or services. Similarly, eligibility criteria imposed for safety considerations must be based on actual risks and not on generalizations or assumptions about potential dangers. For example, a civil suit in Maryland used both the ADA and the Fair Housing Act to challenge the eviction of two older women from a
group home. Both women have mental disabilities and use wheelchairs. This case challenged a licensing regulation requiring that residents be able to exit the building without assistance in emergency situations (AARP, 1992-1995). Attorneys representing the plaintiffs pointed out that such broad regulations are based on generalized rules that stereotype persons with disabilities. Because many long-term care, health care, and residential programs use similarly arbitrary criteria for admission or continued stay, more civil suits may be forthcoming.

Occupational therapists, knowledgeable about the relationship between Title III and associated regulations and amendments such as the Rehabilitation Act (1973 & 1986, Public Laws 93-112 and 99-506) and the Fair Housing Act (1973 & 1988), can provide consultation that is sensitive to the needs of both elderly persons with disabilities and the institutions that serve them. The Uniform Federal Accessibility Standards (Architectural and Transportation Barriers Compliance Board, 1988) presents the requirements for design, construction, and alteration of buildings.

Certain types of long-term care services are exempted from Fair Housing and ADA statutes. Excluded from coverage by both laws are facilities owned by religious organizations. The regulations indicate that the exemption is very broad, so that a day care center or nursing home operated by a church would not be subject to the ADA, even if it were open to the public. However, if an adult day care center that was not a religious entity rented space from a religious organization, then it would be considered a public entity and not exempt.

Title IV: Telecommunication

Diminution of some or all of the senses is a recognized consequence of aging, hearing loss being one of the most prevalent. A 25% reduction in speech comprehension occurs between age 50 and 80 years with prescycosis, the most common cause of bilateral hearing impairments among the elderly. The reduction is particularly noticeable with complex, rapid patterns of speech (Dawson et al., 1987). Both visual and hearing impairments rank among the 15 most prevalent chronic conditions in Americans aged 65 years and older. Hearing losses often lead to disability, social isolation, depression, cognitive loss, and psychosis (Macken, 1986).

Title IV requires all intrastate and interstate phone companies to establish telecommunication relay services, effective July 1993. Thus, any person with a communication disability can use this relay system for routine or emergency situations, at no additional cost. A network of operators who assist those using telecommunications devices for the deaf (TDDs) has been established. Operators act as a voice interpreter if the receiving party does not have a TDD. Title II requires all emergency service centers to have both TDDs and computers (Wolffe, 1991).

Even though 25 states currently have TDD distribution programs and 17 states have dual-party relay systems, many older persons do not access this service because they either do not acknowledge having a hearing problem or they are unaware that telecommunication systems and devices are available for their type of impairment. However, this system can provide access to greater communication with friends and family, lessening social isolation.

To educate older persons on the effects of hearing loss and introduce them to available assistive devices, occupational therapists, among others, can develop libraries of information on communication impairments, assistive devices, adaptations, and information on rights and options under the ADA. Because many elderly have both visual and hearing impairments, accommodations for multisensory losses must be considered when choosing devices to assist in communication (Segalman, 1991).

Summary

The Americans With Disabilities Act holds promise for improving the quality of life for older Americans. The law is designed to end discrimination that prevents persons with disabilities from enjoying all aspects of life, from work, to recreation, to tasks essential for daily living. It can also aid in improving our perception of the older person's capacity to make a continuing contribution to society. With its provisions to make everything from transportation and businesses to housing and health services more accessible, the ADA promises to help older persons remain in their homes longer as they encounter age-related disabilities. Accommodations at work sites will enable these older adults to continue working in paid and voluntary positions.

Fully implemented, the ADA gives older persons with physical and mental disabilities the opportunity to live in less restrictive settings. It offers some of the greatest gains to frail elderly persons who are only able to maintain their independence in the community through a delicate balance of services and supports. The statute also protects elderly persons who reside in nursing facilities, entering disabled residents to full participation appropriate to their needs and capabilities. Fundamental to the implementation of the ADA is the understanding that "separate but equal" services will not satisfy the requirements of the law. The goal is integration of persons with disabilities into everyday life to the greatest extent possible.

A number of barriers prevent older persons from benefiting from the ADA. Many are unaware of the law or their rights under the law or may not view themselves as disabled. According to a survey conducted by the National Senior Citizens Law Center (AARP, 1992), even agencies and organizations that work with the elderly have a limited understanding of the ADA. Respondents reported an...
overall need for training about the ADA, increased information about accommodations for older persons with physical and cognitive disabilities, and techniques to promote independence and empower these persons. Occupational therapists can serve as consultants to state and local agencies, providing staff member and consumer education and acting as a resource when expertise in accommodations as covered in the Act is needed.

It is only when older persons and their advocates become familiar with the ADA that they will seek its application to the widest variety of situations intended under the law. To ensure that older people with disabilities have comprehensive protection from discrimination requires the participation of all occupational therapists who work with this population. This means that occupational therapists must maintain an ongoing collaboration with agencies and businesses that serve elderly persons.

A commitment to the principles of the ADA begins with full compliance in our own practices and facilities. We need to examine the availability of accommodations for age-related impairments in vision, hearing, endurance, and continence that restrict full participation. We must also include older persons as collaborators in designing and implementing accommodations for their needs.

The ADA has a legal as well as philosophical basis for advocacy in providing services to promote full participation of older adults and elderly persons with disabilities in society. The challenge for occupational therapists and other rehabilitation professionals is to continue developing services and models of care that improve and maintain function for older persons with disabilities, thus enhancing the quality of their lives and enabling them to remain integrated in their communities.

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Rehabilitation Act Amendments of 1986 (Public Law 99-506).


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