

Commentary: Implementation of the Americans with Disabilities Act in the Workplace

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A working knowledge of the Americans with Disabilities Act (ADA)¹ has become increasingly important for mental health professionals. We are routinely asked to assist employers and service providers with the types of individualized functional assessments required under the various Titles of the Act, and we may be find the Act useful in advocating for our patients' rights. In our roles as "covered entities," we can be held directly responsible for meeting the ADA's statutory and regulatory requirements in a variety of ways: through private practice providing direct services to patients (Title III),² through our roles as employers (Title I for businesses with more than 15 employees),³ or through state or local government practice at state hospitals or community mental health centers (Title II).⁴ In addition, we may be required to meet similar standards under another federal antidiscrimination provision,^{5,6} because we accept Medicaid or Medicare payments or are recipients of federal research grants.

In the accompanying article, Dr. Westreich⁷ ably discusses the general applications of the three main Titles of the ADA. The purpose of this commentary is to expand on several issues raised in his article: (1) Title V and the distinctions within the ADA as to how the use of alcohol versus other substances is treated; (2) how the more general, overarching themes within the ADA apply to people disabled by addiction disorders, despite these distinctions; (3) the importance of jurisdictional and factual distinctions in interpreting particular case decisions; (4) the effects of recent case law on individuals' rights to sue

state governments; and (5) the less well-known ADA antidiscrimination protections for people who associate with people with disabilities. Finally, this commentary will explore another addiction-related ADA issue: the application of the ADA to psychiatric hospitals and other covered entities that are considering developing tobacco-free policies.

Alcohol Versus Other Substances

Regardless of whether it is a matter of addiction or physical mobility disability, a key theme within the ADA is the requirement for individualized assessments—both of the individual with the disability and of the public or private entity involved—to determine the scope of their responsibility and the reasonableness of the accommodation being considered. The Act encourages the use of alternative dispute resolution, and most ADA disputes are resolved without going to court. By one estimate, approximately 90 percent of all ADA employment claims that proceed to court are resolved in favor of the employer.^{8,9} With the exception of a few categorical exclusions deemed politically necessary for the passage of the Act (e.g., pyromania, gender identity disorders), the focus of the individualized assessments under the ADA must be on functional abilities rather than on diagnostic labels, *per se*.

Title V of the ADA contains a variety of provisions regarding particular applications of the ADA, including specific provisions regarding drug and alcohol use. To varying degrees, these differ from other provisions, in that they blend functional and categorical components, in an effort by Congress to distinguish between (1) the use of illegal drugs and the illegal use of otherwise legal drugs, (2) the use of alcohol, and

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(3) the use of tobacco. Congress clearly intended to deny protection to people who engage in the illegal use of drugs, whether or not they are addicted, but to provide protection to addicts so long as they are not currently using drugs. The definition of “current illegal use of drugs” in the regulations is based on the report of the Conference Committee: “illegal use of drugs that occurred recently enough to justify a reasonable belief that a person’s drug use is current or that continuing use is a real and ongoing problem.”¹⁰

At the same time, Congress recognized that alcohol is a legal, although regulated, substance. Unlike alcohol, which can be used in a legal and responsible manner, use of illegal drugs or illicit prescription drugs can be categorically banned both on and off the job, regardless of the individual’s ability to perform the essential requirements of the job, without offending the ADA. However, an alcoholic who can meet the functional requirements of his or her job and who meets the rules generally required of all employees (including not having measurable blood alcohol levels while on the job) cannot be fired or otherwise discriminated against in employment, even if using alcohol outside of work.

General Application of ADA Principles to People With Addiction Disorders

Even with these distinctions, the common ADA themes that apply to people with other disabilities also apply to people with addiction disorders. It must always be kept in mind that the ADA was intended to level the playing field, not to be a source of special treatment. For example, under Title I of the ADA, any employee may be terminated if he or she is unable to perform the essential functions of his or her job, with or without a reasonable accommodation. The ADA does not require written job descriptions, but well-written functionally based job descriptions are the best defense an employer has in defining the essential functions of the job in question. Another common theme is that an employer is only required to accommodate a “known” disability of a qualified applicant or employee. It is up to the person to disclose, and generally employers can ask only about abilities related to essential job functions, not disabilities, *per se*. The focus on the person’s ability to meet the essential demands of the job protects the interests of both employer and employee.

As noted in the accompanying article, addicts often deny their addictions. However, one of the com-

mon themes in the ADA across all disabilities is that the individual is under no obligation to disclose his or her disability. Nor is there any obligation to accept an accommodation offered. However, in either case, the individual remains responsible for fulfilling the essential functions of the job. The only instance in which an employer is obligated to provide an accommodation that has not been requested is when an individual’s known disability impairs his or her ability to know of, or effectively communicate a need for, an accommodation that is obvious to the employer. Under the ADA, a cognitive disability (i.e., the ability to know) is defined relative to the norm for the general public (e.g., one to two standard deviations below the mean on standardized psychometric testing). In the case in which the alcoholic successfully denies his or her problems until it is too late to inform the employer because he or she has already been terminated, (1) the disability is not known to the employer, and (2) it is unlikely that the failure to request an accommodation is due to a cognitive impairment of the person’s ability (relative to the general population) to know or communicate a need for an accommodation (as opposed to his choice, however distorted—even if denial is a common pattern with alcoholics and other substance abusers).

These attempts to balance the exceptions for substance abuse with the general themes of the ADA are also seen in the Title I regulations regarding drug testing. Policies or procedures to ensure that an individual who formerly engaged in the illegal use of drugs is not currently engaging in illegal use of drugs must be reasonable and must be designed to accurately identify the illegal use of drugs. However, the regulations do not authorize any procedures that would disclose the lawful use of substances (e.g., psychiatric medications taken as prescribed). This is consistent with the right of the individual with disabilities to determine whether to disclose his or her disability to the employer. If the results of a drug test reveal the presence of a lawfully prescribed drug or other medical information, it must be treated as a confidential medical record and not placed in a general personnel file.

Jurisdictional and Factual Distinctions

The holding of any ADA case can be either analogized to another situation, thereby providing legal guidance or precedent, or distinguished from it (particularly on jurisdictional and factual grounds),

thereby identifying no legal relevance to the case at hand. Unless the Supreme Court has set a national standard in deciding an issue, there is likely to be some degree of divergence of opinions across jurisdictions on almost any issue. Thus, the applicable law in any particular jurisdiction may be quite different from a case holding published in the national journals. As noted by Dr. Westreich,⁷ the United States Supreme Court held in *Cleveland v. Policy Management Systems*¹¹ that statements made when applying for Supplementary Security Disability Income (SSDI) benefits do not automatically bar a person from pursuing an ADA claim that he or she can in fact work if given reasonable accommodations, nor does it erect a strong presumption against the recipient's ADA success. The Court held that the person must sufficiently explain why the statements on the SSDI application (that the person is "totally disabled" and cannot work) are consistent with their subsequent ADA claim that the individual can now perform the essential functions of the job, at least with reasonable accommodation. Prior to the *Policy Management Systems* ruling, there was a significant split between jurisdictions, resulting in different approaches used by at least some forensic examiners in the different jurisdictions.

The business adage of "location, location, location" can also be useful in reference to where in the trial process the ruling applies. For example, cases cited by commentators frequently reflect midlitigation issues. A case holding that a person may or may not be sued for an alleged violation does not necessarily inform the reader as to who won when the case finally went to trial or was settled, nor the likelihood of success in similar cases in the future.

Effects of Recent Case Law

I would like to expand on Dr. Westreich's discussion of a recent U.S. Supreme Court case, *Board of Directors of the University of Alabama v. Garrett*.¹² As he noted, *Garrett* narrowed the scope of enforcement against states for money damages in cases brought by private individuals, under the doctrine of Eleventh Amendment "sovereign" immunity. However, several points must be clarified. First, the Eleventh Amendment immunity applies only to actions brought by individual citizens against states. Eleventh Amendment immunity does not apply to the other public entities that ADA Title II covers. Individuals can still sue local city and county govern-

ments and other political subdivisions under the ADA for money damages despite the *Garrett* decision. Even under *Garrett* and similar U.S. Supreme Court rulings, money damages can be awarded in suits brought against a state by the U.S. government (i.e., in suits brought by the Equal Employment Opportunity Commission or the Justice Department), as the Eleventh Amendment immunity protections apply only to suits brought by private citizens. Individual citizens can bring Title II violations to the attention of these government agencies by sending a written complaint letter. The federal government investigates these complaints and attempts to resolve them short of litigation whenever possible.

In addition, Eleventh Amendment immunity does not prohibit all suits brought by individuals under the ADA against state governments, only those for money damages. Private citizens may still sue states for prospective and injunctive relief¹³ (e.g., changes in policies, both before and after a discriminatory action is initiated), but may not sue for money damages. Attorney fees can still be awarded to prevailing parties who succeed in getting discriminatory policies and procedures changed. The ADA does not require the individual to wait until discrimination occurs to file a complaint with the government or to file a private lawsuit if discrimination is imminent.

Associates Also Covered by ADA

Dr. Westreich⁷ accurately describes the three primary ways an individual is covered by the ADA: having a physical or mental impairment that substantially limits one or more major life activities of such individual; having a record of such an impairment; or being regarded as having such an impairment. What is less well known is that Titles I and III of the ADA also extend antidiscrimination protections to people associated with an individual with disability.¹⁴ This would include relatives, foster parents, employers, friends, and service providers, if they were (or were about to be) discriminated against on the basis of their association with an individual with a disability. The association protections are extended to state and local governmental entities as a whole through the Title II regulations,¹⁵ as well as through Titles I and III directly for those governmental activities that may be covered by those provisions as well (e.g., employment under Title I, and any governmental activities such as state or community psychiatric services that

are billed to the client under Title III). Thus, the association provisions of the ADA could be used to protect private psychiatric or social services practices or governmental community mental health service providers against discrimination when leasing otherwise available office space. There has not been a significant amount of litigation reported in the national journals over the association provisions of ADA. Nevertheless, these provisions reflect important considerations when making administrative and clinical decisions that may have intended or unintended discriminatory consequences for people associated with individuals with a disability.

A Particular Application

As a final point, let us look at the prohibition of smoking as addressed by the ADA. In addition to antiretaliation protections and other less well-known sections, Title V includes the statement that "nothing in this Act shall be construed to preclude the prohibition of, or the imposition of restrictions on, smoking in places of employment covered by title I, in transportation covered by title II or III, or in places of public accommodation covered by title III."¹⁶ The few cases with regard to smoking have not been raised under this Title V provision. Rather, cases have arisen under Title I addressing questions such as whether no-smoking policies for all employees are required as a reasonable accommodation for one individual employee with asthma or whether the no-smoking policies that an employer and employee have previously agreed on as a workplace accommodation for asthma have been adequately implemented.

There has been increasing interest in prohibiting smoking in psychiatric facilities, including state hospitals. It is important to distinguish between restrictive smoking policies (e.g., no smoking indoors with supervised outdoor breaks for smoking) and absolute no-smoking policies (without access to outdoor breaks), both of which could be described as smoking bans or no-smoking policies. A more radical approach has recently been announced by the governing body operating the three state psychiatric facilities in Nebraska. These institutions will shortly move from restrictive smoking policies to an absolute smoking ban, indoors and outdoors across their entire campus grounds.¹⁷ A consent decree in effect from the early 1990s until 1995, resulting from previous attempts to ban smoking for patients but not

staff, brought about the smoking policies currently in place in Nebraska's state psychiatric hospitals.¹⁸ Generally, the consent decree includes an absolute ban on smoking within the buildings but provides a number of scheduled outdoor breaks (under supervision, in fenced yards and other enclosed locations) for those patients who wish to smoke but do not have privileges to go outside the buildings unsupervised.

The announced plan in the Nebraska system is to be smoke-free or, possibly more extensively, tobacco-free (including snuff and chewing tobacco) grounds-wide on all three campuses by January 1, 2003. Clearly, Title V of the ADA articulates that public and private entities may enact these types of policies. However, even if technically legal, any such plan raises critical questions: is it good policy, and what are the costs and benefits of ensuring that these policies are implemented in a nondiscriminatory manner? Although the discussion herein will focus primarily on Title II as it applies to state psychiatric hospitals, similar considerations may arise for private hospitals under Title III of the ADA. (As noted above, state psychiatric hospitals and other public treatment facilities may arguably also be covered by Title III as well, to the extent that they charge for their services and are therefore engaged in commerce.)

First, as in any policy discussion, it is important to distinguish what is legal from what is both legal and makes sense. For example, the legality of forcing cessation of smoking on long-term psychiatric patients is only one consideration when investigating the clinical implications. Smoking rates by people with schizophrenia are higher than in the general public.¹⁹ It is unclear whether this is due to a predisposition to nicotine addiction,^{18,19} self-medicating regulation of neurotransmitter receptors by nicotine,^{20,21} boredom, or one of the few decisions people with severe and persistent mental illness retain after institutionalization. There is a developing literature on the effect of voluntary cessation and use of a nicotine patch, differential effects of cessation of smoking on people with schizophrenia versus the general public,²⁴ and the effects of building-wide smoke-free policies on short-term acute psychiatric hospitals.²⁵ However, there is a paucity of studies on the effects of forced cessation of smoking in acute and long-term psychiatric hospitals.²⁶ Likely targets for future study include smoking relapse rates after discharge, fire hazards created by illicit smoking (unsupervised and

indoors), aggression²⁷ and seclusion rates, and use of medication. For example, the literature indicates various interactions between nicotine and/or smoking and available blood levels of psychiatric medications.²⁸ What are the implications for stabilization and discharge planning for patients with schizophrenia? What is the effect on rehospitalization rates both for the individual and for various psychiatric populations, and how does that affect allocation of scarce public mental health resources? Does nicotine interact in such a way as to benefit persons with certain disorders while harming persons with others? Does the decision to smoke or not represent a substantial matter of choice for some persons who by virtue of their illnesses have so few other choices to make? Is smoking as a health problem the same priority for all persons, particularly those struggling to gain their freedom from involuntary confinement?

My own experience with discharge of long-term patients with schizophrenia from the current restricted smoking environment in Nebraska (i.e., access to outdoors smoking only during defined outdoor breaks throughout the day) to the unrestricted smoking environment available in the community suggests that this is enough to trigger relapse of smoking in particularly susceptible patients. There is no reason to expect the relapse rate would be much less than 100 percent of the individuals who have not quit voluntarily. Among people with severe mental illness, smoking relapse rates appear to be extremely high, even among those who voluntarily attempt to quit and among those who participate in formal smoking cessation treatment.

Without a reasonable determination of costs and benefits to the individual and to the mission of the public mental health system, it is extremely difficult to argue that the benefits of a total ban outweigh the adverse consequences, even if the ADA issues discussed later in this article were successfully managed. In addition, a major theme in contemporary rehabilitation services for people with mental illness is personal empowerment—making choices and taking responsibility for one's own life. Categorical imposition of an absolute restriction, especially when the justification does not involve law, an individualized clinical assessment, or consideration of others' welfare (e.g., second-hand smoke), is directly contradictory to the themes of modern rehabilitation.

Clinical and policy issues aside, to the extent that an absolute ban on smoking is adopted, ADA and

legal requirements must be met to articulate a plan and implement a policy in a nondiscriminatory manner. Of course, individualized clinical assessments can be used to justify restrictions of smoking or any other privilege for inpatients if implemented in the least restrictive manner, without running afoul of antidiscrimination laws. As Dr. Westreich⁷ points out, one of the ways people can be excluded from ADA coverage is if their behavior constitutes a danger to others or, arguably, to themselves. Even prior to the ADA, the concept of least restrictive alternative and individualized assessments have passed constitutional muster to justify other restrictions under civil commitment law generally.

Assuming a person or situation is not excluded from ADA coverage, as a general rule of thumb, people with disabilities cannot be treated differently on the basis of having the disability. Thus, both patients and staff must be subject to the same ban, and staff must be subjected to consequences at least as severe as those imposed on patients for violations. If patients' contraband is confiscated (e.g., tobacco, lighters, snuff, and chewing tobacco) then so must staff's. If patients are not allowed to possess these products even if they do not use them, then similar rules must apply to staff, leading to the further question of tobacco products in staff cars. Will patients who have privileges to go off campus, whether under supervision or independently, be able to smoke when they are off hospital grounds? What are the legal bases for this decision (pro or con), and can it be implemented in a nondiscriminatory manner if staff are allowed to leave campus and smoke during non-working hours (e.g., on lunch break)?

Although not required by ADA, other legal provisions in a particular jurisdiction may need investigating to determine whether confiscated contraband must be returned or can be destroyed, and, if destroyed, whether it must be paid for. If a staff member's contraband is returned to him or her, a patient's contraband cannot be treated differently simply on the basis of his or her classification as a person with a disability. If the policy is to keep the patient's contraband until discharge, how can this be made equivalent for staff? Clinically, returning cigarettes to patients at discharge almost ensures the already high likelihood of immediate relapse to smoking, thereby defeating the point from a health standpoint. Because patients are under a great deal of scrutiny, thereby increasing the likelihood of the discovery of

contraband tobacco and smoking-related products, what steps must be taken to ensure that staff are under equivalent levels of scrutiny? How will this policy be implemented in a nondiscriminatory manner regarding people who visit patients or who use the hospital grounds for other reasons (such as the baseball diamond for neighborhood Little League games)? These considerations demonstrate the interwoven ADA and non-ADA policy issues and may have a serious fiscal impact, such as direct implementation costs, staff retention rates, union contract considerations, and the like.

Most long-term inpatients with schizophrenia reside in state-run or other publicly funded hospitals or residential facilities, but similar questions would have to be resolved in private facilities considering smoking bans either under Title III or under other federal nondiscrimination laws (e.g., section 504 of the Rehabilitation Act), because they receive federal funds such as Medicare or Medicaid. For organizations considering a grounds-wide smoking ban, it is important to recognize that the rules that affect employees working with people with disabilities must be the same as the rules for employees who do not work with people with disabilities under the association provisions of Titles I and III of the Act and/or the Title II regulations.

In the case of a state psychiatric hospital's governing body approving an absolute no-smoking ban (or more inclusive no-tobacco product ban) on any state psychiatric hospital grounds, the "association" provisions clearly come into play. Some might argue that the association provisions would apply across *all* state employees (and all visitors) on *all* state property (e.g., the Nebraska State Capitol Building grounds, state parks, and outside the University of Nebraska football stadium). Others might argue they apply only within the same governmental unit—in this case, the Nebraska Department of Health and Human Services, which has several thousand employees in addition to those at the three psychiatric hospitals, including those at a large state developmental disabilities institution, four state Veteran's Homes, and other disability-related services, as well as a myriad of other administrative offices serving people without disabilities, such as welfare, professional licensure, and children's programs. In answering these questions, courts are likely to look at common administrative control (e.g., who cuts the checks?) and budgetary independence, whether looking at a huge

entity such as state government or smaller entities such as private psychiatric clinics or hospital chains.

Blanket rules requiring the involuntary cessation of smoking by psychiatric inpatients, absent an individualized clinical determination related to the patient's psychiatric treatment needs or a life-threatening medical condition, arguably runs counter to the "integration regulation" which requires a "public entity [to] administer. . . programs. . . in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The integration principle was upheld in the U.S. Supreme Court case, *Olmstead v. L. C.*²⁹ The *Olmstead* Court held that Title II of the ADA requires states to place persons with mental disabilities in community settings rather than in institutions, when the state's treatment professionals have determined (1) that community placement is appropriate, (2) that the transfer from institutional care to a less-restrictive setting is not opposed by the individual, and (3) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. The Court emphasized that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings. Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it.

As demonstrated by *Olmstead* and the general ADA principles discussed in the accompanying article and this commentary, any separate, special, or different programs that are designed to provide a benefit to persons with disabilities cannot be used to restrict the participation of persons with disabilities in general, integrated activities. An individual with a disability is not obliged to accept an accommodation, aid, service, opportunity, or benefit that he or she chooses not to accept. Taken together, the language of the ADA and its regulations is intended to prohibit exclusion and segregation of individuals with disabilities and the denial of equal opportunities enjoyed by others, based on, among other things, presumptions, patronizing attitudes, fears, and stereotypes about individuals with disabilities. As outlined above, forced abstention from smoking by psychiatric inpatients in public and private facilities requires careful attention to nondiscriminatory implementation. However, Title II entities may have to overcome the additional argument that such a ban, no matter how well inten-

tioned as a public health measure, is obliging people with psychiatric disabilities to accept a benefit not of their choosing and in violation of their rights to be treated in the least restrictive and most inclusive manner.

In conclusion, it should be clear that there is no legal barrier to the initial decision to adopt a grounds-wide smoke-free policy, provided it is applicable to all—staff, patients, and visitors alike. Indeed, there are excellent public health arguments that make such a policy quite compelling and may outweigh the policy and clinical arguments against a total ban at a particular institution. The sticky issues arise in how to implement such a policy legally in a nondiscriminatory manner “in the trenches,” adequately anticipating the unintended consequences. Now that the decision to go forward has been adopted by the governing body common to Nebraska’s three state psychiatric hospitals, the psychiatrists, psychologists, and other members of the organized medical staffs of each hospital are embarking on this journey.

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