PATTERNS IN ALLEGATIONS OF WORKPLACE DISCRIMINATION FILED BY AMERICANS WITH SUBSTANCE USE DISORDERS UNDER TITLE I OF THE AMERICANS WITH DISABILITIES ACT

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The purpose of this study was to investigate the patterns in allegations of workplace discrimination by individuals with substance use disorders (SUDs). The goal of the research was to describe the discrimination, both actual and perceived, that has occurred against individuals with SUDs through analysis of the United States Equal Employment Opportunity Commission (EEOC) Integrated Mission System (IMS) database in comparison to a group of individuals with other physical disabilities (GENDIS) as defined by the Americans with Disabilities Act (ADA).

An ex post facto, causal comparative quantitative design was used with the EEOC IMS database to examine the ADA Title I complaints received by the EEOC from people with SUDs from 1992 through 2011 (n = 8,432) in comparison to the GENDIS group over the same time period (n = 82,618). Results revealed statistically significant differences in the pattern of issues alleged by the two groups. The SUD group was, on average, significantly younger, had a significantly higher proportion of males, had proportionally more individuals who identified as Caucasian and as Other, and proportionally fewer individuals who identified as Hispanic/Mexican and Asian than did the GENDIS comparison group. People with SUDs were significantly less likely than the GENDIS group to have their allegations result in a merit-based case resolution. Implications for counseling practice as well as counselor education and supervision are discussed.
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CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

This study was proposed to investigate the patterns in allegations of workplace discrimination by individuals with substance use disorders (SUDs), including both active and recovering users. The stigma of SUDs has a negative impact on the workplace environment, quality of life, and well-being of individuals with SUDs (Dunigan et al., 2014; Gold, 2004; Kerrigan, Kaough, Wilson, Wilson, & Bostick, 2004; Mak et al., 2015; Schomerus, 2014; Sprong, Melvin, Dallas, & Koch, 2014). The goal of this study was to describe the discrimination, both actual and perceived, that has occurred against individuals with SUDs through analysis of the United States Equal Employment Opportunity Commission (EEOC) database in comparison to a control group of individuals with physical disabilities as defined by the Americans with Disabilities Act (ADA).

The purpose of this study was to increase the body of research regarding these workplace discrimination experiences of individuals with SUDs by exploring the discrimination allegations made by individuals with SUDs under the ADA as part of the NEARP. Through a thorough investigation of the national EEOC database, the workplace discrimination experiences of individuals with SUDs are better understood within their context. Below is a list of definitions of key terms that were used throughout this study.

Definitions of Key Terms

The following definitions provide summary explanations of key terms that were used within specific contexts in this study.
**Americans with Disabilities Act (ADA)** - 1990 federal legislation designed to provide civil rights protections for people with disabilities in the areas of employment, public services, public accommodations, and communications.

**Charging party (CP)** - complainant with a substance use disorder or general disability who has file a claim with EEOC, under ADA Title I.

**Civil rights** - rights that all citizens of a society are afforded by virtue of membership in that society. Civil rights protections are implemented to ensure that people with different characteristics are not treated unfairly on the basis of prejudice, stereotypes, or negative attitudes toward groups of people.

**Complainants with SUD** - a person diagnosed with SUD who filed at least one of the 8,432 allegations under Title I of the ADA with the EEOC during the 1992-2011 observation period.

**Discrimination** - behavior that shows prejudice. Failure to treat people equally because of a bias based on characteristic such as race, religion, sex, gender, national origin, sexual orientation, and/or disability.

**Employment discrimination** - discrimination in job application procedures, hiring, firing, advancement, compensation, fringe benefits, or job training.

**Equal Employment Opportunity Commission (EEOC)** - EEOC is an independent federal agency created by Congress to enforce, educate, and provide technical assistance regarding all federal laws prohibiting employment discrimination, including the ADA, Title I.
**General disability population (GENDIS)** - represents 82,618 EEOC charges, under ADA Title I filed by individuals with asthma, chemical sensitivities, diabetes, disfigurement, missing digits or limbs, non-paralytic orthopedic impairment, and paralysis.

**Individual with a disability** - an individual who has a physical or mental impairment that substantially limits one or more of his/her major life activities; has a record of such impairment; or is regarded as having such an impairment.

**Integrated Mission System (IMS)** - database maintained by the EEOC to track all allegations of employment discrimination. Allegations filed under Title I of the ADA will be used to constitute this study’s dataset.

**Issues or allegations** - the primary unit of measure in this study is an allegation of employment discrimination filed by a person with a SUD or another disability (GENDIS) with the EEOC since the original effectuation of the ADA on July 26, 1992. Each allegation is treated as one distinct data point in the IMS system.

**Qualified individual with a disability** - an employee or applicant with a disability who has the necessary skills, education, experience and other job related requirements to perform the essential functions of a position.

**Reasonable accommodations** - any change or adjustment to a job or work environment that permits a qualified applicant or employee with a disability to participate in the job application process, to perform the essential functions of a job, or to enjoy the benefits and privileges of employment equal to those enjoyed by employees without disabilities.

**Resolution** - this refers to the final EEOC determination as to whether or not discrimination actually occurred. Resolutions are dichotomously classified as Merit, favoring the
charging party (a determination that discrimination did occur) or Non-Merit, favoring the respondent employer (a determination that discrimination did not occur).

**Respondent** - employer who is responding to a filed EEOC allegation of employer discrimination, under ADA Title I.

**Substance Use Disorder (SUD)** - when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

**Vocational Rehabilitation (VR)** - a federally funded program administered by states to provide career planning, vocational training, postsecondary education, job placement, and job retention services to Americans with disabilities.

**Substance Use Disorders**

Substance use disorders (SUDs) are among the most prevalent and severe mental health conditions in the world, with an estimated 76.3 million people worldwide experiencing substance use issues (Schomerus, 2014). Alcohol abuse alone has been estimated to account for 4% of all deaths and 5% of disability adjusted life years (Schomerus, 2014). In the U.S., substance use accounts for an average of 105 overdose deaths each day along with 6,748 individuals seeking emergency treatment for drug related issues (Medicaid, 2017). It was reported in 2010 that drug overdose was the leading cause of injury death in the U.S. and was more lethal for individuals 25-64 years of age than motor vehicle accidents (Medicaid, 2017).

Currently in the U.S. it is estimated that about 47 percent of adults experience serious negative consequences as a result of an addictive disorder over a 12-month time period, with a 23 percent co-occurrence (of two or more addictions; Sussman, Lisha, & Griffiths, 2011).
According to Sussman and colleagues (2011), the 12-month prevalence of addictive behaviors with substances are as follows: cigarettes—15%, alcohol—10%, and illicit drug use—5%, with the remaining 17% being attributed to addictive behaviors in the areas of eating, gambling, internet use, love, sex, exercise, work, and shopping (p. 13). There are two areas of classification for addictive behaviors, namely, (a) SUDs, or addictive disorders specific to the use of alcohol and other drugs, and (b) process addictions. Process addictions, rather than involving use of a substance, are defined by a series of pathological behaviors that expose individuals to mood-altering events through which they experience a sense of pleasure and become dependent. Of the general population in the U.S., it is estimated that SUDs affect 9 percent of people 12 and older, accounting for 22.3 million individuals (Sprong et al., 2014). The National Institute on Drug Abuse (NIDA, 2015) reported that the abuse of tobacco, alcohol, and illicit drugs costs American society more than $600 billion each year related to crime, lost work productivity, and healthcare. The effect of addiction on individuals, families, and society accounts for the attention that this disability garners from a variety of specialists such as medical professionals, mental health professionals, rehabilitation professionals, and public health officials.

Addictive disorders, whether specific to alcohol, tobacco, or other illicit drugs, are defined as conditions that occur in a complex pattern of biological and psychological rewards, resulting in an uncontrollable compulsive behavior. The presence of addictive behaviors is thought to be a result of a complex combination of biological, environmental, and psychological factors. This pattern is generally regarded as having three main components: (a) a biological reward for a behavior, followed by (b) the repetition of such behavior in a compulsive manner, leading to (c) an eventual loss of control over the occurrence of the behavior (Sussman et al., 2011).
In the first phase of addiction, an individual becomes “intensely preoccupied with a behavior that at first provides a desired or appetitive effect” (Sussman et al., 2011, p. 1). The desired effect is attributed generally to the reward pathways of the brain, contained within the mesolimbic dopaminergic system, as well as a complex combination of other neurotransmitters and hormones thought to be involved in the reward process such as serotonin, norepinephrine, hypothalamic-pituitary-axis (Sussman et al., 2011). The next step is characterized by the reward seeking behavior occurring in several repetitions, becoming an increasingly compulsive behavior mediated by a “compulsive circuit (nucleus accumbens, ventral pallidum, thalamus, and orbitofrontal cortex)” (Sellman, 2010, p. 7). Finally, the compulsive behavior is identified as an addictive disorder when the individual demonstrates a “loss of ability to choose freely whether to stop or continue the behavior (loss of control) and leads to experience of behavior-related adverse consequences” (Sussman et al., 2011, p. 2).

**Etiology and Course**

In regard to the etiology of addiction, research on the genetics of addiction has supported the idea that there is a significant heritability factor in addiction. Heritability does not refer to one specific, or even a few primary genes, but rather to a complex combination of hundreds of different genetic markers (Sellman, 2010; Thombs & Osborn, 2013). Heritability estimates for SUDs generally range from 40 percent to about 60 percent, whereas estimates for specific substances have been reported at 40 percent for hallucinogens, 70 percent for cocaine, and over 50 percent for alcohol (Sellman, 2010). Addiction, thus, cannot be defined by “nature” alone, but must be considered in the context of other complex macro and micro level “nurture” factors such as intrauterine experience, past traumatic life events, disability status, other mental and
physical health issues, family disadvantage, social and cultural influences, and public policy (Sellman, 2010; Thombs & Osborn, 2013).

A refined model of addiction that emphasizes the interaction of genetic, biological, and social interactions is needed to fully understand the origins of addictive behaviors. This paradigm emphasizes a “nature via nurture” rather than a “nature vs. nurture” orientation. An individual with potential genetic susceptibility to substance addiction may never necessarily be exposed to a particular substance; therefore, it is generally accepted that social and familial factors play a larger role in the initiation of substance use. The continued use of a substance, or maintenance of substance use patterns, on the contrary, is viewed to be much more dependent on genetic and biological factors (Thombs & Osborn, 2013).

Although researchers have made several inroads in exploring the etiology of SUDs, much is still unknown, which has led to continuous debates regarding the nature of addiction. One common model used to explain addiction, particularly among self-help groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), is the disease paradigm (Thombs & Osborn, 2013). The disease model, rather than being one specific conceptualization, is comprised of several different perspectives that emphasize the heritability of addiction, referred to as the susceptibility constructions, and others that emphasize the biological changes in the structures of the brain when exposed to different substances, denoted as the exposure constructions (Thombs & Osborn, 2013). Two most commonly espoused symptoms of addiction in the disease model are tolerance and withdrawal. Tolerance refers to the process by which individuals must use increasingly greater amounts of a substance to achieve the sought-after results, whereas withdrawal is used to describe the negative physiological symptoms that occur
when an individual’s blood or body tissue concentrations of a specific substance decline following an extended period of substance use (Thombs & Osborn, 2013).

SUDs typically follow a chronic and relapsing course for most individuals. Evidence has suggested that, although many individuals with SUDs experience periods of significant improvement and stability, fewer than 10 percent of people who experience alcohol or other drug addiction will have continuous long-term abstinence (Sellman, 2010). The relapse rate, regardless of physical dependence, has been reported at over 70% for any given 12-month period (Sussman et al., 2011). For these reasons, SUDs are often compared to three other common types of chronic medical illnesses: Type 2 diabetes, hypertension, and asthma. As with these three diseases, individuals with SUDs experience comparable rates of symptom recurrence and relapse as well as similar rates of treatment adherence. Individuals with these chronic conditions have been found to adhere to diet and/or behavioral recommendations only about 30 percent of the time (Sellman, 2010).

White (2012), who conducted a meta-analysis of 415 scientific studies that examined recovery/remission rates for people with SUDs, reported that an average of 49.9 percent of adults who once met lifetime criteria for SUDs no longer meet those criteria. Of note is that only 17.9 percent of these individuals achieved recovery/remission through complete abstinence based treatment. Most of the non-abstinent remissions occurred within community-residing populations, where SUDs may be less severe.

What is meant by the term “recovery?” Whether an individual with a SUD can fully “recover,” or, rather, achieve long-term remission continues to be debated. Several brain imaging studies provide support for the utility of abstinence in the recovery process. Studies of the effects of substance use on the brain have indicated that prolonged use can have detrimental
consequences in cognitive functioning, neurotransmitter functioning, and general 
neurophysiological functioning (Mon et al., 2014; Rosenbloom & Pfefferbaum, 2008; van Eijk, 
Demirakea, Frischknecht, Hermann, Mann, & Ende, 2013; Wang, Volkow, Thanos, & Fowler, 
2004). Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) imaging 
has demonstrated that through sustained abstinence, some aspects of cognitive and 
neurophysiological functioning can significantly improve, some within even the first 14 days, 
while other deficits tend to be more enduring and irreversible (Mon et al., 2014; Rosenbloom & 
Pfefferbaum, 2008; van Eijk et al., 2013; Wang et al., 2004). Evidence of neurophysiological 
recovery supports the notion of some form of recovery, whereas the lasting deficits further 
substantiate the disease model of addiction.

**Definition and Diagnosis of Substance Use Disorders**

The definition of SUD varies depending on the who is defining it and the functional 
purpose of the definition. Many terms have been used previously to describe a person 
experiencing addictive issues as a result of alcohol and other drug use. Some of those terms 
include addict, alcoholic, substance abuser, substance dependent person, and individuals with 
alcohol and other drug (AOD) disorders, to name a few (Linton, Campbell, & Gressick, 2016).

For the purpose of uniformity and to avoid any stigmatizing labels, SUDs, defined as “when the 
recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, 
such as health problems, disability, and failure to meet major responsibilities at work, school, or 
home,” will be used in this paper to refer to all alcohol and other drug related impairments 
(SAMHSA, 2017).

**Definitions.** From a legal perspective, it is important to understand the definitions 
contained in the ADA. Under the ADA, disability is defined in a three-pronged manner as:
a) a physical or mental impairment that substantially limits one or more major life activities of such individual;

b) a record of such an impairment; or

c) being regarded as having such an impairment (Lowe, 2016).

SUDs are covered under this definition, but with several specific exceptions. In the case of alcohol use, a person with an alcohol use disorder is covered under ADA if she or he is qualified to perform the essential functions of the job, but is not protected for any use of alcohol that affects job performance or renders the employee not “qualified” (EEOC Technical Assistance Manual, 2002). An individual actively using illegal drugs is not protected by ADA, but those who are not currently using and those who have been “rehabilitated” are protected under ADA on the basis of past substance use (EEOC Technical Assistance Manual, 2002; Rubin, Roessler, & Rumrill, 2016).

The EEOC database, the IMS, has two categories representing SUDs. The first category, alcoholism, is defined in the codebook as being characterized by addiction to alcoholic beverages including both current and recovering “alcoholics.” The second category, drug addiction, is defined as being characterized by addiction to a controlled substance or illegal narcotic, including both current and recovering drug addicts. These two categories were combined for the purpose of this study to represent the population of individuals with SUDs.

**Diagnoses.** Medically, the diagnosis of SUD has varied over time, and, for mental health professionals, the definition contained in the Diagnostic and Statistical Manual (DSM) has generally guided this process. The release of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) marked several changes in how SUDs are diagnosed (American Psychiatric Association, 2013). These changes were made in efforts to improve the
validity and utility of substance use diagnoses from the previous diagnostic criteria of the DSM-IV. The main changes made to the DSM-5 substance use diagnosis were the omission of the “recurrent legal problems” criterion, the addition of a “craving” criterion, and the combining of the abuse and dependence diagnoses to be replaced by new mild (i.e., two or three of the 11 criteria met), moderate (i.e., four or five criteria met), and severe (i.e., six or more criteria met) categories (Peer, Rennert, Lynch, Farrer, Gelernter, & Kranzler, 2013).

Co-Morbidity

SUDs can be categorized both as mental health disorders and as disabilities, but they are unique in the rates of co-morbidity with both disabilities in general, and other mental health conditions. Individuals with disabilities are particularly susceptible to experiencing SUDs when compared to the general population (Sprong et al., 2014). In fact, data suggest that SUDs occur at rates 200 to 400 percent greater in people with disabilities than in people without disabilities (Sprong et al., 2014). The rate of SUDs varies depending on the type of disability; for example, the rates for persons with spinal cord injury, vision impairments, amputations, and traumatic brain injuries range from 40 to 50 percent. Sprong et al. (2014) suggested several potential reasons for the high prevalence of SUDs in people with disabilities including the following:

a) Medication and health problems

b) Societal enabling

c) Lack of identification of problems

d) Lack of identification of accessible and appropriate prevention and treatment services (p. 4).
Approximately 8.9 million people diagnosed with mental health disorders also experience SUDs, accounting for roughly 40 percent of all SUDs (Sprong et al., 2014). Padwa, Larkins, Crevecoeur-MacPhail, and Grella (2013) reported that between 20 and 50 percent of consumers presenting for mental health treatment have experienced a SUD in their lifetime, whereas over 50 percent of those with SUDs have had a mental health disorder. Sellman (2010) cited multiple studies indicating that the comorbidity of psychiatric disorders for individuals with SUDs was from 75 to 90 percent with the most common diagnosed mental disorders being social phobia, major depression, and post-traumatic stress disorder.

**Disability Stigma**

Overall people with disabilities, whether SUDs or other mental or physical impairments, have experienced more stigma than any other group in human history (Corrigan, 2014; Smart, 2016). Not only has disability been present in all societies throughout human history, it has been stigmatized in most, leading to atrocities such as the murder of children with disabilities, the forced sterilization of persons with disabilities, institutionalization, and genocide (Corrigan, 2014; Smart, 2016). In the United States, persons with disabilities are two times more likely than persons without disabilities to be unemployed, three times as likely to live in poverty, twice as likely to drop out of high school, two times as likely to have inadequate resources such as transportation and healthcare, more likely to encounter employment discrimination, and less likely to eat out, socialize, or attend a religious service (Smart, 2016).

The basic components of stigma include stereotyping, prejudice, and discrimination. Prejudice was defined by Allport (1954) as “an avertive or hostile attitude toward a person who belongs to a group simply because he belongs to that group, and is therefore presumed to have the objectionable qualities ascribed to the group” (p. 7). In this context, prejudice toward
individuals with SUDS are attitudes and beliefs held by a person ascribing negative qualities to those with SUDs. In an effort to conceptualize the basis of these unjust attitudes toward people with disabilities, Smart (2016) identified nine different sources of this prejudice, including:

a) the salience of the perceived defining nature of disabilities,

b) distressed identification,

c) economic threat,

d) safety threat,

e) ambiguity towards people with disabilities,

f) overgeneralization of the effects of disability,

g) moral accountability for the cause and management of disability,

h) an emphasis on beauty, fitness, and youth,

i) the fear of acquiring a disability.

The first source, the salience of the perceived nature of disability, refers to the phenomenon whereby a person regards another individual’s disability as the most important, and, at times, the only aspect of the individual. Regarding substance use, a person with a SUD may be viewed primarily for her or his addiction and may be referred to as an “addict” or an “alcoholic” (Schomerus, 2014). The other qualities of that individual, such as age, gender, educational level, or personality qualities, are generally overlooked, thereby exaggerating the difference between someone with and someone without a SUD (Smart, 2016).

Distressed identification, sometimes called inferred emotional consequence of the disability, happens when a person automatically assumes that an individual’s disability is the worst aspect of that individual’s life, an unending tragedy. Although managing a SUD may certainly be difficult, that difficulty does not necessarily imply it is “tragic” or even “bad.”
Further, distressed identification is characterized by a belief that the person with the SUD must have a low self-worth and have low worth to others as well (Smart, 2016).

It is not uncommon for people with disabilities to be viewed as both an economic and safety threat to society. In terms of economic impact, the arguments typically stem from the loss of tax dollars from lack of employment, the government money spent on disability programs, and increased insurance premiums. These attitudes tend to place a monetary value on an individual and determine value based on an individual’s ability to produce profit, however, it is much easier to attempt to quantify disability “losses” as opposed to the societal value of disability (Smart, 2016). Specific to SUDs, economic concerns can include potentially reduced vocational productivity, healthcare costs, and the cost of housing and harm reduction programs such as “wet houses” and needle and syringe exchange programs (Schomerus, 2014).

Regarding safety, people with disabilities can be perceived as a threat to those without disabilities. Some qualities ascribed to people with various disabilities include violence, destructiveness, aggression, and antisocial behavior (Smart, 2016). SUDs are especially characterized by the public for criminalized behavior and the tendency toward deception, a trait that is present in the criteria for SUD in the DSM-5 (Schomerus, 2014). As with other disabilities and mental health disorders, there is a tendency for individuals to “maintain a safe distance” from individuals with SUDs (Smart, 2016).

Next, ambiguity of disability refers to the ambiguous response most individuals have toward disability, characterized by responses of fear, anger, and pity (Smart, 2016). The “fear of the unknown” is one of the most common sentiments toward disability. For people without disabilities, ambiguity toward disability creates a tension of ambivalence leading to response
amplification and interaction strain, such as short durations of conversations, less eye contact, and avoidance of personal topics (Smart, 2016).

The overgeneralization of the effects of disability, also called “spread,” is the assumption that the effects of an individual’s disability permeate into all other aspects of that individual’s life. Although it is common for a disability to have a widespread impact, most individuals with disabilities see their condition as an attribute, rather than a problem (Smart, 2016). An example of spread for an individual with a SUD would be the assumption that the SUD causes issues in other areas of a person’s life such as romantic relationships, parental skills, and vocational capability (Schomerus, 2014).

Moral aspects of SUDs further complicate how they are perceived by people without disabilities. As noted by Smart (2016), the perceived cause of a disability can also affect the degree of stigma related to the disorder, as individuals view a person as responsible for the cause of her or his disability. The same is often true for management of disability – a common presumption is that individuals with disabilities must follow the societal “rules,” which include facing disability with courage and optimism, mastering the disability, being resilient, independently managing disability, maintaining a motivation and desire to “recover,” and making others comfortable with the disability (Smart, 2016). An individual with a SUD is often thought to have made the “choice” to use the given substance resulting in the addiction and is viewed as responsible for controlling her or his use and attending rehabilitation programs such as AA or NA (Schomerus, 2014).

Society places an emphasis on health, fitness, and beauty. In most circumstances, beauty and health are regarded to be a result of individual effort, a message accentuated in popular media (Smart, 2016). Therefore, a person with a SUD experiencing related, or even unrelated,
health concerns would be considered at fault via lack of effort to control health related concerns. An individual with an alcohol use disorder who is diagnosed with cirrhosis of the liver may be seen as “lesser” due to health concerns and “lack of effort” to avoid health complications associated with alcohol use.

Lastly, prejudice can stem from an individual’s fear of acquiring a disability. Smart (2016) identified an existential angst experienced by people without disabilities about what life with a disability would be like, resulting in a “collective neurosis,” or anxiety and fear of disability that is experienced by large groups of people within society. People without disabilities may avoid contact with a person with a disability altogether as a means of escaping or ignoring the natural tendency to imagine themselves as living with a disability (Smart, 2016).

In summary, these sources, albeit not an exhaustive list, explain the underlying causes of the public stigma attached to disability. Not all disabilities carry an equal degree of stigma; however, SUDs are among the most stigmatizing conditions (Schomerus, 2014; Smart, 2016). In fact, Smart (2016) identified three different continua of stigmatization based on the aforementioned sources of prejudice toward individuals with disabilities including a continuum for visibility of disability, one for cause of disability, and another for type of disability.

Regarding visibility, Smart (2016) proposed a continuum of stigmatization related to ambiguity of disability. Visible disabilities with stable courses are typically the least stigmatizing, followed by visible disabilities with episodic courses, invisible disabilities with stable courses, and finally, the most stigmatizing, invisible disabilities that are also episodic in nature. In terms of type of disability, psychiatric disabilities are typically the most stigmatizing, with physical disabilities being the least stigmatizing. Therefore, SUDs in both categories fit the
mold for those disabilities that are most stigmatizing, being classified as invisible, episodic and psychiatric in nature.

Smart (2016) also described the continuum of prejudice related to the cause of disability. Generally, disabilities that are acquired later in life, as opposed to being present at birth, or congenital, are perceived to be more preventable, therefore increasing the perception of accountability for the individual with the disability. The exception to this rule is when the acquisition of a disability is perceived to be a result of a “noble endeavor” such as a combat or an industrial injury, making those disabilities less stigmatizing than congenital disabilities, followed by acquired disabilities not of “noble” causes. Lastly, the most stigmatized in terms of perceived cause are those acquired disabilities in which the person is thought to have contributed to the acquisition process (e.g., HIV/AIDS, obesity, SUDs; Smart, 2016).

**Stigma of Substance Use Disorder**

Research supports the notion identified by Smart’s (2016) continua of stigma that invisible, episodic, and acquired conditions such as SUD are the most highly stigmatized by the general public (Schomerus, 2014). One survey of the U.S. population found that SUDs provoke a higher desire for social distance when compared to other mental health diagnoses. Ninety percent of respondents in the survey were unwilling to have contact with an individual with cocaine dependence, followed by 70% for those with alcohol dependence, 63% for individuals diagnosed with schizophrenia, and 47% for individuals diagnosed with depression (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Schomerus, Lucht, Holzinger, Matschinger, Carta, & Angermeyer, 2011). A replication study by Pescosolido, Martin, Long, Medina, Phelan, and Link (2010) revealed that this pattern of public opinion remained unchanged over the course of a decade. This same social distance effect has been identified in studies examining SUDs relative
to medical conditions including cancer, diabetes, and even other highly stigmatized conditions such as AIDS (Schomerus, Matschinger, & Angermeyer, 2006).

The perception of the general public that SUD is a behavioral and controllable “choice” rather than a “real” condition where symptoms arise involuntarily contributes to the degree of stigma related to these disorders (Schomerus, 2014). The aforementioned survey of the U.S. population found that 44% and 49% of respondents viewed case vignettes of cocaine dependence and alcohol dependence, respectively, as depicting “mental illness” compared to 88% for schizophrenia and 68% for depression (Link et al., 1999). Almost identical results were obtained by Schomerus, Matschinger, and Angermeyer (2013) in a 2011 survey conducted in Germany, suggesting that this phenomenon has remained relatively durable across time. In fact, a decade long epidemiological study by Chartier, Miller, Harris, and Caetano (2016) revealed that substance use stigma has remained stable over time in the U.S.

Further evidence for the uniqueness of the stigma attached to SUDs can be found by studying public attitudes regarding the cause of SUDs relative to other mental health conditions and behavior-related medical diseases. Although research has shown similar rates of heritability between psychiatric disorders and SUDS, the public tends to view SUDS as more controllable (Schomerus, 2014). Surveys of population attitudes in the United Kingdom conducted in 1998 and 2003 revealed that substance-dependent individuals were viewed as responsible for their “problem” by the highest percentages of individuals (68% in 1998; 60% in 2003), followed by alcohol-dependent individuals (60%; 54%), individuals with eating disorders (34%; 33%), and finally those with mental health conditions such as depression, panic attacks, and schizophrenia (4%; 13%; Crisp, Gelder, Goddard, & Metzler, 2005). A similar study by Corrigan, Lurie, Goldman, Slopen, Medasani, and Phelan (2005) found that adolescents in the U.S. attributed
responsibility to individuals with alcohol dependence significantly more than those with mental health diagnoses.

Despite research revealing commonalities in behavioral adherence to treatment between SUDs and other chronic medical conditions, the same patterns of causal attribution can be observed when examining attitudes toward substance use in comparison to behavior-related medical diseases (Schomerus, 2014). In fact, Schomerus and colleagues (2006) found that 85% of Americans believed a person with alcohol use disorder to be at fault for her or his condition, whereas 68% attributed responsibility for those diagnosed with AIDS, 45% for individuals with myocardial infarction, and 33% for those with diabetes. Therefore, the extent of blame, or responsibility for one’s own condition, is one unique characteristic of SUDs when compared with other similar mental health and behavior related medical conditions.

Schomerus (2014) noted that the two groups of stereotypes that seem to be of significance for individuals with SUDs in terms of potential causes for discrimination are weakness of will and violence. Crisp and colleagues (2005) noted in their survey that half of the respondents believed individuals with alcohol-dependence “could pull themselves together if they wanted to,” relative to 17% who held that belief for those with depression and 8% who believed that to be true for schizophrenia. Additionally, the review of studies of public perception by Schomerus et al. (2011) revealed that those with substance-dependence were consistently rated as the most “unpredictable and dangerous,” followed by alcohol specific dependence and schizophrenia (which alternated as second and third most violent between studies).

Stigmatization of people with SUDs does not only occur in the public, but also within settings in which individuals have been trained to provide services for those with substance use
issues (Ronzani, Higgins-Biddle, & Furtado, 2009). An examination of individuals in substance use treatment found that individuals who were often in treatment had more frequent stigma experiences and perceptions (Luoma, Twohig, & Waltz, 2007; Schomerus, 2014). These discriminatory experiences at the hands of healthcare professionals have shown to decrease the likelihood that an individual with a SUD seeks treatment services (Fortney, Mukherjee, Curran, Fortney, Han, & Booth, 2004).

To better explain the degree of stigma attached specifically to SUDs, van Boekel, Brouwers, van Weeghel, and Garretsen (2013) adapted Corrigan’s attribution model of public discrimination toward persons with mental illness specifically to examine the negative attitudes held toward individuals diagnosed with SUDs. Corrigan, Markowitz, Watson, Rowan, and Kubiak (2003) developed the original model for mental health conditions, asserting that stigma and discrimination developed first from an individual’s perception of the controllability and dangerousness of the condition, which lead to beliefs about personal responsibility, an affective response, and finally to discriminatory or helping behavior while accounting for familiarity and social-demographic variables as well. In the adaptation constructed for SUDs the affective responses are expanded and identified specifically as fear, pity, and anger, all leading to a determination of intention to impose restrictions on individuals with SUDs as mediated by familiarity (van Boekel et al., 2013).

In an effort to examine the model in the public, van Boekel and colleagues (2013) surveyed public opinions on imposing restrictions on people with SUDs in the Netherlands. Of note, over half of the participants in the study agreed with imposing restrictions on individuals with SUDs such as not being permitted to take public office or to care for children. Overall, the proposed model to explain people’s intentions to impose restrictions was partially applicable,
with a significant positive association being seen between willingness to impose restrictions and perception of personal responsibility, expectancy of aggressiveness, feelings of anger, and feelings of fear (van Boekel et al., 2013).

Livingston, Milne, Fang, and Amari (2012) suggested three main reasons for the uniqueness of stigma toward individuals with SUDs. The first involves SUDs being symbolically linked to other stigmatized health conditions such as HIV/AIDS, hepatitis C, other mental health conditions, unsafe behaviors such as impaired driving, and social problems like poverty and criminality. The second reason involves SUDs being treated as a moral and criminal issue, which is particularly true in the U.S. for specific substances that have been regarded as illegal. Some substances (e.g. heroin) are more highly criminalized and are treated with more punitive measures. Use of illegal substances increases the degree of stigma experienced as opposed to use of legal substances, such as alcohol, especially in the U.S. (Schomerus, 2014). Lastly, people with SUDs are perceived as having control over their condition. Making a causal attribution to the person with a substance use disorder dictates the social response of viewing substance use as a moral deficit in which the person has corrective control (Livingston et al., 2012).

**Process of Stigmatization.** An understanding of the process of stigmatization is necessary to examine the effects of public stigma on structural discrimination and self-stigma. Stigmatization starts as a person or group of persons is labeled due to differences. Then, the person or group of persons is linked with undesirable characteristics and consequently experiences loss of status and/or discrimination (van Boekel et al., 2013). Stigmatization can occur on a personal level due to prejudiced beliefs, stereotyping, and discriminatory action, but it also can be embedded into institutional practice and policies, which is known as structural
discrimination (Jones & Corrigan, 2014). Public stigma has a reciprocal effect on structural discrimination as both can serve to increase the other (van Boekel et al., 2013). For example, widely held beliefs, such as, people with SUDs should be punished rather than helped can impact structural-level policies, thereby lowering support for public health-oriented drug control policies including funding for treatment and harm reduction practices (Kulesza, Matsuda, Ramirez, Wentz, Teachman, & Lindgren, 2016). This structural discrimination based on moralistic and punitive attitudes toward individuals with SUDs can be both intentional and unintentional. Even though some policies and practices are grounded in research and not intended to discriminate, they increase stigma and barriers to treatment and recovery for people with SUDs nonetheless (Kulesza et al., 2016; Schomerus, 2014).

One area affected by structural discrimination against people with SUDs is access to healthcare and treatment. For example, many private insurance plans exclude substance use related conditions, which seemingly is related to health-risk assessment, but embodies the underlying moral stance on the degree of self-responsibility and controllability of the SUDs (Schomerus, 2014). Within mental health care, SUDs can be a contraindication of mental health treatment, and many countries choose to separate mental health care and substance use treatment (Rubak, Sandbaek, Lauritzen, & Christensen, 2005). Thus, many people with co-occurring symptoms have substance use issues that are undiagnosed and untreated (Albanese, Clodfelter, Pardo, & Ghaemi, 2006). Another example of seemingly unintentional healthcare structural discrimination is the lack of access to organ transplants and medical treatment for people with Hepatitis C, a policy not shown in research to be clinically necessary (Rehm, Fischer, Hayden, & Room, 2003).
Another area of structural discrimination related to substance use is healthcare spending. Lack of available financial resources related to substance use can reduce availability and quality of treatment options and reduce public funding available for harm reduction programs. Examples of these programs include housing assistance, employment assistance, and other harm reduction measures such as overdose prevention and syringe/needle exchange programs (Kulesza et al., 2016; Schomerus, 2014; van Boekel et al., 2013). A survey in Germany revealed that, when asked which of nine medical conditions funding could best be cut, the highest percentage of participants (78%) selected alcohol use. Similarly, when asked which conditions should on no account be cut, alcohol use was selected least frequently by participants (Beck, Dietrich, Matschinger, & Angermeyer, 2003). A replication study in 2004 supported the presence of these attitudes toward healthcare funding for SUDs (Schomerus et al., 2006).

Some forms of structural discrimination pose a direct threat to the autonomy of individuals with SUDs. Compulsory treatment policies wherein individuals are mandated to treatment are one specific example. A 1996 survey of attitudes toward compulsory treatment in the U.S. showed that, regarding substance use treatment, 41% of participants supported mandatory hospital treatment, 39% agreed with mandatory outpatient treatment, and 25% approved of mandated medication (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). Follow-up surveys in the U.S. a decade later showed no significant changes in attitudes toward this legally coerced treatment for individuals with SUDs (Schomerus, 2014; Schnittker, 2008).

Whereas many research studies have examined explicit sources of stigma such as public stigma and structural discrimination, Kulesza and colleagues (2016) suggested that examining implicit sources of stigma may be a more accurate reflection of actual substance use stigma. The main reason for this recommendation was the impact of social desirability bias inherent to
explicit measures of stigma. Implicit stigma, or self-stigma, can be greatly affected by the explicit stigma sources of public stigma and structural discrimination. Self-stigmatization involves both emotional and cognitive components as the person applies negative beliefs about his or her disease or disorder, in this case substance use, to her or himself (Schomerus, 2014). In fact, as an acquired disability, many individuals who develop substance use issues internalize previously held biases related to substance use in addition to experiencing outside sources of stigma (Smart, 2016). As Corrigan, Watson, and Barr (2006) reported, many individuals are aware of the stereotypes regarding their disability and most even agree with them.

Self-stigma has an adverse effect on an individual’s well-being, treatment efficacy, and willingness to seek treatment, and is thus a major barrier toward recovery (Kulesza et al., 2016; Mak et al., 2015, Schomerus, 2014). As the negative stereotypes about the disorder are integrated into the individual’s sense of self, both self-esteem and self-efficacy are decreased, leading to consequences such as depressive symptoms, loss of morale, and an increased need for inpatient treatment (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Rusch et al., 2009; Schomerus, 2014). As noted by Mak and colleagues (2015), self-stigmatization often deters individuals from help seeking, treatment participation, and medication adherence while also increasing risk for premature service termination.

Self-stigmatization can affect both clinical and personal recovery for individuals with SUDs. In terms of clinical recovery, defined as alleviation of psychiatric symptoms and return to baseline premorbid functioning, those with higher self-stigma demonstrate high levels of depression, emotional discomfort, and more severe psychiatric symptoms (Mak et al., 2015). For personal recovery, or a person’s potential for attaining self-fulfillment despite limitations from
mental health conditions, self-stigma has a negative impact on well-being, life satisfaction, attainment of personal goals, and levels of personal life meaning (Mak et al., 2015).

High levels of shame, a construct relating closely to level of self-stigma, has been demonstrated to be positively associated with perceived stigma and sense of rejection, and negatively associated with mental well-being and quality of life (Luoma et al., 2007). Further, if a substance is used as a coping strategy for shame, it can negatively affect recovery by increasing substance use, which in turn increases the level of experienced shame (Dearing, Stuewig, & Tangney, 2005; Luoma, Kohlenberg, Hayes, & Fletcher, 2012). Schomerus and colleagues (2011) found that, even when controlling for depressive symptoms, severity of dependence, duration of dependence, and previous number of detoxifications; negative stereotypes of oneself decreased self-esteem and reduced an individual’s drinking-refusal self-efficacy, or confidence in abstaining from drinking in the future.

Interestingly, the study by Schomerus et al. (2011) linked the formation of these negative self-stereotypes with the individual’s perceptions of the prevalence of negative stereotypes in the public. Regardless of problem duration, problem severity, and mental well-being, the participants in the study who perceived a higher prevalence of negative stereotypes among the public also demonstrated higher levels of self-stigma. These findings indicate that the presence of public stigma may account for a significant level of variance in level of self-stigma experienced with substance use disorder. Conversely, studies of public stigma of mental health disorders have consistently shown that countries with higher levels of public stigma also have the highest levels of self-stigmatization (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012; Mak et al., 2015; Schomerus, 2014). This aggregation of evidence suggests that the issue of self-stigma may be less of a dysfunctional cognition, as it is typically perceived, and more of a
product of the societal and institutional stances taken on substance use (Mak et al., 2015; Schomerus, 2014).

**Disability Legislation**

There is a long global history of institutional and individual discrimination against individuals with disabilities, and in particular, individuals with SUDs. Due to this discrimination, individuals have been limited in their opportunities with respect to employment, housing, health care, relationships, faith-based communities, friends, communities, and legal protections (Corrigan, 2014). In the past few decades, the global community has moved toward taking a firmer stance on the affirmation of basic human rights for individuals with disabilities and combatting structural and individual discrimination. Perhaps the most substantial global policy on this issue was the United Nations Convention on the Rights of Persons with Disabilities in 2007, which focused on a shift toward rights-based approaches to disability (Rubin et al., 2016). This convention called for an end to significant human rights violations such as forced sterilization and involuntary long-term institutionalization, and it encouraged equal access through use of accommodations as well as national awareness campaigns to counteract negative cultural attitudes toward disability (Jones & Corrigan, 2014).

Historically in the U.S., Americans with disabilities have been subjected to various discriminatory practices, including eugenics, institutionalization, and segregation (Jaeger, 2004; Rubin et al., 2016; Shapiro, 1993; Smart, 2016). In response to these discriminatory practices, individuals with disabilities formed the disability rights movement in the 1960s, a social consumer movement with the goals of empowerment and collective rights of people with disabilities (Rubin et al., 2016; Shapiro, 1993; Smart, 2016). The impetus for this movement was twofold, including a large-scale growth in the disability community between 1940 and 1970,
which occurred due to the higher survival rate of veterans with disabilities, commonly attributed to advances in medical practice and technology. The other foundational aspect of this movement was the presence of other effective models of social activism that could be emulated stemming from the civil rights movements of minorities and women, as well as the then-recent Vietnam War protests (Rubin et al., 2016).

One of the main conclusions drawn from the general civil rights movements in the U.S. by the disability rights movement was that the courts had little ability to combat the structural discrimination against a certain group of individuals without federal legislation to support those rights (Rubin et al., 2016). Until this point, legislation regarding disability in the U.S. had focused on income maintenance payments rather than integration into mainstream society (Rubin et al., 2016). The lack of civil rights legislation left Americans with disabilities in the 1970s having their access to employment opportunities suppressed and facing segregation in education, transportation, housing, and other areas of life (Hahn, 2003). Disability interest groups played a key role in moving the agenda of the American disability policy forward, leading to the passage of numerous legislative acts regarding rights of Americans with disabilities including the Architectural Barriers Act of 1968, the Urban Mass Transportation Act amendments of 1970, the Rehabilitation Act of 1973, the Education for All Handicapped Children Act of 1975 (now entitled the Individuals with Disabilities in Education Act), the Civil Rights of Institutionalized Persons Act of 1980, the Voting Accessibility for the Elderly and Handicapped Act of 1984, and the Fair Housing Act Amendments of 1988 (Rubin et al., 2016). These important antidiscrimination/disability rights laws laid the foundation for the passage of the most powerful and comprehensive legislation addressing discrimination encountered by people with disabilities, the Americans with Disabilities Act of 1990 (Rubin et al., 2016; Smart, 2016).
Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990 by President George H. W. Bush. The ADA was the first comprehensive civil rights law addressing the needs of people with disabilities in the U.S. (Rubin, et al., 2016; Scotch, 2001; Smart, 2016). The ADA consists of five titles that address disability rights in various sectors of society. Title I of the ADA addresses issues in employment; Title II pertains to public services; Title III mandates non-discrimination in privately owned public accommodations; Title IV outlines requirements for telecommunications; and Title V covers miscellaneous provisions. Title I (employment), the main title of the ADA examined within this study, prohibits employers from discriminating against qualified job applicants and workers with disabilities. Title II prohibits public services as well as state and local governments from discriminating against people with disabilities in their programs and activities. Title III (private sector) prohibits privately operated public accommodations from denying goods, programs, or services to people based on their disabilities. Title IV (telecommunications) requires telephone companies to provide voice transmission relay services that allow people with speech and hearing impairments to communicate over the phone, as well as mandating that federally funded television public service messages be closed-captioned (Rubin et al., 2016).

The ADA defines a person with a disability as a person with a physical or mental impairment, which substantially limits functioning in one or more major life activities, a person who has a record of such impairment, or a person who is regarded as having such impairment. This definition set forth in the ADA expanded on the previous definition found in the Rehabilitation Act of 1973 (Rubin et al., 2016; Shapiro, 1993; Smart, 2016). Under Title I of the ADA, a qualified person with a disability is one who meets the primary requirements of the job
and can perform the essential functions of the job, with or without reasonable accommodations. Essential functions are defined by the employer and must be identified in a written job description that is given to all applicants for the position. Reasonable accommodations can include (but are not limited to) modification of equipment or environment, provision of interpreters or readers, and a flexible schedule (Rubin et al., 2016).

Although the ADA provided comprehensive civil rights coverage for Americans with disabilities, a series of case law decisions highlighted by *Sutton v. United Airlines* in 1998 narrowed the protections provided by ADA (Nissen & Rumrill, 2014). For example, in the *Sutton v. United Airlines* case the U.S. Supreme Court concluded that individuals with correctable disabilities were not covered by the ADA due to the disability not substantially limiting a major life activity when “corrected” (Rubin et al., 2016). In a response to this “mitigating measures” exclusion, several amendments to the ADA were introduced in the form of the ADA Amendments Act (ADAAA), which was signed into law by George W. Bush in 2008, effective January 1, 2009 (Rubin et al., 2016; Smart, 2016).

The ADAAA restored protection that been limited by court decisions and broadened the original scope of coverage set forth in ADA. Some of the changes included added protections for people whose disabilities are temporary in nature, repealment of the “mitigating measures” exclusion, expansion of the list of major life activities that can be substantially limited by a person’s impairment, reaffirmation that only one major life activity needs to be substantially limited, and addition of a list of impairments that “virtually always constitute a disability” (ADAAA, 2008). In the expansion of major life activities, the ADAAA specifically included internal functions that are not readily apparent to others, such as the endocrine system, normal cell growth, and digestion, a subject of debate previous to the ADAAA’s original passage (ADA
The conditions listed in ADAAA as presumptively limiting major life activities include deafness, intellectual disability, autism, epilepsy, diabetes, cancer, HIV infection, multiple sclerosis, muscular dystrophy, cerebral palsy, mobility impairments requiring the use of a wheelchair, post-traumatic stress disorder, major depressive disorder, schizophrenia and bipolar disorder (ADA National Network, 2016; Rubin et al., 2016).

For mental health diagnoses, most conditions found in the DSM are covered as a disability; however, there are certain conditions that are covered with exceptions and some that are excluded altogether. Regarding substance use, Section 104 of the ADA excludes all individuals who are actively using illegal drugs, but still protects those who have gone through or are currently in rehabilitation, as well as those who have been erroneously identified as substance users (Cummings, Lucas, & Druss, 2013; Lowe, 2016; Rubin et al., 2016). In the case of alcohol use, a person with an alcohol use disorder is covered under ADA and entitled to consideration of accommodation if she or he is qualified to perform the essential functions of the job, but is not protected for any use of alcohol that affects job performance or renders the employee not “qualified” (EEOC Technical Assistance Manual, 2002). Active use of illegal substances is always excluded from ADA coverage; however, those who are “recovering,” as defined by those not “currently” using substances and receiving treatment, and those who have successfully completed treatment are protected under ADA on the basis of their past SUD (EEOC Technical Assistance Manual, 2002; Rubin et al., 2016). The EEOC Technical Assistance Manual on the ADA issued the following guidelines on “current” use:

a) If an individual tests positive on a drug test, he or she will be considered a current drug user, so long as the test is accurate.
b) Current drug use is the illegal use of drugs that has occurred recently enough to justify an employer’s reasonable belief that involvement with drugs is an ongoing problem.

c) “Current” is not limited to the day of use, or recent weeks or days, but is determined on a case-by-case basis (EEOC Technical Assistance Manual, 2002).

In the U.S., there are other federal laws and regulations that address substance use in the workplace. Legislation such as the Americans with Disabilities Act fall under the category of laws designed to protect the civil rights of American workers. There are another group of laws that are designed to target workplace substance use, an example of which is the Drug-Free Workplace Act of 1998 (Safety Management Clinic, 2008). This act applies to public entities and any private companies or individuals that are federal contractors and grantees, as well as “safety-sensitive industries.” These industries include fields pertaining to public safety and national security including employees in aviation, trucking, railroads, pipelines, and other transportation industries (Safety Management Clinic, 2008).

Under the Drug-Free Workplace Act, any employer is legally within its rights to create and enforce a drug-free workplace policy. While it may seem the spirit of the ADA and the Drug-Free Workplace Act are in conflict, the limitations in protections for individuals with SUDs enable the two to legally coexist. Under the ADA, employers are legally prohibited from firing, refusing to hire, or promoting someone due to a history of substance use or if she or he is actively enrolled in a drug or alcohol program (Safety Management Clinic, 2008). Employers may not single out employees for drug testing due to an appearance of being under the influence of a substance, and employers may not ask employees about legal prescription drug use as part of a prehiring or prepromotion drug test (EEOC Technical Assistance Manual, 2002; Safety
Management Clinic, 2008). Reported ADA violations account for nearly one-half of all suits regarding drug-free workplace programs (Safety Management Clinic, 2008).

**Equal Employment Opportunity Commission (EEOC)**

Title I of the ADA establishes the employment provisions of the law, and the EEOC as the enforcement administrator of Title I. The EEOC determines when violations of the ADA have occurred and exists to enforce the ADA, among other federal employment laws, in its mission to limit workplace discrimination for people with disabilities (McMahon, Edwards, Rumrill, & Hursh, 2005).

Any person who believes that his or her employment rights have been violated on the basis of disability and wants to make a claim against an employer must file a charge of discrimination under ADA Title I with the EEOC. A third party may also file a charge on behalf of another person claiming to be mistreated. For example, a family member, social worker, or other representative can file a charge on behalf of someone with an intellectual disability. The charge must be filed by mail or in person with the local EEOC office within 180 days of the date of the alleged violation. The 180-day filing deadline is extended to 300 days if the charge is also covered by a state or local anti-discrimination law (EEOC, 2017).

The EEOC will send the parties a copy of the charge and may ask for responses and supporting information. Before formal investigation, the EEOC may select the charge for EEOC's mediation program. Both parties have to agree to mediation, which may prevent a time-consuming investigation of the charge. Participation in mediation is free, voluntary and confidential.

If mediation is unsuccessful, the EEOC investigates the charge to determine if there is "reasonable cause" to believe discrimination has occurred. If reasonable cause is found, the
EEOC will then try to resolve the charge with the employer. In some cases, where the charge cannot be resolved, the EEOC will file a court action. If the EEOC finds no discrimination, or if an attempt to resolve the charge fails and the EEOC decides not to file suit, it will issue a notice of "right to sue," which gives the charging party 90 days to file a court action. A charging party can also request a notice of "right to sue" from the EEOC 180 days after the charge was first filed with the Commission, and may then bring suit within 90 days after receiving the notice (EEOC, 2017).

**Employment Issues Facing Individuals with SUDs**

Vocational planning for individuals with SUDs is especially important because sustained work can be a positive factor in increasing quality of life, life satisfaction, overall health, social well-being and personal acceptance of disability (Dunigan et al., 2014; Gold, 2004; Kerrigan et al., 2004; Roessler & Rumrill, 1998; Sprong et al., 2014). The combination of systemic and personal barriers that face individuals with SUDs create a unique set of restrictive factors that limit access to employment, which in turn can exacerbate substance use issues and create barriers to recovery (Cummings et al., 2013; Gold, 2004; Sigurdsson, Ring, O’Reilly, & Silverman, 2012). Kerrigan and colleagues (2004) emphasized the importance of employment in the context of recovery explaining that those unable to access employment opportunities are at a higher risk to return to substance use. Given the importance of employment in recovery, along with the high unemployment rates for individuals with SUDs, with estimates ranging from 65% to more than 80%, it is important to gain a better understanding of both the macro and micro level barriers to employment for this population.

Although the ADA has had an impact in reducing employment discrimination for people with disabilities, there persists a form of structural discrimination in the unique way SUDs are
treated under the law relative to other similar conditions (Cummings et al., 2013; Gold, 2004; Lowe, 2016; Walter, 2004). Through the exceptions for SUDs, the ADA reinforces the stigmatized view of SUDs as fundamentally distinct from other mental health conditions and behavioral health diseases. Although research draws strong connections between SUDs and mental health conditions such as depression in terms of genetic influence and neurological underpinnings, as well as connections to behavioral health diseases such as type 2 diabetes regarding heritability, symptom relapse, and lack of treatment adherence, substance use is subject to its own set of rules (Sellman, 2010). For instance, individuals who are actively having a depressive episode, or individuals actively experiencing symptoms from type 2 diabetes are protected from employment discrimination, whereas an individual with substance use disorder is not protected during an active symptom relapse (EEOC Technical Assistance Manual, 2002). Given the scientific evidence regarding the nature of substance use disorder, the difference in treatment must then be explained by a combination of other factors including cultural stigma and legitimate safety concerns as identified in the Drug-Free Workplace Act.

Further, the ADA does not address specific “loopholes” that have been used as a means to restrict access to certain benefits such as disability insurance and employer “no-rehire” policies. As identified by Lowe (2016) disability insurance benefits are frequently disparate for individuals with SUDs. For example, a person with a health condition who relapses is generally provided salary replacement benefits until age 65 regardless of condition, whereas individuals with SUDs often receive salary replacement benefits for only two years (Lowe, 2016). The implication is that insurance companies have the discretion to implement disparate insurance plans without needing to review medical evidence supporting coverage, but rather base the
decision on the stereotypical view that substance use is not a disabling condition worthy of
insurance benefits (Lowe, 2016).

Similarly, Walter (2004) described several court cases where employees who lost
employment due to substance use and subsequently completed a rehabilitation program were
denied re-hire due to an employer general no-rehire policy. In one specific example, Raytheon
Co. v. Hernandez, Joel Hernandez was terminated by Raytheon Co. due to a positive screening
for cocaine. Upon completion of a rehabilitation program, Mr. Hernandez applied to be rehired
and was denied based upon a company no-rehire policy for those terminated for workplace
misconduct. The court, in this case, determined that so long as Raytheon did not specifically
base the decision not to re-hire Hernandez on his status as someone with a “former” substance
use disorder, but rather on a neutral no-rehire policy, it was a legitimate nondiscriminatory
reason under the ADA (Walter, 2004). Although the court, in this case, did officially recognize
Hernandez’s status as a person with a disability under ADA, it reinforced the idea that Mr.
Hernandez’s original positive screen was an act of behavioral misconduct under company policy,
rather than the product of symptom relapse from a health condition.

Another systemic level issue relates to how the EEOC has historically adjudicated
complaints of employer discrimination for individuals with SUDs. The EEOC assigns cases to
one of three priority levels: high, medium, and low (Gold, 2004). Due to SUDs being an
“invisible” condition that is heavily reliant on self-reported data, substance use cases are
typically assigned as low priority (Gold, 2004). For the substance use cases assigned as high
priority, the claims have resulted in a non-merit resolution in more than 95% of cases (Allbright,
2004). Further, for medium priority substance use claims that resulted in nonbinding mediation,
only 25% of employers agreed to participate in the mediation process (Moss, Swanson, Ullman, & Burris, 2002).

In terms of vocational services available for individuals with SUDs, barriers often exist within state/federal VR services, as well as in a lack of collaboration between substance use treatment programs and VR services. As noted by Gold (2004), despite the high co-occurrence of substance use issues across all types of disability, the federal-state VR system does not typically hire or train counselors specifically with specializations in this area. Additionally, despite research suggesting its benefits, there has been a general lack of services available to assist individuals with SUDs by the VR system such as advanced education opportunities, job skills training, and supported employment services (Gold, 2004). Although individuals with SUDs work closely in treatment programs with substance use counselors, substance use counselors typically do not have the advanced vocational expertise to assist individuals in attaining employment, and the degree of collaboration between the substance use treatment system and the federal-state VR system is limited (Glenn & Moore, 2008).

In addition to the structural discrimination faced by individuals with SUDs, there are also some common environmental barriers to employment. Individuals with SUDs often reside in areas that have fewer employment and career opportunities and experience poor access to childcare (Gold, 2004; Sigurdsson et al., 2012). Due to trends in the American economy that have resulted in exponential increase in reliance of education credentials and skill requirements for both the primary (e.g., professional) and secondary (e.g., semi- and unskilled) labor markets, education has become an increasingly important factor in employment stability. With low levels of education, individuals with SUDs experience difficulty in the modern workforce, relying
heavily on part-time and temporary positions without career advancement and health care insurance, and earning wages near the federal minimum (Gold, 2004; Sigurdsson et al., 2012).

Personal factors for individuals with SUDs also play a role in the barriers to employment. Research has shown that individuals with SUDs often lack general “soft” skills that are relevant to attaining and maintaining work opportunities. Such soft skills include interviewing skills, on-the-job behaviors such as punctuality and consistent attendance, appropriate dress, personal grooming, and hygiene (Sigurdsson et al., 2012). Sigurdsson and colleagues (2012) also identified interpersonal and social skills such as getting along with supervisors and peers, communicating clearly and professionally, and empathizing with employer perspective as additional soft skills necessary for employment stability.

Further, personal factors related directly to substance use impairments create additional barriers to the employment process. Gold (2004) identified medical illness, loss of social and familial support, and illegal activity as factors that could interfere with educational opportunities, job skill acquisition, career development plans, and ultimately employability. In addition, substance related legal charges create criminal record barriers that can exclude individuals with SUDs from specific labor force sectors and types of jobs (Gold, 2004).

Although structural discrimination, personal factors, and disease factors play a role in the high unemployment rates of individuals with SUDs, Baldwin, Marcus, and De Simone (2010) indicated that the assumption that poor employment outcomes are strictly a result of these factors is insufficient. After an advanced labor market analysis for individuals with SUDs, 20% of the employment gap and 30% of the wage gap relative to those without disabilities is not explained by functional limitations and other productivity-related variables (Baldwin et al., 2010).
Baldwin and colleagues (2010) asserted that these gaps are potentially due to stigma-related discrimination against individuals with SUDs by employers.

As a facet of stigma, discrimination refers to enacted prejudice, or negative reactions to a member of a stigmatized group (Jones & Corrigan, 2014). Discrimination experiences can be harmful for any individual in any circumstance, but workplace discrimination for individuals with SUDs is a particularly salient experience that can have a particularly profound effect on well-being and quality of life (Chan, McMahon, Cheing, Rosenthal, & Bezyak, 2005). At times, discrimination can occur as an isolated incident that a person may be able to at least physically escape, whereas in the workplace, an individual typically is dependent on returning to the situation where that discrimination could occur almost daily. This process can be especially impactful when the employer or supervisor is involved in the discrimination process as there is an inherent power differential for the employee (Wood, Braeken, & Niven, 2013). For individuals with SUDs, stress, anxiety, and other affective and psychological consequences of workplace discrimination can be triggers for use and relapse, making a consistent stressful workplace experience a large barrier for recovery (Sigurdsson et al., 2012).

In a study examining the drivers of workplace discrimination against people with disabilities in the pre-ADAAA era, Chan and colleagues (2005) found that claims of workplace discrimination to the EEOC were more prevalent among people with conditions that were considered to be controllable and unstable. As part of the research used to categorize conditions based on perception of disabilities, SUDs were found to be rated most negatively in terms of controllability, and among the most negative for stability (Chan et al., 2005). People with conditions in this category were perceived as being in greater control of their disorders, less worthy of pity, and inferior in terms of prognosis than those with physical disabilities. In the
analysis examining the discrimination allegations of individuals with SUDs, the researchers found discharge (56%) and hiring (10%) to be the two most common issues. In addition, SUDs were among the seven lowest conditions in terms of merit resolutions with a 12% merit resolution rate, a score that was 44% below that of the overall sample (Chan et al., 2005).

**National EEOC ADA Research Project (NEARP)**

The National EEOC ADA Research Project (NEARP) is an exhaustive data-mining effort which relies upon the master database used by the EEOC to track investigations of workplace discrimination. NEARP investigators seek to develop disability or industry-specific profiles of employment discrimination, explore the contentious issues involved in workplace discrimination, document the interface of disability with other demographics, evaluate extant theories of stigma, and predict EEOC investigatory outcomes (McMahon et al., 2005). The NEARP researchers seek answers to a particular set of questions to shed light on barriers to the labor force participation gap. These questions include the following:

a) Are there discrete organizational behaviors that in the aggregate constitute workplace discrimination?

b) What is the specific nature and scope of workplace discrimination against Americans with disabilities?

c) Does workplace discrimination affect Americans with disabilities in different ways as a function of personal characteristics such as type of impairment, gender, age, race, or ethnicity?

d) To the extent that employers perpetrate workplace discrimination, does it vary as a function of the employer’s industry, location, and size?
e) When Americans with disabilities file allegations of workplace discrimination, what proportion of these has merit, and what proportion lacks merit at the conclusion of a complete investigation?

f) Does the resolution of allegations vary as a function of either complainant or employer characteristics? (McMahon et al., 2005, p. 1-2).

According to McMahon and McMahon (2016), over 75 researchers and graduate students across America have participated in NEARP studies. Since 2005, 70 journal articles have been published by authors from 18 universities.

As reported by McMahon and McMahon (2016) the EEOC master Integrated Mission System (IMS) database is used as a management tool to monitor workflow, performance, trends, and outcomes for EEOC field office investigators. The NEARP team was the first to utilize this database for research purposes under the scrutiny of multiple university IRBs and the EEOC Office of Research, Information and Planning. Since its inception, NEARP has obtained data on 547,866 closed allegations spanning from the effective date of ADA Title I in 1992 through December 31, 2011. This study seeks, as part of NEARP, to use the IMS database to examine patterns in the discrimination allegations made by individuals with SUDs.

**Rationale for the Present Study**

SUDs are prevalent for individuals across all ages, races/ethnicities, genders, socioeconomic statuses, and ability statuses (Thombs & Osborn, 2014). As many as 9 percent of individuals over the age of 12 live with a substance use disorder (Sprong et al., 2014). For many of these individuals, their disorder is treated in a unique fashion when compared to similar disorders or disabilities (Schomerus, 2014; Smart, 2016). Studies have shown that people tend to
see SUDs as more controllable than similar mental health conditions and behavioral health diseases and also regard individuals diagnosed with substance use disorder as responsible for the onset of their condition (Crisp et al., 2005; Schomerus 2014; Schomerus et al., 2006).

Overall, the workplace discrimination experiences of individuals with SUDs have been largely overlooked, as most studies have included people with substance use diagnoses as a subgroup of people with disabilities or of people with mental health conditions. As noted by Baldwin et al. (2010) the workplace discrimination experiences of individuals with SUDs appear to be uniquely manifested in job loss rates after hiring, accounting for the high levels of job instability in this population. The findings of Baldwin and colleagues (2010) suggested that employer discrimination may be one of the causes of poor job stability for individuals with SUDs.

**Purpose of the Present Study**

The purpose of this study was to increase the body of research regarding these workplace discrimination experiences of individuals with SUDs by exploring the discrimination allegations made by individuals with SUDs under the ADA as part of the NEARP. Through a thorough investigation of the national EEOC database, the workplace discrimination experiences of individuals with SUDs are better understood within their context. The IMS database enabled the researcher to examine the characteristics of the individual experiencing the discrimination (e.g., age, gender, race/ethnicity), the characteristics of the workplace in which the discrimination is taking place (e.g., geographical region, size of company, type of industry), and whether the discrimination was deemed to have legally taken place (merit resolution) or was deemed to be a case of perceived discrimination (non-merit resolution).
Once profiled, the workplace discrimination experiences of individuals with SUDs were compared to the experiences of individuals with other disabilities in order to investigate any existing significant differences in the workplace discrimination experiences of individuals with SUDs. This knowledge provided a basis for continued research into how, where, and to whom these discrimination experiences typically occur, leading to a more accurate understanding of why discrimination against individuals with SUDs occurs in the workplace, and subsequently what is needed from researchers and practitioners to help decrease stigma and corresponding discriminatory practices against this population in the workplace and beyond.

**Research Questions**

1. What are the patterns in allegations of workplace discrimination filed by Americans with SUDs in terms of the types of allegations filed, characteristics of charging parties, and case resolutions or outcomes of the EEOC’s investigatory process?
2. Do patterns in workplace discrimination allegations filed by Americans with SUDs differ from those in allegations filed by Americans with other disabilities in terms of the types of discrimination that is alleged to have occurred?
3. Do patterns in workplace discrimination allegations filed by Americans with SUDs differ from those in allegations filed by Americans with other disabilities in terms of charging party characteristics?
4. Do patterns in workplace discrimination allegations filed by Americans with SUDs differ from those in allegations filed by Americans with other disabilities in terms of the rate of merit case resolutions?
CHAPTER II

METHODOLOGY

To address the research questions noted in the previous chapter, the researcher implemented an ex post facto, causal comparative quantitative design that includes both descriptive and inferential (non-parametric) analyses. The over-arching purpose of the study is to gain a thorough understanding of the workplace discrimination experiences of Americans with SUDs.

Data Source

Under an Interagency Personnel Agreement (IPA) involving the EEOC, Professor Brian T. McMahon, and Virginia Commonwealth University, a nationwide project was begun in 2003 to utilize the IMS for research purposes in order to provide evidence-based answers to the questions regarding discrimination allegations under the ADA. Dr. McMahon and VCU colleagues proceeded to extract and refine IMS in order to retrieve, verify, and examine closed ADA allegations. An informal network of 25 research volunteers was organized to form the NEARP.

To conduct this investigation, the researcher, via NEARP, secured permission to access the EEOC’s Integrated Mission System database with proper protections for the Charging Parties (applicants or employees) and Respondents (employers). Only “closed” allegations are captured in the NEARP database. NEARP values the results of the investigations conducted by EEOC personnel, and it uses the EEOC “resolution codes” to classify outcomes as either “merit” (which favor the Charging Parties) or “non-merit” (which favor Employers). Information gathered pertained to the type and number of complaints of employment discrimination under Title I of the ADA filed by individuals with SUDs and the manner in which the EEOC resolved those
complaints. From approximately three million records involving all allegations of employment discrimination, a “study dataset” was extracted to include only those variables related to the research questions regarding the comparability of the disability categories. To protect the identity of Charging Parties and Respondents, the extraction process adhered to specific guidelines:

1. The unit of study was an allegation; it was not an individual Charging Party, nor an individual Respondent. A single Charging Party may bring more than one allegation or may bring the same allegation on more than one occasion (e.g., in 1997 and again in 2005).

2. Only unique allegations that do not involve recording errors or duplications were included in the study dataset.

3. To maximize confidentiality, all identifying information regarding Charging Parties and Respondents were purged except for age, race/ethnicity, gender, and disability status of charging parties and North American Industry Classification System code (NAICS code), number of employees, and location (a broad U.S. census track region) of employers.

4. Study data was strictly limited to allegations brought under Title I of the ADA. Allegations brought under other federal employment statutes that are not directly related to disability status including the Civil Rights Act, Equal Pay Act, Age Discrimination in Employment Act, and the Family and Medical Leave Act were not considered.

5. Due to the wide variations in state anti-discrimination statutes based on disability, state charges also were excluded to maintain a consistent definition of both disability and discrimination.

6. To maintain consistency in definitions and procedures among the study variables, only allegations received, investigated, and closed by the EEOC were included. This required
the exclusion of allegations referred by the EEOC to litigation for disposition in civil court, federal or state.

7. Only allegations have been closed by the EEOC during the study period, defined as July 26, 1992 (first effective date of ADA Title I) through December 31, 2011, were included in the study dataset.

8. Open allegations (still under investigation) were excluded from the study. This exclusion exists to ensure that all allegations in the study dataset are “closed” as either Merit (reasonable cause for discrimination) or Non-Merit (no reasonable cause for discrimination).

The variables to be used in this study and the manner in which these data were collected were recently described by McMahon and McMahon (2016) in their overview of the NEARP. Inclusion and exclusion criteria are also explained. Application of these criteria resulted in a study dataset of 8,432 allegations of employment discrimination pertaining to the target group, individuals with SUDs. The comparison group consisted of the aggregation of all known physical impairment groups, but excluding behavioral, sensory, neurological conditions such as autism, intellectual disabilities, brain impairment, cerebral palsy, repetitive strain injuries, and other non-specific neurological disorders. The comparison group is subsequently referred to as “general disability” (GENDIS) and includes 82,618 allegations.

**Variables Considered in the Present Study**

The primary unit of measure in this study was an allegation of employment discrimination filed by a person with a SUD or another disability (GENDIS) with the EEOC since the original effectuation of the ADA on July 26, 1992. Each allegation was treated as one distinct data point in the IMS system; if one individual filed more than one allegation with the
EEOC under Title I of the ADA, each allegation was investigated and adjudicated separately. The number of allegations is greater than the number of charging parties in the IMS database because many charging parties file more than one allegation. In EEOC parlance, allegations are referred to as ‘Issues.’ An Issue describes the nature of the unlawful personnel action alleged by the Charging Party (CP). There are 41 unique Issues that have some level of allegation activity ranging in frequency from 8 to 177,177 in the overall EEOC complaint database. In order of frequency found in the NEARP Codebook (McMahon, 2012), these 41 Issues include Discharge, Failure to Accommodate, Terms/Conditions of Employment, Disability Harassment, Hiring, Discipline, Constructive Discharge, Layoff, Promotion, Other Issues, Wages, Demotion, Suspension, Reinstatement, Job Assignment, General Benefits, Intimidation, Insurance Benefits, Recall, Training, Union Representation, Involuntary Retirement, Unfavorable References, Job Classification, Pension Benefits, Qualification Standards, Referral, Seniority, Testing, Segregated Unions, Posting Notices, Severance Pay, Tenure, Maternity Leave, Waiver of ADEA Rights, Early Retirement Incentive, Segregated Facilities, Apprenticeship, Record Keeping, Advertising, and Segregated Local Unions. It is worth noting that the top 5 Issues on this list account for 76% of all allegation activity. Four of these 5 have been thoroughly documented in special issues of peer-reviewed journals devoted to each (Hurley, 2010; McMahon, West, & Hurley, 2006; McMahon, Hurley, West, Fong, Roessler, & Rumrill, 2008; Roessler, Hurley, & McMahon, 2010; Shaw, Chan, & McMahon, 2012; West, 2008).

**Characteristics of the charging party**

As stated above, the characteristics of the charging party include gender (female/male), race/ethnicity (Caucasian, African American, Hispanic/Mexican, and Other), and disability type.
Disability type (i.e., SUD or GENDIS) served as the two-level independent or grouping variable for all non-parametric comparisons in this study.

Resolution

This refers to the final EEOC determination as to whether or not discrimination actually occurred. For purposes of this study, Resolutions are dichotomously classified as Merit, favoring the charging party (a determination that discrimination did occur) or Non-Merit, favoring the respondent employer (a determination that discrimination did not occur).

Sample Selection

The sample required to answer the research questions for this investigation included the entire population of ADA Title I complaints received by the EEOC from people with SUDs, a category combining alcoholism and drug addiction categories, from 1992 through 2011 (n = 8,432). The comparison group, known as GENDIS, included NEARP codebook categories of asthma, chemical sensitivities, diabetes, disfigurement, missing digits or limbs, non-paralytic orthopedic impairment, and paralysis (n = 82,618). The following outlines the definitions listed in the NEARP codebook for the two categories comprising the target SUD population.

Alcoholism

Characterized by addiction to alcoholic beverages. (This category includes both current and recovering alcoholics.)

Drug Addiction

Characterized by addiction to a controlled substance or illegal narcotic. (This category includes both current and recovering drug addicts.)
Data Analysis

Non-parametric tests of proportion were used to examine the relationships between SUDs and GENDIS allegations in terms of frequencies expected and observed. This test statistic does not require independence of study data (some Charging Parties file more than one allegation), equivalent group sizes, or normality of distribution assumptions. Results of these analyses provided Z scores (distributed generally as $X^2$) and 99% confidence intervals. To minimize the likelihood of Type 1 errors, the significance level were set at .001.

For each categorical dependent variable (i.e., issues, gender, race/ethnicity, and resolution), a Pearson chi-square test was first utilized to test the homogeneity of proportions across the disability groups. If the Pearson chi-square test indicates the existence of significant proportional differences, standard residuals greater than an absolute value of 2.0 were used to determine the presence of statistically significant differences. Data were imported into the Statistical Package for the Social Sciences (SPSS) version 21 for all analyses.
CHAPTER III

RESULTS

This chapter provides a complete description of the results of this investigation. Findings are presented in both descriptive and inferential terms to illustrate the distribution of scores across the two referent groups. As noted in the Methodology Chapter the researcher applied primarily nonparametric statistics to answer the research questions. Research Question 1 was the over-arching question that guided all analyses.

Research Question 1: What are the patterns in allegations of workplace discrimination filed by Americans with SUDs in terms of the types of allegations filed, characteristics of charging parties, and case resolutions or outcomes of the EEOC’s investigatory process?

The answers to Research Question 1 are fully contained in the foregoing findings pertaining to Research Questions 2-4. Research Questions 2-4 addressed the specific analyses that are described in this chapter. Because these analyses reflect population data with large groups and cell sizes, all statistical tests were evaluated using the significance level of alpha = .001. For analyses using a Pearson Chi-Square test, standard residuals with an absolute value of 2.0 or higher were used to indicate statistically significant differences within individual post-hoc comparisons.

Types of Discrimination

Research Question 2: Do patterns in workplace discrimination allegations filed by Americans with SUDs differ from those in allegations filed by Americans with other disabilities in terms of the types of discrimination that is alleged to have occurred?
The first analysis explored the specific types of circumstances under which the alleged discriminatory actions occurred (also known as issues) as reported by people with SUDs, in comparison to the issues alleged by members of the GENDIS group. Table 1 presents a comparison of the issues in EEOC Title I allegations for both groups. The * symbol denotes statistically significant differences between the two groups in the proportions of allegation type.

### Table 1

*Issues Involved in ADA Title I Allegations: 1992-2011*

<table>
<thead>
<tr>
<th>Charging Party Issue</th>
<th>SUDs (N=8,432)</th>
<th>GENDIS (N=82,618)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Discharge*</td>
<td>47.8</td>
<td>4,032</td>
</tr>
<tr>
<td>Reasonable Accommodation*</td>
<td>9.2</td>
<td>773</td>
</tr>
<tr>
<td>Terms/Conditions*</td>
<td>7.9</td>
<td>663</td>
</tr>
<tr>
<td>Hiring*</td>
<td>6.1</td>
<td>512</td>
</tr>
<tr>
<td>Harassment*</td>
<td>6.0</td>
<td>503</td>
</tr>
<tr>
<td>Discipline*</td>
<td>3.6</td>
<td>303</td>
</tr>
<tr>
<td>Suspension*</td>
<td>3.0</td>
<td>251</td>
</tr>
<tr>
<td>Constructive Discharge*</td>
<td>1.9</td>
<td>160</td>
</tr>
<tr>
<td>Promotion</td>
<td>1.7</td>
<td>146</td>
</tr>
<tr>
<td>Demotion</td>
<td>1.7</td>
<td>143</td>
</tr>
<tr>
<td>Other</td>
<td>1.7</td>
<td>140</td>
</tr>
<tr>
<td>Reinstatement</td>
<td>1.5</td>
<td>125</td>
</tr>
<tr>
<td>Wages*</td>
<td>1.3</td>
<td>107</td>
</tr>
<tr>
<td>Category</td>
<td>Score</td>
<td>Frequency</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-------</td>
<td>-----------</td>
</tr>
<tr>
<td>Benefits</td>
<td>0.9</td>
<td>79</td>
</tr>
<tr>
<td>Intimidation*</td>
<td>0.8</td>
<td>66</td>
</tr>
<tr>
<td>Layoff*</td>
<td>0.7</td>
<td>62</td>
</tr>
<tr>
<td>Assignment*</td>
<td>0.7</td>
<td>55</td>
</tr>
<tr>
<td>Union Representation*</td>
<td>0.6</td>
<td>54</td>
</tr>
<tr>
<td>Prohibited Medical Inquiry</td>
<td>0.5</td>
<td>40</td>
</tr>
<tr>
<td>References Unfavorable*</td>
<td>0.5</td>
<td>39</td>
</tr>
<tr>
<td>Posting Notices*</td>
<td>0.4</td>
<td>33</td>
</tr>
<tr>
<td>Benefits Insurance</td>
<td>0.4</td>
<td>31</td>
</tr>
<tr>
<td>Recall*</td>
<td>0.3</td>
<td>23</td>
</tr>
<tr>
<td>Training*</td>
<td>0.2</td>
<td>20</td>
</tr>
<tr>
<td>Job Classification</td>
<td>0.2</td>
<td>15</td>
</tr>
<tr>
<td>Involuntary Retirement</td>
<td>0.1</td>
<td>11</td>
</tr>
<tr>
<td>Testing</td>
<td>0.1</td>
<td>10</td>
</tr>
<tr>
<td>Exclusion/Segregated Unions</td>
<td>0.1</td>
<td>8</td>
</tr>
<tr>
<td>Referral</td>
<td>0.1</td>
<td>6</td>
</tr>
<tr>
<td>Benefits: Pension*</td>
<td>0.1</td>
<td>5</td>
</tr>
<tr>
<td>Qualification Standards*</td>
<td>0.1</td>
<td>5</td>
</tr>
<tr>
<td>Severance Pay</td>
<td>&lt;0.1</td>
<td>3</td>
</tr>
<tr>
<td>Seniority*</td>
<td>&lt;0.1</td>
<td>2</td>
</tr>
<tr>
<td>Tenure</td>
<td>&lt;0.1</td>
<td>2</td>
</tr>
<tr>
<td>Segregated Facilities</td>
<td>&lt;0.1</td>
<td>1</td>
</tr>
<tr>
<td>Advertising</td>
<td>&lt;0.1</td>
<td>1</td>
</tr>
</tbody>
</table>
As can be seen in Table 1, the most common allegations filed by people with SUDs during the 1992-2011 retrospective observation period involved discharge (47.8%), reasonable accommodation (9.2%), terms and conditions (7.9%), hiring (6.1%), harassment (6.0%), discipline (3.6%), suspension (3.0%), constructive discharge (1.9%), promotion (1.7%), and demotion (1.7%). Readers will note that the five most common types of issues filed by people with SUDs (n = 6,483) comprised 76.9 percent of the total number of allegations filed by that group. The most common allegations in the GENDIS group involved discharge (30.3%), reasonable accommodation (22.6%), terms and conditions (9.0%), harassment (7.5%), discipline (4.2%), hiring (4.2%), layoff (2.3%), constructive discharge (2.3%), wages (1.9%), and promotion (1.9%). Similarly, the five most common types of issues in the GENDIS group (n = 60,840) comprised 73.6 percent of that group’s total allegations.

A chi square analysis revealed statistically significant differences in the pattern of issues alleged by people with SUDs in comparison to the pattern of issues alleged by the GENDIS group ($\chi^2 (41, N = 91,050) = 1958.509, p < .001$). Specifically, people with SUDs were more likely than the GENDIS group to allege discrimination related to discharge, hiring, suspension, union representation, unfavorable references, and posting notices. People with SUDs were less
likely than the GENDIS group to allege discrimination related to reasonable accommodation, terms and conditions, harassment, discipline, constructive discharge, wages, intimidation, layoff, assignment, recall, training, pension benefits, qualification standards, and seniority.

**Characteristics of Charging Parties**

*Research Question 3:* Do patterns in workplace discrimination allegations filed by Americans with SUDs differ from those in allegations filed by Americans with other disabilities in terms of charging party characteristics?

The second set of analyses concerned the demographic characteristics of ADA Title I charging parties who have SUDs and how they differ from the demographic characteristics of the GENDIS comparison group. The three demographic characteristics considered in this investigation were age, gender, and race/ethnicity. The mean age for charging parties with SUDs was 42.18 years ($SD = 8.241$), whereas the mean age for charging parties in the GENDIS group was 45.85 years ($SD = 10.552$). A t-test revealed that charging parties with SUDs were, on average, significantly younger than charging parties in the GENDIS group ($t(82,737) = 29.060$, $p < .001$).

With regard to gender, charging parties with SUDs were 27.8 percent female and 72.2 percent male, whereas the GENDIS group was composed of 49.1 percent females and 50.9 percent males. A chi square analysis revealed that the SUDs group had a significantly higher proportion of males than did the GENDIS comparison group ($\chi^2(1, N = 90,054) = 1380.275$, $p < .001$).

As seen below in Table 2, the racial/ethnic profile of the SUDs group was 62.4 percent Caucasian, 24.4 percent African American, 6.2 percent Other, 5.4 percent Hispanic/Mexican, 1.2
percent Native American/Alaskan Native, and 0.4 percent Asian. The GENDIS group was 58.7 percent Caucasian, 24.1 percent African American, 9.8 percent Hispanic/Mexican, 4.9 percent Other, 1.2 percent Asian, and 1.2 percent Native American/Alaskan Native. A chi square analysis revealed that the SUDS group had proportionally more individuals who identified as Caucasian and as Other, and proportionally fewer individuals who identified as Hispanic/Mexican and Asian than did the GENDIS comparison group ($X^2 (5, N = 81,234) = 226.448, p < .001$).

Table 2

_Charging Party Race/Ethnicity Involved in ADA Title I Allegations: 1992-2011_

<table>
<thead>
<tr>
<th>Race</th>
<th>SUDs (N=8,432)</th>
<th>GENDIS (N= 82,618)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Caucasian*</td>
<td>62.4</td>
<td>4,795</td>
</tr>
<tr>
<td>African American</td>
<td>24.4</td>
<td>1,877</td>
</tr>
<tr>
<td>Other*</td>
<td>6.2</td>
<td>476</td>
</tr>
<tr>
<td>Hispanic*</td>
<td>5.4</td>
<td>415</td>
</tr>
<tr>
<td>Nat. Amer./Alaska Native</td>
<td>1.2</td>
<td>90</td>
</tr>
<tr>
<td>Asian*</td>
<td>0.4</td>
<td>31</td>
</tr>
</tbody>
</table>

_Note._ * = $p < .001$

**Rate of Merit Case Resolutions**

_Research Question 4:_ Do patterns in workplace discrimination allegations filed by Americans with SUDs differ from those in allegations filed by Americans with other disabilities in terms of the rate of merit case resolutions?
The final comparison involves the legal outcomes or Resolutions of the EEOC investigatory process with respect to allegations brought by Charging Parties with SUDs and by the GENDIS group. For purposes of comparison, the researcher collapsed all case resolutions into two categories, merit resolutions and non-merit resolutions. Merit resolutions include withdrawal with benefits, settlement with benefits, successful conciliation, and conciliation failure. Non-merit resolutions include no cause and administrative closures. Less than one-fifth (18.8%, \( n = 1,586 \)) of allegations by people with SUDs were resolved with merit and 81.2 percent \( (n = 6,846) \) were non-merit resolutions. For the GENDIS group, the proportions of merit and non-merit resolutions were 22.1 percent \( (n = 18,256) \) and 77.9 percent \( (n = 64,362) \) respectively. A chi square analysis revealed that people with SUDs were significantly less likely than the GENDIS group to have their allegations result in a merit-based case resolution \( (X^2 (1, N = 91,050) = 48.520, p < .001) \).
CHAPTER IV

DISCUSSION

The following discussion section was organized by discussion of each research question sequentially. Research questions two through four are encapsulated within the first research question, thus the discussion will begin with research question two and continue through research question four. The results of each question will be discussed in detail along with corresponding implications for practice and research within the fields of clinical counseling and rehabilitation counseling. Limitations and implications for future research will also be presented.

Types of Discrimination

Research Question 2: Do patterns in workplace discrimination allegations filed by Americans with SUDs differ from those in allegations filed by Americans with other disabilities in terms of the types of discrimination that is alleged to have occurred?

In absolute terms, the list of most commonly alleged types of discrimination is quite similar for both the SUDs and GENDIS groups. The top three allegations; discharge, reasonable accommodations, and terms/conditions, are the same for both the SUDs and GENDIS group making up roughly 64.9% of all allegations in the SUDs group and 61.9% of all allegations in the GENDIS group. The top six allegations, with only slight adjustment in rank order, are congruent for both the SUDs and GENDIS groups.

Viewing the types of discrimination alleged by people with SUDs and other disabilities more closely, however, reveals a number of proportional differences. Statistically significant differences in the frequencies of types of discrimination were seen in 20 of the 42 different issues between the SUDs group and the GENDIS group. Among the ten most commonly occurring
types of discrimination filed, individuals with SUDs were significantly more likely to allege discrimination in the areas of discharge, hiring, and suspension, whereas the SUDs group was significantly less likely to allege discrimination in the areas of reasonable accommodation, terms/conditions, harassment, discipline, and constructive discharge.

**Discharge**

Beginning with the most prevalent allegation category for both groups, discharge-related complaints were filed more often by people with SUDs than they were by other ADA charging parties (47.8% to 30.3%, respectively), suggesting that people with SUDs perceive they are unfairly terminated from employment due to their disability at a much higher rate than those in the GENDIS group. According to the EEOC regulations (2018), allegations related to discharge encompass all those pertaining to involuntary termination of employment status on a permanent basis. Research has revealed a strong association of unemployment and substance use that is consistent across race/ethnicity, sex, and age groups, as substance use is more prevalent across all substance categories in Americans who are unemployed (Compton, Gfroerer, Conway, & Finger, 2014). These findings regarding discharge support the findings by Baldwin et al. (2010) that Americans with SUDs reported significantly higher rates of involuntary job loss.

**Hiring**

The present results also indicate that people with SUDs perceive they are discriminated against in the process of obtaining employment (i.e., hiring) at a much higher rate than those in the GENDIS group. According to the EEOC regulations (2018), hiring issues occur when there is a failure or refusal by an employer to engage a person as an employee. Along with the higher rate of discharge, this provides more insight into the current trends in unemployment for
Americans with SUDs, which indicate that only 55.1% of Americans with SUDs are employed full-time in comparison to 59.2% of Americans without SUDs (SAMHSA, 2014). Certainly, the present findings suggest that workers with SUDs, in comparison to people with other disabilities, encounter more discrimination-related barriers to both acquiring and retaining employment. More nuanced information regarding how discrimination affected people with SUDs in the hiring process would be revealing; for example, how might disclosure have played a role in the perceived hiring discrimination?

**Suspension**

Also, results from the present analyses revealed that people in the SUDs group perceived discrimination more frequently in the suspension process relative to those in the GENDIS group. According to the EEOC regulations (2018), suspension violations occur when an employee is suspended because of her or his disability. Due to the nature of SUD related impairments and their impact on job performance, it is not surprising that suspension would be a more common allegation category for those with SUDs as opposed to other types of discipline that were more frequent in the GENDIS group. The top three issues in which Americans with SUDs alleged discrimination at higher rates (i.e., discharge, hiring, and suspension) involved the charging party being separated completely from the workplace.

**Significant issues among the GENDIS group**

Interestingly, those with SUDs were less likely than their GENDIS counterparts to allege discrimination on the basis of reasonable accommodation (i.e., an employer failed to provide reasonable accommodation to the known physical or mental limitations of a qualified individual with a disability), terms/conditions (i.e., denial or inequitable application of rules relating to
general working conditions or the job environment and employment privileges which cannot be reduced to monetary value), harassment (i.e., intimidation or antagonism directed at an individual because of disability in non-employment situations or settings), discipline (i.e., the assessment of disciplinary action by an employer against an employee), and constructive discharge (i.e., employee is forced to quit or resign because of the employer’s discriminatory restrictions, constraints, or intolerable working conditions; EEOC, 2018). Many of these issues require being employed and currently instated in a position in order to occur, possibly suggesting that individuals with SUDs are either terminated from employment, suspended, or unable to obtain employment altogether, which would preclude them in many circumstances from experiencing issues such as not receiving a reasonable accommodation, experiencing workplace harassment, or being disciplined on the job. Furthermore, many companies have formal drug and alcohol policies and thus would be less susceptible to someone alleging discrimination on the basis of terms/conditions of employment; they would not hire individuals with SUDs in the first place.

The portrait of alleged discrimination against individuals in the SUDs group is one of difficulty attaining and maintaining employment relative to those in the GENDIS group. The implications of such issues for people with SUDs are significant. Research has demonstrated the difficulties that unemployment and inability to maintain steady employment can have on mental health and substance use issues (Cummings et al., 2013; Gold, 2004; Kerrigan et al., 2004; Sigurdsson et al., 2012). For those with SUDs, these workplace discrimination experiences may be exacerbating symptomology of the SUDs and thus decreasing the likelihood of attaining employment in the future through direct and indirect consequences of substance use.
Clinical implications for type of discrimination alleged

In working with individuals with SUDs, mental health and rehabilitation counselors should take into account the affective and vocational implications of these most commonly reported issues in the workplace. In the mental health field, attention must be given to the impact of perceived workplace discrimination, particularly in the discharge process as it accounts for nearly half of all the discrimination allegations from people with SUDs. The negative affective impact of unfair treatment in the hiring process may also be important to note during the treatment process (Compton et al., 2014). For example, a consumer with an SUD who has not secured employment after several job interviews may benefit from exploring his feelings of frustration, failure, and diminished agency that, if left unaddressed, could serve to demotivate his future job search efforts. Unfortunately, there is little available research on evidence-based counseling techniques and interventions to address the experience of employment discrimination by individuals with SUDs (Baldwin et al., 2010). Other studies examining experiences of employment discrimination have suggested that the individuals who experience workplace discrimination are exposed to a type of chronic stress that causes depressive symptoms and is extremely harmful to an individual’s self-image (Hamilton, Alagna, King, & Lloyd, 1987). The most important therapeutic tasks in working with individuals who have experienced workplace discrimination include empathy, validation, and assisting the consumer in gaining skills to resist the tendency to devalue herself or himself (Hamilton et al., 1987; Pendergrass, Kimmel, Joesling, Petersen, & Bush, 1976). Other helpful treatments include self-advocacy and assertiveness training, utilization of peer supports groups, development of support network, and additional stress-coping skills (Choudhury, 2013; Hamilton et al., 1987; Pendergrass et al., 1976; Sidle, 2008).
The inability to attain or maintain employment, as is common among those with SUDs alleging workplace discrimination, is another factor that can contribute to a consumer experiencing affective symptoms due to the complex stress of occupational instability (Grant et al., 2016). Research has shown the negative psychological impact of the stigma of substance use and unemployment respectively, yet when an individual experiences both he or she may experience a more-than-additive psychological impact given the reciprocal nature of these two discouraging phenomena (Cummings et al., 2013; Gold, 2004; Kerrigan et al., 2004; Sigurdsson et al., 2012). Clinically, it is important to address both the affective and substance related consequences of workplace discrimination, while considering referring a consumer to group counseling along with vocational rehabilitation services to address the experience of workplace discrimination and assist the consumer in the job seeking process. Validation of the experience of discrimination is critical to assisting consumers therapeutically with counteracting the tendency to devalue oneself after experiencing discrimination in the workplace (Hamilton et al., 1987). Research in workplace stress management has demonstrated the utility of both cognitive therapy (CT) and rational emotive behavior therapy (REBT) in reducing and managing adverse workplace experiences such as prejudicial attitudes and discriminatory actions (Choudhury, 2013; Sidle; 2008). For example, a clinician might ask the consumer to relate an instance when she was subjected to a stigmatizing reaction when a co-worker or employer learned of her SUD status. Exploring the affective impact of this incident, how she responded to the stigmatizing reaction, and what meaning she ascribes to the context in which the situation occurred could help the consumer establish more effective strategies for dealing with stigmatizing reactions in the future.
In the vocational rehabilitation process, rehabilitation counselors must be aware of the potential for workplace discrimination of those with SUDs, the complex interaction between the stigma of the SUDs and the stigma of unemployment, as well as the impact of increased affective and SUD symptomology on the employment process. Rehabilitation counselors must be aware of available mental health and substance use resources for referral for consumers who experience workplace discrimination across the various issues. It is important for rehabilitation counselors to develop relationships with employers and educate employers and prospective employees both on SUDs as well as the legal protections available to those with SUDs. A consumer with SUDs may need additional services in the pre-interview process to prepare for potential barriers to employment as well as information about the disability disclosure process. Additionally, a consumer with SUDs may require more intensive job coaching and follow-up services beyond 90 days after obtaining employment to proactively address issues that could lead to perceived unfair discharge. Fully addressing this issue may require the state vocational rehabilitation system to reconsider its case closure criteria for successful rehabilitation, which currently require the consumer to be employed for only 90 days before closing his or her case (Rubin et al., 2016).

**Research implications for type of discrimination alleged**

In terms of research implications, future inquiry is warranted to examine these discrimination issues both quantitatively and qualitatively. With the available data, allegation issues could be used as moderator variables to explore differences that may exist (in terms of charging party characteristics and merit rate) between the different issues. For example, an examination of the different patterns in allegations of discharge across ethnicity identifications of Americans with SUDs could yield important information regarding inequalities in the types of discrimination experienced. Furthermore, the different issue profiles between the two referent
group categories combined in this study (alcohol use and other substance use disorders) could be examined individually to reveal any potential differences between the two. Outside of the database, more research is warranted to examine the complex interaction of SUDs and being discharged from employment, due to the high perceived occurrence of unfair discharge in this population relative to the GENDIS group, with a particular focus on increased affective and SUD symptomology. Qualitatively, it would be valuable to explore the experience of perceived workplace discrimination for those with substance use disorders, particularly those who have been discharged from employment, using a phenomenological approach.

**Characteristics of Charging Parties**

*Research Question 3:* Do patterns in workplace discrimination allegations filed by Americans with SUDs differ from those in allegations filed by Americans with other disabilities in terms of charging party characteristics?

Findings varied such that there were significant differences in the gender, age, and ethnic status distributions of charging parties with SUDs relative to those with other disabilities. Individuals alleging discrimination in the SUDs group were significantly younger and comprised of more males relative to those in the GENDIS group. Regarding ethnicity, those in the SUDs group were more likely than the GENDIS group to identify as Caucasian or Other, whereas those in the GENDIS group were more likely than the SUDs group to identify as Hispanic or Asian.

**Gender**

The gender gap between the two groups was striking, with 72% of the SUDs group being male as compared to 51% of the GENDIS group. Examining the population data available for individuals with SUDs reveals that 12-month and lifetime prevalence rates for drug use disorders
(DUDs) and alcohol use disorders (AUDs) are higher for males compared to females in the U.S. (Grant et al., 2015; Grant et al., 2016). Grant and colleagues (2015; 2016) found that males were 1.7 times more likely than females to develop a DUD both in a 12-month period and over a lifetime course and were twice as likely as females to develop an AUD in both respective periods of time. Further, even though the Bureau of Labor Statistics (2017) reported that general American labor force is comprised of 53.1 percent males and 46.9 percent females, two-thirds of all employed people with SUDs are males (Larson, Eyerman, Foster, & Gfroerer, 2007). Therefore, the gender disparities observed between the SUD and GENDIS groups in this study may be attributable to the simple fact that males were more likely to have SUDs than are females.

Taking into account types of substance used across genders, Larson and colleagues (2007) revealed that, among those employed full-time in the U.S., male rates of past year illicit drug abuse and dependence (3.3%) and past year alcohol abuse and dependence (11.8%) were both higher than those of their female counterparts (1.8% and 5.7%, respectively). Thus, differences in genders seen in this study can be partially explained by the higher rates of SUDs among males, and partially by the fact that males with SUDs are more likely to be employed than women with SUDs. It is also important to factor in other gender differences in SUDs between males and females such as differences in substance use (types of drugs used, methods of ingestion, amount used, etc.), differences in perceptions of employers toward males with SUDs versus females with SUDs, differences in males and females with SUDs in willingness to report discrimination, and even differences in occupations and industries represented by males with SUDs relative to females with SUDs (Brady & Randall, 1999; Greenfield, Back, Lawson, & Brady, 2010; Larson et al., 2007; Vasilenko, Evans-Polce, & Lanza, 2017). An illustration of
population differences in job setting as noted by Larson and colleagues (2007), was that females were more likely than males to be employed in a setting which had a written drug and alcohol policy and access to an Employee Assistance Program (EAP). Additionally, of the top five occupations with the highest prevalence of current illicit drug use, three were found to be overwhelmingly dominated by males (i.e., 97.4% of construction workers, 96.2% of installation maintenance and repair, and 87.2% of transportation and material moving occupations were male; Larson et al., 2007).

Clinical implications to address the gender gap. Even with estimates of the full-time workforce among people with SUDs being two-thirds male, 72% of workplace allegations being made by males still makes for an underrepresentation of females. The significant proportional gender gap in the number of discrimination allegations made by individuals with SUDs behooves clinical mental health and vocational rehabilitation counselors to carefully consider elements of gender identity and socialization that may influence perceptions of workplace discrimination, assertiveness, career choice and occupations, and social supports that may be related to employment and psychological outcomes. For example, familial expectations that were placed on a female consumer regarding assertiveness and/or self-advocacy are likely to be different from the expectations that a male consumer was subjected to growing up. It is important to consider the additional stigma a female may experience in the workplace in addition to stigma for SUDs. For example, substance use in general, particularly heavy alcohol use, has been shown to be more socially acceptable for males (Brady & Randall, 1999; Greenfield et al., 2010; Vasilenko et al., 2017). While there is little available data on specific counseling interventions that are effective for working with women with SUDs who experience workplace discrimination, recommendations for working with women who have experienced workplace discrimination
suggest that clinicians should assume that the woman has experienced discrimination, that if the woman has complained in any way there is likely to have been retaliation, and that any extreme affect or behavior should be interpreted in terms of victimization, until proven otherwise (Hamilton et al., 1987).

Several research studies examining gender differences in substance use have indicated that females may be less likely to disclose a SUD or enter treatment due to a plethora of negative consequences associated with the societal attitudes and gender role expectations for females with regard to substance use (Brady & Randall, 1999; Greenfield et al., 2010; Vasilenko et al., 2017). In general, females begin using substances later than males, face stronger partner pressure to use substances, enter treatment earlier than their male counterparts, and have significantly higher rates of comorbid psychiatric disorders (Brady & Randall, 1999; Greenfield et al., 2010; Vasilenko et al., 2017). It is important for mental health and rehabilitation practitioners to work with females and their families to understand the negative impact of these societal attitudes, examine the underlying mood-related and trauma-related comorbid conditions, and assist them in assertiveness training when needed to disclose potential discriminatory employment experiences and to enter treatment programs when necessary.

**Research implications to address the gender gap.** In terms of research implications, it is important to ascertain the potentially different meanings that males and females ascribe to workplace discrimination and career development. The workplace continues to change in the U.S. as more females enter the workforce, including traditionally male dominated occupations, potentially increasing their exposure to substances and substance use culture. In light of these shifts, researchers must continue to monitor the psychosocial impact of these changes in substance use patterns in females, as well as the impact on the societal attitudes toward female
substance use (Greenfield et al., 2010). These phenomena could be examined using qualitative methods such as phenomenological, constant comparative, and grounded theory analyses using techniques such as structured interview and focus groups. Within the IMS database, more research can be done into gender, using it as a moderator variable or as a covariate to examine the differences in issues, other charging party characteristics, types of SUDs (i.e., alcohol or other substance use), and merit rate resolutions. With a particular focus across time, these issues could also be examined longitudinally to investigate how recent history has impacted the gender differences seen in this study.

Age

On average, those alleging discrimination in the SUDs group were significantly younger than those in the GENDIS comparison group. A variety of age-related characteristics of SUDs may contribute to these results. While ages of onset for SUDs vary dramatically, the prevalence of SUDs is generally higher in younger individuals and declines with age across the population (Grant et al., 2015; Grant et al., 2016; Vasilenko et al., 2017). SUDs considerably contribute to an individual’s morbidity and mortality, including premature mortality, infectious disease, and comorbid health conditions, thus shortening the lifespan of people with SUDs (Vasilenko et al., 2017). In addition, those with SUDs have been linked with higher stress reactivity and impulsivity, which are also associated with shorter lifespans (Compton et al., 2014). Another unique aspect impacting the population of individuals with SUDs is the possibility that an individual may recover over time and no longer meet criteria for a SUD (Sellman, 2010). Among those with SUDs who are employed full-time, the age profile is similar to that of the general population of people with SUDs. Of those employed full-time, past year illicit drug and alcohol dependence or abuse was highest among those aged 18-25 (7.5%; 18.4%), followed
by those aged 26-34 (3.3%; 12.3%), those aged 35-49 (1.9%; 7.8%) and finally lowest in those aged 50-64 (0.7%; 4.0%; Larson et al., 2007). On the other hand, the rates of substance use are much higher for those who are unemployed, with the exception that heavy alcohol use is more common among employed people between the ages of 18-25 than it is among unemployed people in that age range (Compton et al., 2014). So while substance use rates decrease with age, an individual with a SUD will likely have more difficulty maintaining and obtaining employment over time, which increases the likelihood of substance use and further decreases opportunities to reenter the workforce (Compton et al., 2014). One possible explanation can be elicited from the earlier data on type of discrimination alleged. That is to say, due to the higher rate of discrimination alleged in the discharge and hiring process, those with SUDs may be less likely to attain and maintain employment as they age if they continue to actively use substances. Combined, these factors may provide a rationale for the statistically significant age disparity seen between the SUDs group and the GENDIS group. Certainly, the consumer’s age and developmental level must be given full consideration in vocational rehabilitation efforts with consumers who have SUDs.

Clinical implications of age discrepancies. For clinical mental health and vocational rehabilitation counselors working with individuals with SUDs, it is important to understand the impact that age may have on the individual’s psychological well-being, occupational options and status, likelihood of experiencing discrimination in the workplace, and overall recovery process. With younger individuals more likely to experience workplace discrimination, clinical counselors should address potential obstacles in recovery that could be encountered by younger Americans with SUDs in the workplace, as well as be aware of the potential effects of unemployment for those at a younger age who could also be dealing with greater levels of
economic instability due to lack of continuity and opportunities in the workplace early in the career development process. Psychoeducational approaches to providing this information could help young consumers with SUDs understand the importance of staying in the workforce as a vehicle toward economic self-sufficiency, as well as underscoring the importance of SUD treatment and recovery to those long-term goals. For vocational rehabilitation counselors, it is important to be aware of the potential for workplace discrimination for those with SUDs at a younger age, and they should assist these consumers in learning their rights under the ADA and other employment-related legislation. It is also important to guide consumers with SUDs in an exploration of the potential risks and benefits of disclosing their SUDs to prospective and current employers.

**Research implications of age discrepancies.** More information to guide recommendations for practice could be gathered through intensive examination of the impact of age on the workplace discrimination experiences of Americans with SUDs. Within the IMS database, a cross sectional examination of age as a moderator variable would provide foundational data on the differences in allegations of workplace discrimination between different age groups in terms of type of SUD, type of discrimination alleged, charging party characteristics, and merit rate. Further, more research is warranted into the impact of age of onset for substance use disorder in the career development process which could be accomplished through the use of quantitative, qualitative, and mixed methodologies. Quantitatively, large-scale national surveys would help to identify age characteristics of substance use across the U.S., while also allowing for regional comparisons and conclusions to be made. Further, qualitative case studies would help bring deeper meaning to the acquisition of SUDs and the personal impact of SUD use on career development across the career lifespan.
As the American population continues to age and the Baby Boomer generation reaches retirement age, researchers and practitioners alike must be aware of the cultural implications related to issues of access to treatment and the increase in retirement age as both are potential risk factors for increased substance use in certain populations, such as African Americans (Compton et al., 2014). This marks a notable intersection for potential discrimination on the basis of age and substance use (Hooyman, Kawamoto, & Kiyak, 2015). Strategies to focus on strengths and opportunities for older individuals with substance use disorders to fully participate in the workforce will be increasingly important for this population.

**Ethnicity**

It terms of ethnicity, individuals alleging discrimination in the SUDs group were significantly more likely to identify as Caucasian or Other and significantly less likely to identify as Hispanic or Asian relative to the GENDIS comparison group. Notably, the rates of allegations for those identifying as African Americans was not statistically significant between groups. This finding is somewhat surprising given the double stigma status of African Americans and those with SUDs. For instance, research on the intersectionality of racial/ethnic bias and addiction stigma has shown that individuals of racial/ethnic minority status with SUDs were subject to higher implicit bias via healthcare providers, were more likely to be arrested, and received harsher criminal sentences than their Caucasian counterparts with SUDs (Kulesza et al., 2016; Shaw et al., 2012). Given the differences relative to the discrimination experiences of those corresponding ethnicities within the GENDIS group, this result indicates a potential interaction in an individual’s culture/ethnicity and SUDs.

An examination of the overall population of those with SUDs in the U.S. reveals that the ethnic/racial distribution of SUDs in the U.S. population is fairly similar to the proportions of
allegations by Americans with SUDs in this study. Specifically, the lifetime prevalence of AUDs is highest for individuals identifying as Native American (43.4%), followed by White (32.6%), Hispanic (22.9%), Black (22%), and Asian/Pacific Islander (15.0%; Grant et al., 2015). Similarly, the lifetime prevalence of DUDs was found to be highest among those identifying as Native American (17.2%), followed by White (10.8%), Black (9.9%), Hispanic (7.2%), and Asian/Pacific Islander (4.0%; Grant et al., 2016). An examination of the population proportions across time by Vasilenko and colleagues (2017) demonstrated that estimated prevalences of SUDs were higher for individuals identifying as White at younger ages and higher for those identifying as Black at older ages, indicating a potential interaction between age and ethnicity with regard to substance use. This suggests that the developmental aspects of SUDs may be culturally and contextually bound, meaning the onset and maintenance of SUDs appear to be at least somewhat dependent on an individual’s cultural background and environment.

Another important contextual consideration is the available data on the ethnicity of Americans with SUDs employed full-time, given that the present study is specifically examining instances of discrimination within the workplace. With regard to past year alcohol dependence or abuse among those employed full-time, prevalence was again highest for those identifying as Native American (10.7%), followed by Two or More Races (10.1%), Hispanic (10.0%), White (9.6%), Native Hawaiian/Pacific Islander (9.4%), Black (7.3%), and finally Asian (4.6%; Larson et al., 2007). In terms of past year illicit drug dependence or abuse among individuals employed full-time, those identifying as Native American were highest (4.5%), followed by Two or More Races (4.3%), Native Hawaiian/Pacific Islander (4.3%), Hispanic (3.2%), Black (2.9%), White (2.5%), and Asian (1.1%; Larson et al., 2007). Two of the most notable pattern shifts from the general population of Americans with SUDs to the population of Americans with SUDs
employed full-time were the decrease in rank-order prevalence of White individuals with SUDs relative to Hispanic and Black individuals with SUDs and the increase in rank-order of Hispanic individuals with SUDs with regard to their White and Black counterparts. Indeed, the demographic information available for Americans with SUDs employed full-time reveals that ethnicity may be the most significant departure revealed in the present study from the actual demographic profiles of Americans with SUDs that are available. For instance, the Native American/Alaskan Native population demonstrated the highest substance use proportions across both the general population and employed full-time population, yet this pattern was not reflected in the number of allegations filed by these individuals in the present study. However, this finding may be explained, in part, by the lack of representation for Native Americans/Alaskan Natives in the EEOC IMS database.

**Caucasian.** Examining the specific differences seen across ethnic identities, the findings of higher rates of alleged discrimination by those identifying as Caucasian in the SUDs group is noteworthy. The high proportion of males in the SUDs group would indicate a higher rate of reported discrimination by those who are both Caucasian and predominantly male, the only demographic group in the study that would not necessarily be considered a double minority due to minority status in gender identity or ethnicity notwithstanding other unknown demographic considerations. The primary stigma for this group would be their disability status as an individual with a SUD and as such, it is reasonable that people in this group may be more likely to attribute unfair treatment to their sole minority grouping status, as opposed to a female or African American with SUDs having to interpret unfair treatment in the workplace as a function of multiple minority statuses. Further, the demographic profile for charging parties is limited to disability type, age, gender, and ethnicity, and as such we do not have access to important
information on socioeconomic status, geographic region, and occupational industry, among others, that may explain the higher rate of alleged discrimination in Caucasians with SUDs relative to those in the GENDIS group. Other important demographic information across the two comparison groups that was unavailable such as the socioeconomic level, sexual orientation, education level, marital status, and geographic region could reveal further interactions that might provide more rationale for these differences. As with gender, it is important to consider the potential differences across ethnic/cultural backgrounds in terms of differences in how and what substances are used (types of drugs used, methods of ingestion, amount used, etc.), differences in perceptions of employers toward individuals from different backgrounds, differences in willingness to report discrimination, and differences in the occupations and industries represented by those of different ethnic/cultural backgrounds.

**Other.** Americans with SUDs identifying as Other also alleged more workplace discrimination at a statistically significant rate relative to the GENDIS group. The groups not nominally recorded by the demographic information in this study that would comprise the Other group would include groups such as Native Hawaiian and Other Pacific Islander and Two or More Races, which comprise 0.4 percent and 1.8 percent of the U.S. workforce respectively, along with those who do not identify with the given ethnic/racial groupings in general (Bureau of Labor Statistics, 2017). The relatively high prevalence rankings for both of these groups as evidenced by Larson and colleagues (2007) could partially explain the higher number of allegations seen in this group relative to the GENDIS group. These higher rates of allegations are likely a product of the high prevalence rates of SUDs combined with the high levels of stigma faced by these underrepresented minority groups, which likely have a reciprocal impact on each other.
Hispanic. Americans with SUDs who alleged workplace discrimination were less likely to identify Hispanic heritage than were charging parties with other disabilities. It is important to note that the terms Hispanic or Latino/a are representative of a relatively heterogeneous group that may vary significantly by nativity and country of origin. Currently, Hispanic/Latinos are the largest ethnic group in the U.S. and are also the fastest growing group in terms of entrance into SUDs treatment programs (Guerrero, Marsh, Khachikian, Amaro, & Vega, 2013; Otiniano Verissimo, Grella, Amaro, & Gee, 2014). It has been theorized that the relatively high rates of SUDs in this population, particularly AUDs, are related to stress-coping frameworks, as well as the minority stress model positing that due to disadvantaged positions and increased experiences of discrimination, there is an increase in SUDs seen among Hispanic/Latinos (Otiniano Verissimo et al., 2014). Another hypothesis related to heavy drinking in the Hispanic/Latino population is related to the cultural phenomenon of “exaggerated machismo” wherein the ability to binge drink in large amounts is associated positively with perceptions of masculinity (Tran, Lee, & Burgess, 2010).

According to the Bureau of Labor Statistics (2017), about 16.8 percent of the U.S. workforce is Hispanic/Latino. Therefore, given what is known about the rates of SUDs in this population, it is noteworthy that only 5.4 percent of allegations by Americans with SUDs came from this population, a statistically significant disparity from their GENDIS counterparts at 9.8 percent of allegations. In an investigation of discrimination experiences of minority groups in the U.S., Tran and colleagues (2010) found that Hispanic individuals reported the setting in which they experienced the most discrimination was getting a job, accounting for 38.81 percent of discriminatory experiences, with an additional 25.25 percent of discriminatory experiences reported occurring at work. It is possible that the low levels of workplace discrimination
reported due to SUDs could be moderated by levels of perceived racial/ethnic discrimination experienced in the workplace, though it is also possible that workplace discrimination is vastly underreported in this population due to lack of knowledge of legal protections and civil rights.

**Asian.** Americans with SUDs identifying as Asian also alleged statistically lower levels of workplace discrimination, however, unlike the Hispanic/Latino population, this finding appears to be more in line with the available data for the prevalence of SUDs in Asian Americans (Grant et al., 2015, Grant et al., 2016, Larson et al., 2007, Wu & Blazer, 2015). The Bureau of Labor Statistics (2017) indicated that Asian Americans comprise 6 percent of the U.S. workforce, yet account for only about 0.4 percent of SUD workplace discrimination allegations in this study. These results can be best understood in light of the prevalence data for Asian Americans indicating they consistently report the lowest levels, by a wide margin, of SUDs in both the general and full-time employed American population (Grant et al., 2015, Grant et al., 2016, Larson et al., 2007).

It is important not to neglect research and service implications for this population simply due to the smaller prevalence of use in this population. In fact, research by Wu and Blazer (2015) indicated that those who do acquire SUDs in this cultural subset may experience greater levels of in-group discrimination and stigma in addition to general stigma attached to SUDs. Currently, about two-thirds of Asian Americans are foreign-born, meaning that this demographic will continue to be further acculturated into U.S. society, a demonstrated risk factor for increased substance use (Tran et al., 2010; Wu & Blazer, 2015). Much like the Hispanic/Latino population, the Asian American population is anything but homogenous. However, the myth of a homogenous “model minority” persists for Asian Americans, where they are expected to function as upstanding citizens, ultimately reducing access to resources and care such as
substance use treatment (Nguyen, 2015; Wu & Blazer, 2015). Further, the lower degrees of
cultural acceptability, particularly family-related stigma and shame associated with SUDs, as
well as the cultural beliefs about the antecedents of such conditions (e.g., Karma) reduce the
likelihood that Asian Americans will report or disclose use and seek treatment for SUDs
(Nguyen, 2015; Wu & Blazer, 2015). Thus, the occurrence of workplace discrimination for
individuals identifying as being of Asian origin may be higher than reported in this study. As the
population of Asian Americans continues to grow more quickly than any other minority in the
U.S., becoming more acculturated into Western society, the need for treatment and service
provisions specific to individuals of different Asian origins will continue to increase (Nguyen,
2015; Wu & Blazer, 2015).

**African American.** As opposed to those of Hispanic and Asian origin, Americans with
SUDs identifying as African American did not differ statistically in terms of alleged
discrimination from those identifying as African American in the GENDIS group. According to
the Bureau of Labor Statistics (2017), about 12.3 percent of the U.S. workforce identifies as
Black or African American, while the rates of alleged workplace discrimination filed for
Americans with SUDs and in the GENDIS group were nearly identical at 24.4 percent and 24.1
percent respectively. As discussed, prevalence rates for individuals identifying as Black were
among the lowest for AUDs and comparable to other ethnicities ranked on the high end for
DUDs outside of the workplace (Grant et al., 2015; Grant et al., 2016). Within the workplace,
those identifying as Black were again among the lowest prevalence ratings for both alcohol and
drug usage (Larson et al., 2007). Based on prevalence alone, it is not entirely surprising to see a
similar rate of alleged discrimination for African Americans across the SUDs and GENDIS
groups. However, there are several additional factors related to workplace discrimination and
substance use that negatively impact the workplace experience of African Americans that make this finding noteworthy (Broman, Neighbors, Delva, Torres, & Jackson, 2008; Larson et al., 2007; Pete et al., 2015).

On the surface, the prevalence rates for SUDs for African Americans when compared to those of other ethnicities are not cause for unique consideration. However, a closer look at research reveals that SUDs for African Americans tend to persist over longer periods of time (Sigurdsson et al., 2012). Hypothesized explanations for this unique feature of SUDs in African Americans include lack of resources and access to adequate treatment, higher prevalence rates with more criminalized substances such as crack cocaine and heroin, and more adverse health and social consequences when compared to White individuals (Broman et al., 2008; Cheng & Robinson, 2013; Tran et al., 2010). The most notable discrepancies in health and social consequences included increases in unintentional injury, violence, homelessness, premature death, and being overrepresented (Broman et al., 2008; Cheng & Robinson, 2013; Tran et al., 2010). These are just a few of the disadvantages encountered by African Americans that significantly influence their employment opportunities and work participation. In fact, data reveals younger African American males have unemployment rates as high as 33.4 percent (Pete et al., 2015). Further, in the workplace environment Larson and colleagues (2007) reported that Black individuals were more likely than their White or Hispanic counterparts to encounter both pre-hire and random drug testing. Subsequently, these barriers to employment have resulted in increases in adverse health effects, including substance use, creating a negative reciprocal impact of employment difficulties and SUDs (Pete et al., 2015).

The equivalency between allegations in the SUDs and GENDIS groups of individuals identifying as African American in this study could be an indication that African Americans with
disabilities in general also experience some of the same disadvantages as African Americans with SUDs. However, it could be equally likely that both populations are underreporting workplace discrimination. One aspect limiting treatment seeking behavior in African Americans is the reluctance to disclose a disability because it is viewed culturally as a “personal weakness,” which could also impact willingness to disclose discrimination on the basis of a disability. Research has indicated that those who are close with their families are less likely to seek professional assistance for mental health issues, and culturally, it is believed that behavioral health complications tend to improve on their own without treatment or assistance (Cheng & Robinson, 2013.) Thus, the stigma of disclosing a SUD or another disability could be impacting the assertiveness of African Americans in filing a workplace discrimination allegation. Additionally, it is important to consider the implications of the relatively high unemployment rates for African Americans; the lower number of employment opportunities for African American individuals may be impacting the numbers of allegations filed by these individuals.

Due to the level of well-documented disadvantaglement with African Americans, it is important to consider the possibility that the experience of workplace discrimination for African Americans with SUDs is an underreported phenomenon (Broman et al., 2008; Cheng & Robinson, 2013; Kulesza et al., 2016; Shaw et al., 2012; Tran et al., 2010). When working with African Americans with SUDs, practitioners should be aware of barriers to employment and the corresponding health consequences of unemployment including increased risk for SUD symptoms. Further distinguishing this population is the increased duration of SUDs and intensity of consequences for SUDs experienced (Broman et al., 2008; Cheng & Robinson, 2013; Tran et al., 2010). It is important to keep in mind that much of the research speaks directly to those identifying as “Black” which includes African-born Black and Caribbean Black individuals.
who, according to research, have different barriers and risk factors in terms of unemployment and SUDs (Broman et al., 2008; Cheng & Robinson, 2013; Tran et al., 2010). Treatment and service delivery should be sensitive to the individual’s personal cultural context in terms of disclosing disability and discussing legal rights and protections from workplace discrimination.

Native American/Alaskan Native. Much like African Americans with SUDs in this study, those with SUDs identifying as Native American or Alaskan Native in this study did not vary significantly from their GENDIS counterparts in terms of proportion of allegations filed. Upon further examination of this population, Native Americans and Alaskan Natives comprise approximately 1.1 percent of the workforce in the U.S., which is nearly identical in proportion to the percentage of allegations made by individuals of Native American or Alaskan Native descent in both the SUDs and GENDIS groups (Bureau of Labor Statistics, 2017). If the prevalence of disability were equivalent across all ethnic groups, this would be an expected result, however, given the disproportionately high prevalence of AUDs and DUDs in both the general and full-time employed populations of Native Americans and Native Alaskans, the low number of allegations filed is particularly concerning (Bagalman & Heisler, 2016; Grant et al., 2015; Grant et al., 2016; Larson et al., 2007).

A closer examination of SUDs in Native Americans and Native Alaskans reveals a strong relationship between underlying social determinants present in this population and the presence of substance use (Bagalman & Heisler, 2016). Native Americans and Native Alaskans are disproportionately exposed to negative social determinants such as inadequate education, rates of poverty that are nearly double the rest of the U.S. population, discrimination in the delivery of healthcare services, increased prevalence of physical and behavioral health issues, and higher rates of suicide (Bagalman & Heisler, 2016; Chung-Fan, Wilkins-Turner, Liebert, Ellien, &
Harrington, 2011; Etz, Arroyo, Crump, Rosa, & Scott, 2012). Substance use is particularly consequential for Native Americans and Alaskan Natives as those with SUDs have mortality and morbidity rates that are nearly double those who are not Native American or Alaskan Native (Larios et al., 2011).

Another social disparity prevalent in the Native American or Alaskan Native population is high unemployment rates (Bagalman & Heiser, 2016; Chung-Fan, et al., 2011). The unemployment rates for Native Americans or Native Alaskans are consistently more than double the rates for their White counterparts with lower rates for members of non-gaming tribes (Bureau of Labor Statistics, 2017; Chung-Fan et al., 2011). In terms of Native Americans or Alaskan Natives with SUDs, research has indicated that this population has the lowest rate of success in vocational rehabilitation programs relative to Native Americans or Alaskan Natives with other disabilities, as well as in comparison to other races/ethnicities with SUDs (Schact & White, 2003). Employment barriers and other social determinants are stressors linked to increased substance use, and increased substance use leads to an even greater barrier to employment and other important health outcomes such as reduced access to healthcare and treatment.

The research underlying the prevalence of SUDs and other negative risk factors with the Native American and Alaskan Native population suggests that this population would be one of the most likely to experience workplace discrimination at a disproportionate rate. The results that indicate there is not an elevated level of discrimination allegations for Native Americans and Alaskan Natives with SUDs is concerning and may speak to their cultural means of addressing concerns of injustice or disability, or could also be indicative of other institutional barriers (e.g., access to healthcare, involvement in the criminal justice system, and educational opportunities) preventing the proportional reporting of issues of workplace discrimination. More research is
needed examining these specific issues and some of the underlying reasons for the apparent
dearth of allegations on a tribal level respecting the heterogeneity of this diverse category of
individuals (Etz, Arroyo, Crump, Rosa, & Scott, 2012).

When working with individuals of Native American or Native Alaskan descent it is
important for practitioners to keep in mind this heterogeneity as there are significant cultural
differences in individuals (e.g., different tribal affiliations, urban or rural environments, or living
on or off reservations) that impact the types of substances used, the view of substance use, the
availability of employment, and the spiritual and healing practices preferred (Etz et al., 2012;
Larios et al., 2011). Research has indicated that mainstream treatment institutions using
common evidenced-based practices may inspire a sense of distrust due to the history of cultural
oppression and genocide (Larios et al., 2011). For this reason, treatment should be informed by
the individual’s preferences and perspectives on spirituality and healing, while being mindful of
specific risk factors identified. Identity is an important self-concept to be mindful of as lack of
employment opportunities has a universal impact on identity, which can further be impacted by
the specific difficulty in maintaining cultural identity for Native Americans and Alaskan Natives
and the possibility of being excluded from cultural activities due to excessive substance use (Etz
et al., 2012).

**Clinical implications of ethnicity findings.** In order to maintain a culturally competent
practice in working with people with SUDs in both clinical mental health and vocational
rehabilitation settings, it is important to understand the potential impact of an individual’s ethnic
and cultural background. Counselors must carefully consider elements of ethnic identity and
socialization that, as with gender identity, may influence perceptions of workplace
discrimination, assertiveness, career choice and occupations, and social supports that may be
related to employment and psychological outcomes. Further, the practitioner should consider how an individual’s ethnic and cultural background can play a role in the likelihood of developing a substance use issue, the incidence of co-occurring issues, the type of substance that may be used, the amount of substance that is used, the method of ingestion for the substance, the age of onset and duration of substance use, access to treatment, and likelihood of attending a treatment program.

Practitioners must be aware of how these differences mediate the interactions between substance use, employment, and the occurrences of workplace discrimination, as these phenomena will reciprocally affect each other. Addressing stigma related to ethnic/racial identity along with disability status is a complex challenge for clinical practitioners. As such, interventions focused on reducing stigma should be utilized within treatment. Group-based acceptance and commitment therapy has been shown to be a promising intervention for reducing self-stigma, while motivational interviewing and communicating positive stories can be helpful for addressing social stigma (Livingston et al., 2012). In order to address stigma holistically, practitioners must also address stigma at the structural level through contact-based and education programming with employers and other healthcare providers (Livingston et al., 2012).

**Research implications of ethnicity findings.** In terms of research, more exploration needs to be completed within the IMS database with regard to using ethnicity as the independent variable in order to examine how type of SUD, type of issue, gender, age, and merit rate of allegation vary across different ethnic categories. This data would provide more insight into each individual category and serve as a basis for future research into how the experience of workplace discrimination for Americans with SUDs may vary across ethnic groups. In addition, more phenomenological studies on the experience of workplace discrimination in minority
populations with SUDs is warranted to better understand subtle difference in how workplace discrimination manifests for these individuals and how it impacts other aspects of their lives including their quality of life and overall well-being.

**Rate of Merit Case Resolutions**

*Research Question 4:* Do patterns in workplace discrimination allegations filed by Americans with SUDs differ from those in allegations filed by Americans with other disabilities in terms of the rate of merit case resolutions?

People with SUDs prevail significantly less often in allegations made under Title I of the ADA than do those with other disabilities. This is perhaps the most compelling evidence that those with SUDs are treated differently in the workplace relative to those with other disabilities as suggested in previous studies (Baldwin et al., 2010). However, examining some of the differences in the type of discrimination alleged, along with the differences in the gender, age, and ethnicity of the charging party reveal other potentially confounding variables that could explain this significant gap in merit rate of resolution. Additionally, it is clear that with the additional legislative policies in place to govern the use of substances in the workplace, not to mention the potential legal precedence of the U.S. Drug-Free Workplace Act, that there are more legal grounds from which an employer could justify an action perceived as discrimination by an individual with SUDs relative those in the GENDIS group.

Both mental health practitioners and vocational rehabilitation counselors should be aware of the decreased chances of Americans with SUDs receiving a merit result in a workplace discrimination allegation. In addition, practitioners should be prepared for the impact of a non-merit case result on an individual’s overall well-being and future vocational and psychological
functioning. To help inform consumers who have experienced workplace discrimination of their legal options, it is important for practitioners to understand the protections and implications of the substance use clauses in the ADA as well as the U.S. Drug-Free Workplace Act. Caution may be warranted in encouraging a consumer to file a complaint under a statute that restricts or that provides limited protections for people with SUDs. Hamilton and colleagues (1987) identified widespread negative individual and familial emotional consequences for an individual who filed complaints including defensive responses from employers, increases in intensity of workplace stress, rejection or lack of support from co-workers, increased strain on family relationships, and the time and financial costs of the filing process.

In terms of future research implications, one valuable insight from the IMS database would be to run a logistic regression on the variables that are associated with merit-based resolutions for Americans with SUDs. This exploration would provide information on the issues or characteristics that are most associated with merit and non-merit based resolutions, which could inform further research studies and provide in important foundation for educating employers and legislators on sources of discrimination for this population. An understudied related area is the impact of attaining a non-merit based resolution on an individual with an SUD, a phenomenon that could be better understood using mixed method research focusing on Americans with SUDs who have received non-merit based case resolutions.

**Implications for Counselor Education and Supervision**

Beyond the aforementioned clinical and research implications, the findings of this study hold significance for counselor educators and supervisors as well. Findings reported by Ronzani and colleagues (2009) indicated that individuals with SUDs encounter highest levels of stigma when interfacing with healthcare and social service professionals. Counselor educators should
ensure that they themselves are educated on the current research findings and models of SUDs, in addition to continually self-assessing for any biases toward individuals with SUDs (Burgess, Beach, & Saha, 2017). To counteract practitioner stigma, counselor educators should infuse into their curricula education on the biological, genetic, and neurological etiology of SUDs; the co-occurring nature of SUDs with other physical and mental health conditions; the importance of employment on well-being and the negative impact of workplace discrimination on recovery from SUDs; and the nature and negative implications of the stigma experienced by those with SUDs (Goodman, Wilson, Helms, Greenstein, & Medzhitova, 2018).

Presentation of information on individuals with SUDs should align with the social justice and advocacy perspectives consistent with the counselor education approach to other highly stigmatized groups of individuals (Decker, Manis, & Paylo, 2016; Steele, 2008; West-Olatunji, 2010). It is critical to include information about the intersectionality of stigma toward individuals with SUDs who also experience stigma based on other characteristics such as gender, race/ethnicity, sexual orientation, age, religious affiliation, and ability status (Kulesza et al., 2016). Further, in conjunction with other relevant counselor educator advocacy and legislative lobbying efforts, counselor educators should prioritize legislative disadvantagement for individuals with SUDs. (Malott & Knoper, 2012).

The stigma experienced by individuals with SUDs from practitioners is rarely overt in nature. Much of the reported stigma encountered by individuals with SUDs was related to body language and other non-verbal communications (Luoma et al., 2007; Ronzani et al., 2009; Shomerus, 2014). When supervising counselor trainees, supervisors should address any inappropriate or ambivalent verbal or non-verbal behaviors trainees express toward individuals with SUDs. Further, supervisors should also examine their own biases toward individuals with
SUDs to avoid indirectly relating to a counselor trainee’s consumer in a prejudiced manner (Burgess et al., 2017). In terms of evaluation, supervisors should be sure to evaluate counselor trainee competencies for working with individuals with SUDs before the trainee provides direct care and continue to evaluate SUD competencies as a priority emphasis (Glosoff & Durham, 2010).

**Additional Considerations**

The current trends in addiction and substance use, such as the opioid epidemic; emergence of information on gambling, electronic, and other behavioral addictions; and ongoing issues with the treatment of chronic pain, combined with the intrusive and limiting nature of SUDs, demand that SUDs be highly prioritized and understood by mental health counselors and vocational rehabilitation counselors alike. The presence of SUDs and the stigma of SUDs affect the individual both internally and externally. Those with SUDs may internalize negative stigma and attitudes, which can increase other mental health symptoms and, as seen in the co-morbidity statistics, increase the likelihood of experiencing additional mental health issues (Sellman, 2010). From an external perspective, the presence of stigma and negative attitudes toward those with SUDs on individual, societal, and institutional levels can have lasting impact on the overall well-being of those with SUDs through limited employment opportunities, decreased social interactions and social supports, and increased legal issues (Compton et al., 2014; SAMHSA, 2014). The employment discrimination that results from this stigma can be a particularly salient and potentially traumatic experience. For these reasons, it is important to work with individuals with SUDs on their self-perceptions, but also relevant to include a focus on building natural, positive supports in their everyday environments including at home and in
the workplace. Those supports can reinforce and improve effectiveness of internal work with individuals on self-stigma by decreasing the prevalence of negative environmental reinforcers.

Even as the job market fluctuates and evolves in the U.S., unemployment rates have remained relatively high for those with disabilities, including Americans with SUDs (Bureau of Labor Statistics, 2017). Research demonstrates that SUDs are most common among those who are unemployed, which in turn increases the likelihood of other co-occurring symptoms and reduces further employment opportunities. The impact of this cycle is particularly extreme for disadvantaged populations in the U.S. (Compton et al., 2014; SAMHSA, 2014). A positive self-image and well-being is promoted by productive employment opportunities, while experiencing unemployment and workplace discrimination contrastingly decreases well-being and increases the presence of factors that exacerbate SUD symptomology (Chan et al., 2005; Sigurdsson et al., 2012). For mental health and rehabilitation practitioners, it is essential to prioritize career well-being and ensure that the consumer with SUDs has the necessary support and services in place, such as job seeking skills training, job coaching, and legal counsel when necessary.

Workplace discrimination for Americans with SUDs is an understudied topic, and this study is the first step in beginning to understand this particular phenomenon. As this study is quantitative in nature and based on population data from a national database, it does not capture personal perspective or richness in depth in terms of its data. A qualitative study examining the lived experience of workplace discrimination for Americans with SUDs would provide researchers more understanding of individual perceptions of these events and insight into in-depth accounts that would otherwise be unavailable. This could also provide useful information as to what a person experiences in the aftermath of the alleged discrimination.
As new data become available, the current study should be updated based upon the new IMS data acquired through 2017. A particular consideration within the IMS database would be to examine workplace discrimination for Americans with SUDs across specific ADA time periods. For example, it would be beneficial to compare the periods of the initial passage of ADA to the Sutton ADA Supreme Court ruling, with the post-Sutton ADA up to the passage of the ADAAA, with the post-ADAAA up through the present time. This would provide more information as to how these different periods of ADA effectuation have impacted the phenomenon of workplace discrimination for Americans with SUDs. Other variables could also be considered, for example in this study AUDs and DUDs were combined into one SUDs group, whereas it would also be important to examine AUDs and DUDs separately to explore differences in workplace discrimination across the different types of SUDs.

SUDs are one of many emerging disabilities in the U.S (Koch & Rumrill, 2017). Additional work in the IMS database should focus on the workplace discrimination experiences of those with other emerging disabilities. As the disability landscape changes and, with medical and technological advances, some individuals are living longer more productive lives with disability, continued research is needed to explore these increasing and, in some cases, new populations of individuals with disabilities within the context of stigma and employment.

**Limitations**

Although this study has many strengths including population level data across time and multiple variables at several levels of measurement, it is not without limitations that require acknowledgement. For instance, the available charging party demographic data are nominal in nature, which limits the types of data analysis that can be used (to non-parametric statistics). Further, there are many demographic characteristics that have been shown to be relevant to both
employment and SUD outcomes that were not available in the database including marital status, sexual identity, gender identity, socioeconomic status, geographic location, and urban-rural classification (Grant et al., 2015; Grant et al., 2016; Larson et al., 2007).

The data on the nature of the substance use itself is limited as well. Specific data regarding the type of substance used, the severity of substance use, the duration of the SUD, and the preferred method of ingestion were unavailable, yet they may have important implications for symptoms and course of the SUD. For example, different substances carry more stigma than others, depending on individual’s culture and the workplace culture, and thus would affect the likelihood of experiencing workplace discrimination (Brady & Randall, 1999; Greenfield et al., 2010; Vasilenko et al., 2017).

The differing stigmas based upon substance used is a limitation of the grouping of individuals with DUDs and individuals with AUDs into one group of Americans with SUDs. Though there are more similarities than differences in the AUD and DUD groups, differences exist in the manifestation and prognosis of an SUD depending on the substance that is used. There are considerable differences in the medical, psychosocial, and legal consequences of alcohol use when compared to use of illegal substances such as heroin or cocaine. Further research on workplace discrimination should examine differences between these two groups to identify relevant differences in the manifestation of workplace discrimination between AUDs and DUDs.

It is also of note that the manner in which the database codes the allegation is based upon primary disability, meaning if someone experiences discrimination based on SUD, yet they have an alternate primary disability, he or she may file the allegation under another disability. With SUDs having high co-occurrence with mental health disorders and being four-times more likely
among those with other disabilities (Koch & Rumrill, 2017), it is likely that there are many
allegations in the database involving SUDs that are not coded as such. Additionally, this study is
strictly limited to investigating allegations brought under Title I of the ADA, thus, it is likely that
the study population under consideration in this study does not represent the entirety of
Americans with SUDs experiencing workplace discrimination. People with SUDs who
experience unfair treatment in the workplace often choose not to report their experiences to
anyone, and those who do choose to file complaints may do so under other employment-related
legislation such as the Rehabilitation Act of 1973, Civil Rights Act, Equal Pay Act, or Age
Discrimination in Employment Act (ADEA). Allegations by this population could also have
been filed on the basis of race or gender with the EEOC, as the alleged discrimination may not
have occurred exclusively as a result of the SUD (McMahon & McMahon, 2016).

As for the GENDIS comparison group, there are also distinct limitations based upon the
constellation of that sub-sample. As mentioned, the high co-occurrence of SUDs among those
with disabilities means that there may be some crossover effect between the GENDIS and SUD
groups. It is possible that some members of the SUD group also have disabilities that fall under
the GENDIS categorization, and that some members of the GENDIS group have co-occurring
SUDs. Additionally, due to the legal inclusion criteria of SUDs, those with SUDs and those in
the GENDIS group are not held to the same investigatory standards in the determination of
whether discrimination actually occurred. There are more legal grounds for an employer to
justify actions taken against an employee with an SUD than there are to justify actions against
people with other disabilities (McMahon & McMahon, 2016).

Although there was an attempt to limit GENDIS to individuals with physical disabilities
to avoid crossover with psychological and neurological conditions, which have higher rates of
substance usage, there were some fundamental demographic differences in the two populations. In terms of the disability, the reported population of Americans with SUDs is less gender and age neutral when examined alongside the GENDIS group. Part of this is the nature of SUDs wherein a person might meet the criteria for an SUD at a younger age, yet come to a point later in life where symptoms are managed and the person no longer meets the inclusion criteria for an SUD. In the conditions included in the GENDIS group, a majority are conditions that persist across the lifetime once acquired.

The IMS database used in the study provided a unique opportunity to examine population level data of allegations of workplace discrimination in the U.S.; however, the database itself was limited in terms of in depth contextual information. For example, demographic characteristics such as marital status, sexual identity, gender identity, socioeconomic status, geographic location, and type of community would have been valuable in understanding how workplace discrimination allegations for Americans with SUDs differ from those in the GENDIS group. Additionally, more depth of data regarding the nature of the discrimination beyond an issue category along with the lived experience of perceived workplace discrimination could be attained utilizing qualitative methodology.

The same is true regarding information about the nature of the case resolution. The database provides basic information on how the allegation was resolved through the EEOC, but the explanation as to why there was a merit or non-merit resolution is largely missing from the data. While this information being available could present a threat to the anonymity to both the employers and employees, it would provide valuable insight into the nature of the cases and the patterns of legal resolutions. Specifically for SUDs, it would allow researchers to examine how
often the additional legal exclusion criteria for substance use factors into the determination of merit for such cases.

As for the allegations, one further limitation is that it is unknown to the researcher whether or not multiple allegations have been entered into the EEOC by a single charging party. Thus, it is possible and even likely that some of the units of study, the allegations, represent multiple claims made by the same person either at the same point in time involving multiple issues (e.g., wages and promotion), or on more than one occasion (e.g., in 2002 and again in 2007). This confounds the available data when attempting to draw conclusions based on demographic variables on the sample as a whole as the unit of measure is not the charging party, but rather the allegation itself.

It is important to note that all allegations that involve recording errors or duplications are purged from that database. In addition, only allegations that are received, investigated, and closed by the EEOC are included in that database. This excludes allegations investigated by non-EEOC personnel (e.g., investigations by State Fair Employment Practices agencies); allegations referred by EEOC to litigation in civils court, federal or state; allegations that involve the issues of retaliation (due to this issue not pertaining directly to the existence or consequence of disability); and allegations that are open cases not yet resolved by EEOC investigators (McMahon & McMahon, 2016).

Finally, there were limitations in the statistical methods used the study to examine the data; non-parametric tests of proportion, relying primarily on Pearson chi-square tests that are only able to provide descriptive comparisons of data across groups. The researcher was unable to draw any causal inferences based on the data procedures used, but rather sought to explain the patterns of the population of Americans with SUDs and to examine the uniqueness of those
patterns in light of the GENDIS comparison group. These patterns warrant further advanced statistical analyses and qualitative examination into the phenomenon of workplace discrimination experienced by Americans with SUDs.
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