Restaurant Wheelchair Accessibility

Linda McClain, Debra Beringer, Heather Kuhnert, Johna Priest, Emily Wilkes, Sue Wilkinson, Lisa Wyrick

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This study was designed to determine the compliance of restaurants to the wheelchair accessibility standards set forth in the Uniform Federal Accessibility Standards. The standards that were operationalized in this study are also found in Title III of the Americans With Disabilities Act of 1990. The data were collected at 120 sites in three midwestern states. For one who uses a wheelchair, parking the car is often an obstacle to eating out. Only 53% of the restaurants surveyed provided handicapped parking. Entering the building may also be a problem. Of the restaurants that required a ramp, only 66% provided them. Inside the restaurant, the key problems were accessible restrooms and the height of tables. The study provided comparisons between restaurants in rural and urban settings, as well as comparisons between conventional restaurants and fast food restaurants. No notable differences emerged for these comparisons.

The accessibility evolution has finally become a revolution. Concerns about building accessibility are not limited to persons who have disabilities, their families and friends, and rehabilitation and vocation professionals. Building accessibility is now also of concern to those who are in the positions to eliminate existing barriers: builders, business owners and managers, and employers responsible for hiring. Builders and business people are now accountable for implementing the guidelines of the Americans with Disabilities Act of 1990 (ADA). Occupational therapists can have a dramatic effect on the enforcement of the ADA standards. As professionals with knowledge about the functional limitations imposed by particular physical impairments, as well as knowledge about evaluating environments, therapists can serve as an important link between the providers of services and the consumers who have physical disabilities. The ADA's Title III (Final Rule) prohibits discrimination on the basis of disability by private entities in places of public accommodation (ADA, 1990). As occupational therapists provide services for clients who use wheelchairs, they are prepared to assess environments for accessibility and to advocate for the civil rights of their clients. To be advocates, therapists must be aware of the barriers that exist. This study was designed to evaluate wheelchair accessibility in one particular public arena—restaurants.

Literature Review

Barriers are obstacles that restrict choice, frustrate self-help, promote discrimination, and prevent integration (DeJong & Lifchez, 1983). According to Francis (1983), lack of access alters a person's status in the community and may produce irreparable damage. Exclusionary attitudes and practices of those without disabilities, in their lack of sensitivity and commitment toward change, are far greater barriers than the disabling condition itself (Scotch, 1989).

Exclusionary attitudes have not been the only problem; another problem is the attitude of many well-meaning persons that those with disabilities need to be looked after. This outdated attitude is an artifact of the days of institutionalization (Fewster, 1990). In protest, the disability rights movement has advocated rejecting the stigma, isolation, and dependency imposed by barriers.

The beginning of the political and social evolution of mandates can be traced to the first national standards, "Making Buildings and Facilities Accessible to and Usable by the Physically Handicapped," published by the American Standards Association (1961). This agency is now known as the American National Standards Institute (ANSI). The ANSI standards were revised in 1971 and again in 1980.

On the tail of the first ANSI Standards was the Architectural Barriers Act (ABA) of 1968. According to Francis...
(1983), the ABA was a combination of two bills written to ensure that all public buildings financed with government funds were built to be accessible to the physically handicapped. Enforcement of these laws was problematic because they lacked a specific set of required regulations.

The federal government defined physical access as a civil right when it developed the Architectural and Transportation Barriers Compliance Board (ATBCB), an independent federal agency initiated under the Rehabilitation Act of 1973. In 1978 the ATBCB was urged by Congress to formulate a list of minimum guidelines for accessibility. The U.S. Postal Service, General Services Administration, the Department of Defense, and the Department of Housing and Urban Development participated in development of the Uniform Federal Accessibility Standards (UFAS, 1984). Specifications were developed for restaurants, retail shops, grocery stores, teller machines, and correctional institutions, among others.

Advocates continued their work toward a more comprehensive plan, which came to fruition in the ADA. Public Law 101–336. This law has been referred to as “the Emancipation Proclamation for people with disabilities” (Kemp, 1990, p. vii).

Title III of the ADA mandates that every private entity that is open to the public must be made accessible to persons with disabilities. These entities include restaurants, parks, hotels, professional offices, and banks. An overview of the various aspects of the ADA can be found in the American Journal of Occupational Therapy Special Issue on the Americans With Disabilities Act of 1990 (Bowman, 1992). Briefly, other parts of the ADA ensure that employers cannot discriminate against qualified workers who are disabled, that persons with disabilities have access to all state-funded programs and public rail transportation, and that telephone companies furnish telecommunication devices.

Much work remains in regard to mainstreaming persons with disabilities into society. It is unlikely that compliance will occur without rigorous surveillance. In the review by Cooper, Cohen, and Hasselkus (1991) of the occupational therapy literature relative to barriers, the four studies cited (spanning the years 1971 to 1990) all discovered areas of noncompliance relative to the laws of that specific era. Public building accessibility problems were reported by Matin (1987) in a study conducted in Utica, New York. Grocery store and convenience store accessibility problems in midwestern communities were reported by McClain and Todd (1990). Kiernan (1972) studied accessibility deficits in city and state facilities and on a university campus in Madison, Wisconsin. Liston (1971) reported accessibility problems at the Queen’s University in Canada. These studies noted frequent deficiencies in compliance in the areas of toilet rooms, parking, curb ramps, and entrances to buildings. Three of these studies, however, noted some degree of success in changing local attitudes and influencing change as the result of education.

The American Occupational Therapy Association’s (1992) “White Paper: Occupational Therapy and the Americans With Disabilities Act” defined the role of the occupational therapist as twofold: (a) involvement with architects, engineers, and other professionals to determine the accessibility of places frequented by the general public, and (b) in the case of inaccessible facilities, involvement with persons with disabilities to suggest adaptive equipment, auxiliary aids, and environmental adaptations.

Determining whether barriers exist in various environments is a place to start as occupational therapists operationalize their role with the ADA implementation. No study has reported data on restaurant accessibility. Therefore, the purpose of this study was to determine restaurants’ level of compliance to the standards set forth in the UFAS and to determine any differences between urban and rural restaurants and fast food and convenience restaurants on these standards. The UFAS standards have been incorporated since the time of the data collection into the ADA.

Method

Subjects

Thirty rural fast food restaurants, 30 urban fast food restaurants, 30 rural conventional restaurants, and 30 urban conventional restaurants in three midwestern states were surveyed. A restaurant was defined as rural if it was located in an area with fewer than 50,000 people, and urban if located in an area with more than 50,000 people. These parameters for urban and rural populations are in accordance with the Standard Metropolitan Statistical Definition (Cook, Ferritor, & Cooper, 1981). Because of their attachment to a metropolitan area of high population, restaurants in suburbs were considered urban.

Fast food restaurants were defined as restaurants that were arranged to meet the needs of the hurried patron and that used disposable tableware. Conventional restaurants were defined as restaurants using nondisposable tableware. Excluded from this study were eating establishments in shopping malls, schools, hospitals, private clubs, and restaurants without dine-in seating.

Sites were selected by the convenience sampling method (e.g., hometowns of investigators, routes on trips). The investigators developed a system to ensure that not more than two restaurants from the same franchise were surveyed, to provide a broader sample. The investigators also conferred to make sure that their sites did not overlap and that their data represented a diversity of neighborhoods. All but the primary investigator (the first author) collected data.

Instrument

Based on the data collection format reported by McClain,
and Todd (1990) and the UFAS Accessibility Checklist (1990), a data collection form was developed (see Appendix). The instrument was pilot tested and revised. The skill of all six investigators was assessed by the primary investigator.

Procedures

The form shown in the Appendix was used to record data from direct observation and measurement. Upon entering the establishments, the investigators provided a letter to the restaurant manager that described the project and explained the confidential nature of the data and the voluntary nature of their participation. The investigators collected data as noted on the form, taking care to be discreet and not to obstruct patron business.

Analysis

Descriptive statistics were used to determine the level of compliance to the UFAS Standards found in restaurants. The frequency of yes answers to each question on the checklist (see Appendix) were tallied for each restaurant category and converted to percentages for comparison across the categories: rural and urban, fast food and conventional restaurant, fast food urban, fast food rural, conventional restaurant urban, and conventional restaurant rural (see Table 1).

Results

A primary obstacle to dining out is finding a place to park the car. Only 53% of the 120 sites surveyed provided handicapped parking. There was no notable difference between rural and urban restaurants, nor between fast food and conventional restaurants, in provision of handicapped parking (see Table 1). In general, restaurants that provided spaces clearly identified the spaces and made them the required 96 in. wide, but approximately one fourth of them failed to place parking spaces close to the accessible entrance, and two thirds of them did not provide an adjacent access aisle of 60 in. for loading.

A second obstacle that may arise before the person enters the restaurant is the absence of a ramp. Two thirds of the 120 restaurants required a ramp for wheelchair accessibility but only 66% of these provided one. Most restaurants complied with the ramp width specifications, but some had problems with the incline and landing area (see Table 1). Handrails are required on ramps only if the ramp is 72 in. or longer. In this study, 11 ramps required handrails, but only 1 had them.

Getting in the door of the establishment does not seem to be an obstacle. Compliance rates were good for both the door measurements and the hardware (see Table 1).

Restroom accessibility was a global problem. Only 60% of the restrooms were accessible, with urban sites favoring better than rural sites. There was no difference

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Compliance by Percent Across Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
<td>Total</td>
</tr>
<tr>
<td>Handicapped parking</td>
<td>53</td>
</tr>
<tr>
<td>Appropriate number of spaces</td>
<td>81</td>
</tr>
<tr>
<td>Closest to accessible entrance</td>
<td>72</td>
</tr>
<tr>
<td>Spaces clearly identifiable</td>
<td>97</td>
</tr>
<tr>
<td>Spaces at least 96 in. wide</td>
<td>97</td>
</tr>
<tr>
<td>Access aisle of 60 in. width</td>
<td>60</td>
</tr>
<tr>
<td>Building accessible without ramps</td>
<td>31</td>
</tr>
<tr>
<td>Ramp present if needed</td>
<td>66</td>
</tr>
<tr>
<td>Incline no steeper than 1 in: 12 in.</td>
<td>91</td>
</tr>
<tr>
<td>Landing area of 60 in. x 60 in.</td>
<td>76</td>
</tr>
<tr>
<td>Ramp width of at least 36 in.</td>
<td>94</td>
</tr>
<tr>
<td>Door measurements</td>
<td>98</td>
</tr>
<tr>
<td>Door hardware</td>
<td>94</td>
</tr>
<tr>
<td>Restroom accessible</td>
<td>60</td>
</tr>
<tr>
<td>Unobstructed turning space</td>
<td>75</td>
</tr>
<tr>
<td>Stall size 60 in. x 59 in.</td>
<td>48</td>
</tr>
<tr>
<td>Toilet height 17 in. - 19 in.</td>
<td>48</td>
</tr>
<tr>
<td>Grab bars present</td>
<td>84</td>
</tr>
<tr>
<td>Sink height no more than 34 in.</td>
<td>95</td>
</tr>
<tr>
<td>Movable no higher than 40 in.</td>
<td>40</td>
</tr>
<tr>
<td>Reachable towel/hand dryer</td>
<td>61</td>
</tr>
<tr>
<td>Dining area accessible</td>
<td>98</td>
</tr>
<tr>
<td>% of fixed seating accessible</td>
<td>89</td>
</tr>
<tr>
<td>Table size clearance</td>
<td>35</td>
</tr>
<tr>
<td>Aisles between tables</td>
<td>75</td>
</tr>
</tbody>
</table>

Note: Fast = fast food restaurants, Conv = conventional restaurants
Two additional questions, on handrails and raised areas/same services, are reported in text.
between fast food or conventional restaurant access to restrooms. General access was not the only problem. Percentages of compliance with standards relative to specific items within the restrooms, such as turning space, stall size, toilet height, grab bars, sink height, mirrors, and towels-hand dryers, are shown in Table 1.

There were notable differences between conventional and fast food restaurants’ restroom accessibility. The most dramatic difference was the compliance with toilet stall size in conventional restaurants compared with that in fast food restaurants. Fast food restaurants were also in compliance more often with toilet height, grab bars, and reachable towels-hand dryers. However, the conventional restaurants were more often in compliance with mirror height.

Most restaurants (98%) had dining areas that were accessible. The difficulty in negotiating aisles between tables varied; rural restaurants complied more often than urban restaurants. When restaurants have fixed seating, at least 5% of that seating needs to be accessible. Overall, 89% of the restaurants complied with this standard. The biggest problem in the eating area itself was the table knee clearance, although conventional restaurants complied more often than fast food restaurants and rural restaurants more often than urban restaurants. Of the 120 restaurants surveyed, 3 were in complete compliance with all 27 items assessed.

Discussion

The data in this study were collected in three midwestern states. The results, therefore, may not be generalizable to regions outside the Midwest, but the study serves as a model for local assessments or may be expanded for a more inclusive study.

Restaurants require some of the same accessibility standards as other businesses. In general, the data in this study support prior findings reported in the literature, with problems often noted in parking (Kiernan, 1972; Liston, 1971; Martin, 1987; McClain & Todd, 1990), ramps (Liston, 1971; McClain & Todd, 1990), and restroom accommodations (Kiernan, 1972; Liston, 1971; Martin, 1987; McClain & Todd, 1990). In contrast to prior studies (Martin, 1987; McClain & Todd, 1990), the results of this survey of restaurants demonstrated a high degree of compliance to the entrance door specifications.

Beyond the general accessibility issues reported above, several items are unique to an eating establishment. Of these items, the most common problem found was the table height. Those who design equipment for restaurants and those who do the purchasing need to be educated about the ADA specifications, as only one out of three of the restaurants had tables that allowed adequate knee clearance for those in wheelchairs. Even when table size was appropriate, one fourth of the 120 restaurants in this study needed guidance about arranging tables so that aisles allow easy access to them.

The functional problems related to the ADA compliance issues raised in this study cannot be overlooked. The effect of physical barriers in the lives of the clients whom occupational therapists serve is far-reaching and individual. The problems encountered because of environmental barriers range from frustration (if unable to use the pay phone to check on the babysitter), to embarrassment (if unable to fit knees under the table), to humiliation (if unable to access toilet facilities), to total denial of services (if unable to park or exit the car, navigate the ramp, or enter the establishment).

Conclusion

The Americans With Disabilities Act of 1990 promotes the integration of persons with disabilities into the mainstream of independent living (AOTA, 1992). When the guidelines of this legislation are fully realized, perhaps the person who uses a wheelchair can be as casual in choosing a particular restaurant as the person without a disability. The promotion of environments that support independent living skills is a potent approach to minimizing the handicapping effects of physical disabilities.

Appendix

Wheelchair Accessibility Checklist

| Parking | 1. Do they have handicapped parking? Yes No If not, skip to #8. | Yes No 2. Appropriate number of parking spaces. Parking capacity Spaces required up to 10 0 11 to 25 1 26 to 50 2 51 to 75 3 76 to 100 4 101 to 150 5 151 to 200 6 3. Are accessible parking spaces the closest spaces to the building’s accessible entrance? Yes No 4. Spaces are clearly identifiable. Yes No 5. Spaces are at least 96 in. wide. Yes No 6. Adjacent access aisle of 60 in. width. Yes No |
| Ramps | 7. Is the building accessible without ramps? If so, skip to #13. Yes No 8. Are there ramps? If not, skip to #13. Yes No 9. Ramp has incline no steeper than 1 in. for every 12 in. with max. rise of 30 in. per run. Yes No 10. Ramps have landing area at least 60 in. × 60 in. at the top of the ramp. Yes No 11. Ramp width is at least 36 in. Yes No 12. Ramp longer than 72 in. has handrails on both sides. Yes No |
| Doors | 13. Doors have min. clear opening of 32 in. and max. 24 in. depth between sets of doors. Yes No |
14. Doors have hardware that does not require grasping or twisting.

Restrooms
15. Is restroom accessible by wheelchair? Yes No
If not, skip to #22.
16. Is there an unobstructed turning space? (Make sure no door swings into 60 in. X 60 in. floor space) Yes No
17. Stall is at least 60 in. x 59 in. Yes No
18. Toilet height is 17 in-19 in. from floor to top of toilet seat. Yes No
19. Has grab bars. Yes No
20. Sink height is no higher than 34 in. above floor. Yes No
21. Mirrors mounted with bottom edge no higher than 40 in. from floor. Yes No
22. Mirrors mounted with bottom edge no higher than 40 in. from floor. Yes No
23. Towels or hand dryer within reach (48 in. front approach, 54 in. parallel approach). Yes No

Dining Area
24. Can you get to dining area once inside the door? Yes No
If not, stop here.
25. At least 5% of all fixed seats or tables are wheelchair accessible without blocking patron traffic. Yes No
26. Where there are raised eating areas, are the same services and decorative character provided elsewhere in spaces located on accessible routes? Yes No
27. Tables provide knee clearance of at least 27 in. high, 30 in. wide, and 19 in. deep. Yes No
28. Aisles between fixed tables are at least 36 in. wide. Yes No


References