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# **Deviant disabilities: The exclusion of drug and alcohol addiction from the Equality Act 2010**

## **Introduction**

The enactment of the Equality Act 2010 (EA), which garnered support across the political spectrum when initially passing through parliament,<sup>i</sup> was to become one of the dying wishes of the New Labour government. Aimed at simplifying the existing, complex web of legal provisions addressing discrimination, and including further safeguards such as a public authority duty to reduce socio-economic inequalities, Harriet Harman, former Minister for Women and Equality, insisted that the Act would “make Britain a more equal place, and help us build a stronger economy and fairer society for the future” (Directgov, 2009). Trevor Phillips, meanwhile, Chair of the Equality and Human Rights Commission, agreed it would “make Britain a fairer country for all” (BBC, 2010). Those protected characteristics falling within the scope of the Act are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (EA: s.4).

The Act supersedes the Disability Discrimination Act (DDA) 1995 - the first piece of disability non-discrimination legislation in Europe. According to section 1 of the DDA, a person has a ‘disability’ if he or she has a mental (or physical) impairment which has a substantial and long-term adverse impact on his or her ability to carry out normal day-to-day activities. The Disability Discrimination (Meaning of Disability) Regulations 1996 state that addiction to alcohol, nicotine

or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) must not be considered an impairment for the purposes of the DDA. These provisions were carried forward, and the Equality Act 2010 (Disability) Regulations 2010 also sets out conditions that are specifically excluded from constituting a disability, which once again include addiction to alcohol or drugs (s.3(1)). However, again mirroring the DDA, an addiction which originally resulted from the administration of medically prescribed drugs, or other medical treatment, *can* constitute an impairment for the purposes of the Act. A tendency to set fires, a tendency to steal, a tendency to physical or sexual abuse of other persons, exhibitionism, voyeurism, and seasonal allergic rhinitis (or ‘hay fever’) (unless it aggravates another condition) are also all excluded from the meaning of ‘impairment’ (s.3(2) and s.4).

There was some resistance to the carrying over of legislation to specifically omit drug and alcohol ‘addicts’.<sup>ii</sup> In February 2009, the UK Drug Policy Commission (UKDPC), an independent, non-campaigning body providing analysis of evidence related to UK drug policy, asked the Work and Pensions Committee (WPC) to consider whether “the definition of disability as understood through the disability discrimination legislation should be clarified so as to explicitly include substance misuse addiction,” and to furthermore consider “the issue of fairness and equality for those who experience unequal treatment and discrimination on the grounds of their substance misuse addiction or dependence” (UKDPC, 2009: para.1.2). The questions were tabled following the release of a report, produced for the Commission, citing evidence to suggest that 80 per cent of ‘problem drug users’ (PDUs) are unemployed (Harris, 2008). The report explains that: “PDUs are among the most disadvantaged groups in society, frequently having physical and mental health problems as well as offending histories, often coupled with limited

skills or employment experience” (Harris, 2008: 6). Nonetheless, the WPC’s report to the government on ‘how disability equality fits within a single Equality Act’ made no mention of addiction whatsoever (WPC 2009), and there was also no mention of the issue during parliamentary debates on the Equality Bill. This article will address the significance of this exclusion. It will first of all consider the support of prevailing medical and legal discourses for the inclusion of addiction in disability discrimination legislation. It will then briefly discuss the possible reasons for the exclusion in the face of such support. Finally, the discussion will turn to disability studies, and critical legal studies, to consider the consequences of the identification of drug and alcohol addiction with disability.

### **The argument against exclusion**

It would be remiss to embark on a substantive discussion without first addressing the semantic discord over the use of the term ‘addiction’. The word has in fact been eschewed in the health sector because of its stigmatising properties and its unclear definition. Robin Room, for example, notes that “addiction concepts have been extended to cover an ever wider range of behaviours and states” (2006: 285). When plans were mooted in Australia to exclude drug addicts specifically from disability discrimination legislation, it was argued “that the term ‘addiction’ has no diagnostic criteria and is not used in medical, social or academic literature – the term was morally pejorative...it was very difficult to define with any precision what current addiction was...” (Gibson, 2009: 408). The stigmatisation of ‘addiction’ has moreover been aided by the dissemination of public misinformation about drugs and addiction, such as during the US war on crack cocaine when the government and media propagated inflated claims about the drug’s

addictive qualities (Reinarman and Levine, 2004). The term ‘substance dependence’ is generally preferred and, according to the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) (APA, 2000), this results from a history of substance use which includes the ‘abuse’ of the substance, the continuation of use despite related problems, and an increase in tolerance and withdrawal symptoms. A separate category of ‘substance abuse’ is defined as “a pattern of substance use leading to significant impairment in functioning.” One of the following must be present within a 12 month period: (1) recurrent use resulting in a failure to fulfil major obligations at work, school, or home; (2) recurrent use in situations which are physically hazardous (e.g. driving while intoxicated); (3) legal problems resulting from recurrent use; or (4) continued use despite significant social or interpersonal problems caused by the substance use. Substance abuse is therefore a necessary component of substance dependence (APA, 2000: 295).<sup>iii</sup> The UK Drug Policy Commission uses the term ‘problem drug user’ (PDU) to describe those people experiencing a broader range of drug-related issues that may not necessarily include only those who are ‘dependent’ (Harris, 2008).<sup>iv</sup> The drug charities umbrella organisation DrugScope addresses issues associated with drug ‘misuse’, which is defined as “using drugs in a way that results in experience of social, psychological, physical or legal problems related to intoxication and/or regular consumption” – even though such the term may itself be “subjective” and “morally loaded” (Shapiro, 2009: 133). The difficulties with determining what might constitute dependence or addiction correlate with parallel difficulties in defining disabilities, an issue that will be returned to later in the article.

Despite such ambiguity, and in contrast to UK legislation, drug and alcohol addiction, or ‘substance dependence’, are generally classified as disabilities within the international sphere.

The two internationally-recognised systems of mental health disorder diagnosis are the DSM, mentioned above, issued by the American Psychiatric Association, and the *International Classification of Diseases* (ICD), issued by the World Health Organisation (WHO, 2007). Both classify substance dependence as a mental disorder and categorise a range of impairments or behavioural disorders which may result from the use of substances. Article 1 of the *Convention on the Rights of Persons with Disabilities*, adopted by the United Nations General Assembly in December 2006, states that: “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (Convention on the Rights of Persons with Disabilities A/RES/61/106). The emphasis is not only on the person’s impairment, and the resulting effect on that person’s ability to carry out activities, as in UK legislation, but also on how impairments interact with social barriers in order to impede participation.<sup>v</sup> Furthermore, no conditions are excluded from falling within the purview of this provision. The Committee on the Rights of People with Disabilities, which monitors the implementation of the CRPD, has only recently begun work and is yet to make any declaration, recommendation or comment on the definition of disability or impairment for the purposes of the Convention. The United Nations Working Group on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities considered that “drug addiction” should be considered a disability within the meaning of the draft Convention (Gibson 2009). Moreover, proposals from the Ad Hoc drafting committee suggested that ‘disability’ be understood as the “loss or limitation of opportunities to take part in the life of the community on an equal level with others due to physical, social, attitudinal and cultural barriers encountered by persons having physical, sensory, psychological, developmental, learning, neurological or other

impairments (*including the presence in the body of an organism or agent causing malfunction or disease*)” [my emphasis] (UN Enable, 2004). With no other indication in respect of drug use, it seems reasonable to assume that a drug would constitute an ‘agent’ causing ‘malfunction’, that is if such a drug were to lead to a mental or behavioural ‘disorder’. It is worth noting here that the Equality Act distinguishes between addictions born out of medically-prescribed drugs, and those emanating from drugs obtained elsewhere, even though it is inconsequential for diagnostic purposes whether an impairment results from an addiction induced by pharmaceutical drugs, or substances obtained by other means.<sup>vi</sup> Other national jurisdictions either expressly include drug and alcohol dependence within disability discrimination laws, or at least do not expressly exclude it, including some states in the United States, and Australia (Gibson 2009). Section 25 of the Canadian Human Rights Act (1985) defines disability as including previous or existing dependence on alcohol or a drug (Canadian Human Rights Act 1985).

In respect of other international human rights instruments, the list of ‘suspect classifications’ that constitute sufficient grounds for discrimination claims, such as on the basis of sex, disability, race and so on, is non-exhaustive and has been continually updated (Besson, 2005). The Committee on Economic, Social and Cultural Rights, which monitors the implementation of the Covenant on Economic, Social and Cultural Rights, has said that: “States parties should...adopt measures to address widespread stigmatisation of persons on the basis of their health status, such as mental illness...which often undermines the ability of individuals to enjoy fully their Covenant rights” (CESCR, 2009: paragraph 33).

The evidence of stigma experienced by, and discrimination exhibited towards, people dependent

on drugs and alcohol is unequivocal. A recent study by the UK Drug Policy Commission found that just 41 per cent of people would be willing to work with somebody with a history of drug dependence (UKDPC, 2010). In a study to evaluate associations of both stigma and discrimination with the health of illicit drug users, Ahern et al. concluded that “marginalised drug users not only experience high levels of stigma and discrimination, but that these experiences are multi-faceted and are associated with poorer mental and physical health” (2007: 195). A large survey by the Royal College of Psychiatrists’ showed that people with schizophrenia, alcoholism and drug addiction are the most stigmatised group of all those with mental illness (Crisp et al., 2005). A further study on stigmatised attitudes towards people with mental health problems among health professionals found that “[a]ttitudes were less stigmatised to people with substance use disorders who were recovering in remission” (Rao et al., 2009).

Elsewhere, research concluded that people labelled with drug addiction are perceived to be more blameworthy and dangerous compared to individuals labelled with mental illness, who, in turn, are viewed more harshly than those with physical disabilities (Corrigan et al. 2009). According to the Chartered Institute of Personnel and Development (CIPD), more than 60 per cent of employers said they disregarded applications from people with drug or alcohol problems, a criminal record, a history of mental health problems or incapacity (CIPD, 2005). The reason given was often that the users’ own behaviour contributed to their illness. It is probably no surprise to learn that US research found proportionally very few employment complaints from individuals with substance abuse backgrounds in a survey of hiring discrimination. Drug addiction is rarely disclosed during the hiring process, but when it is, employers tend not to hire on the basis of such a disclosure (McMahon, 2008). Given the weight of consensus supporting

the inclusion of drug and alcohol addiction within disability definitions, therefore, why has the condition been excluded from UK law?

### **Making sense of exclusion**

A discrimination case in Australia, concerning a plaintiff who was dependent on methadone (Gibson, 2009),<sup>vii</sup> is illustrative of the legal, political and public anxiety about substance dependence. The plaintiff argued that he had suffered discrimination when he was barred from a social club after disclosing his dependence on methadone. A federal court ruling, on judicial appeal, while not expressly ruling on the definition of disability for the purposes of the Australian Disability Discrimination Act 1992, “clearly opened the way for a finding that opioid dependency constitutes a disability” (Gibson, 2009: 403). The subsequent media storm prompted the tabling of an amendment to the Act to expressly exclude people dependent on a prohibited drug from disability legislation (Disability Discrimination Amendments Bill 2003). Although the bill was put on hold following lobbying from legal, medical and health professionals, in addition to drug user groups, the hostile debate that ensued offered a taste of the public reaction that an amendment to include drug addiction in UK disability discrimination legislation might prompt. The Head of Workplace Policy with the Australian Chamber of Commerce and Industry, said: “The proposition that a drug addicted person is a disabled person in the same way that a person who has some inherent disability or handicap is a disabled person, is really an absurd proposition that offends common sense, and also does a disservice to the important role that disability discrimination laws should have in our community” (Gibson, 2009: 406). A journalist for the Australian *Daily Telegraph*, wrote that the “grossest” aspect of the ruling is that it “puts junkies,

most of whom are enemies of society, in the same category as blind people, and people in wheelchairs” (Gibson, 2009: 404).

Such responses are perhaps unsurprising given Hathaway’s observation that, despite the fact that most drug use is pleasurable and harmless, “[m]ost people do not take illicit drugs and do not like the idea that other people do” (2001: 132). Psychologist Bruce Alexander (1990) considers that the disapproval of drug use may be predicated on cultures’ innate tendencies towards defending themselves, which may go some way towards explaining the ‘moral crusades’ initiated in support of punitive drug policies which exaggerate harms and foreclose any space for innocuous drug use (Weitzer, 2007). The threat is not only to society as a whole, but to individuals themselves. Indeed drug taking, due to its invasive, perhaps unknown consequences, has the potential to threaten everything to do with the conception of a modern, autonomous subject (Foucault, 1994).

The use of alcohol attracts less stigma of course, although there is less of a gap in respect of general attitudes towards intoxication and dependence. Room suggests that an intoxicated person is considered unpredictable and therefore “anxiety-provoking”, since disinhibition offers the possibility of “bad or injurious behaviour” and “to be intoxicated is also to abandon the norm of ‘sober attention as the normative mode of consciousness for every waking minute’, in the modern world of exacting machinery and intellectual work” (2006: 150). Moreover, the perception of a loss of self-control is heavily stigmatised in a society which “attributes morality, success and respectability to the power of the disciplined will” (2006: 150). Dependence on alcohol or drugs has consequently been historically understood as a “disease of the will”

(Valverde, 1998), or a disorder of motivation (West, 2001). Some organisations are working to quash the association between substance use/misuse and a failure of self-control. For example, the United Nations argues that: “[s]cientific evidence indicates that the development of the disease is a result of a complex multi-factorial interaction between repeated exposure to drugs, and biological and environmental factors” (UNODC and WHO, 2008: 1). Moreover, punitive drug policies, or restrictions on the rights of substance misusers, are often predicated on exaggerated links between drug and alcohol use, dependence and crime (Drug Strategy, 2010), although authors have questioned the veracity of such causal links (see, for example, Seddon, 2000; Norström and Pape, 2010).

In such a social context, it is perhaps not surprising that addiction is excluded from disability discrimination provisions. Schneider and Ingram (1993) suggest four categories of target populations as recipients of public programming: the *advantaged*, who are powerful and positively constructed; *contenders*, who are powerful but negatively constructed; *dependents*, who are weak and positively constructed; and *deviants* who are weak and negatively constructed. They classify people with disabilities as *dependents*, whereas those dependent on substances fall within the category of *deviants*. The distinction between deviance and dependence may rest on the extent to which people are perceived to have ‘chosen’ their condition. At some stage, after all, an option to take drugs is exercised. However, despite the evidence cited above on the different factors affecting susceptibility to dependence, there are other arguments refuting the suggestion that ‘choice’ should be determinative at all. Does someone who loses a leg as a result of engaging in a high-risk activity, such as off-piste skiing or drag car racing, forego their claim to reasonable adjustment and equitable treatment? A person dependent on heroin may become

infected with HIV through sharing drug injecting equipment, yet even though the person may similarly be considered ‘responsible’ for her infection, she nonetheless enjoys protection from discrimination on the grounds of her HIV status.<sup>viii</sup> Although the ‘agent of disease’ is a virus, rather than the drug itself, the behaviour that led to the illness is nonetheless the same.

Cambell’s (2005) discussion of “elective disability” is instructive in this regard. Within the context of non-discrimination legislation, some have argued that distinctions should be made between those conditions that continue to exist, or have been worsened, because of an individual’s ‘voluntary’ conduct, and those instances where an immutable disability, or impairment, creates an “innocent” or “deserving” plaintiff. Supporters of this view argue that where a “choice” has been made, ‘society’ should not be obliged to bear the cost of that choice” (Key, 1996: 84). Similarly, notes Cambell, Bonnie Tucker (1998) argues that people who are deaf who opt not to have their deafness “corrected” lose the ‘moral right’ to expect the rest of society to provide financial support to compensate for the lack of hearing. This helps to explain plans by the UK government to tie the receipt of benefits for drug users to their enrolment in treatment programmes (Press Association, 2010). There is an equivalence here with the belief in a ‘deserving’ and ‘undeserving’ poor, the suspicion of welfare, and a conviction that those benefiting from elective ‘charity’ must be both innocent and deserving.<sup>ix</sup> Loseke argues that a new wave of 20<sup>th</sup> century “Victorian” charity, which persists to this day, was comprised of multiple moralities, including an economic morality of individualistic capitalism that must not “threaten the political or economic structures within which it is located” (1997: 432).

## **Disability rights and wrongs**

Having furnished some understanding of the arguments against, and possible reasons for, exclusion, an immediate question that arises is the significance of the discussion for disability in general. What does ‘addiction’ mean for disability? And what does disability mean for ‘addiction’? Viewing drug and alcohol addiction as a disability may well worry those who fear this could dovetail with the discredited ‘disease model’ of addiction (Drew, 1987). But, as we shall see, protesting against the dominance of medical hegemony, and the pathologising of difference or of ‘abnormal’ mental or bodily function/behaviour, has also been a paramount feature of disability studies and the disability rights movement.

Linton suggests that: “The term ‘disability’ is a linchpin in a complex web of social ideals, institutional structures and government policies,” (1998: 10) and in the same way that ‘addiction’ is a contested term, Breman and Woodfield argue that: “there is no single, accepted definition of what ‘disability’ means” (2004: 4). In fact, the UK disability movement, in recent years, has been beset by internal wrangling over an issue which, in simplest terms, is predominantly political in nature – although the foundations and ramifications of the argument burrow much deeper. Discrimination towards persons with disabilities is intrinsic to the debate. The dispute pivots on the merits of the ‘social model’ of disability and its purported conceptual split from the notion of ‘impairment’. In short, the social model of disability asks us to consider that the barriers preventing equitable participation of people who have impairments in public and private life results from the ‘disabling environment’ created by the division between disabled and ‘non-disabled’ people (Oliver, 1990, 1996; Barnes, 2007; Barton, 2006). A binary distinction is made

between impairment, a body/mind affliction, and disability which results from subsequent interaction with society. Barnes sums up as follows: "...whatever the nature or cause of the impairment, or condition, the main problems faced by people viewed as disabled, or 'with disabilities', stems from disabling environmental, economic and cultural barriers" (2007: 204).

The political purposes and successes of the movement in shifting the emphasis from the personal to the social are readily apparent, and have led to a (limited) shift in perceptions of, and institutional responses to, disability in the UK and elsewhere. For example, the Convention on the Right of Persons with Disabilities emphasises that persons with disabilities include those with impairments who may be prevented from full participation in society due to interactions with barriers (UN Convention on the Rights of Persons with Disabilities A/RES/61/106, 2007: Article 1).

It is worth noting at this point that the drafters of the Equality Act paid little heed to international recognition of the social model in codifying a medical model of disability in which the characteristics of the mental or physical impairment, what is meant by the person's ability to carry out daily activities, and the degree to which the impairment has a substantial and long-term effect on such daily activities, are the key components of the claim.<sup>x</sup> Linking the impairment with the ability to carry out daily activities does not embrace those social and environmental factors which may aggravate the effects of an impairment (Gooding, 1996), and the emphasis is on the person's impairment rather than the act of discrimination. Pearson and Watson note that in other countries, specifically Ireland and Australia, and in contrast to the UK and the USA, "there appears to be little legal time devoted to assessing whether a person was covered by the Act, the focus instead being on whether a discriminatory act has occurred" (p.122).

Nonetheless, this conceptual rupture between impairment and disability has been subject to rigorous critique. Detractors have argued that the social model approach “concedes the body to medicine” (Hughes and Patterson, 1997: 326) and fails to adequately account for the impact of bodily impairments on social function. Bickenbach et al. argue that: “The nature of the link between impairment and disability is an important issue for any social theory of disablement, since without some researchable connection it would not be possible to distinguish the socially-created disadvantages of disablement from those of race, gender, class or economic status...Disablement is essentially, conceptually, linked to a health status (or the perception of a health status)” (Bickenbach et al. 1999). Distinguishing ‘brute’, or biological facts, from ‘institutional’, or social, facts, Vehmas and Makela discuss how the social model hinges on a notion of universal oppression. They write that: “Talk about oppression has become a sort of unquestioned mantra in disability studies – there seems to be no context where you could not accuse someone of oppressing disabled people ...there is nothing oppressive in admitting that impairment includes both physical and social dimensions” (2008: 95).

Shakespeare further suggests that social model “ideology seems to have blocked intellectual progress”, for example by impeding research on biomedicine (2005: 146). Colin Barnes, a key figure in the disability rights movement, has fervently rejected the critique. He has argued that suggesting that the conceptual division between impairment and disability is false is “like suggesting that the distinction between the individual and society is false” (2007: 203).

Nevertheless, he does seem to go on to implicitly recognise the fragility of this argument, belying a fear, rather, of the potential for political stagnation or perhaps regression. He writes:

“Whilst such assertions may be of interest to philosophers and some social theorists, I believe that they have little, if any, practical value in terms of research, policy and practice” (2007: 203).

Those to have discussed mental disability have tended not to address drug and alcohol dependence – at least from a theoretical perspective.<sup>xi</sup> This is hardly surprising. In addition to the specific social, political and cultural contexts in which drug and alcohol dependence occurs, mental health problems or disorders have in general remained outside the scope of disability theories who have largely trained their sights on physical impairments. Tom Shakespeare only recently wrote that: “The strength of disability studies is demonstrated whenever scholars from other areas draw on social-model and rights-based analysis to cast light on *other areas of social exclusion, such as mental illness, HIV/AIDS and old age*” (my emphasis) (2005: 146).<sup>xii</sup> Indeed, this exclusion is not only apparent at the level of theory, but reflects the low priority afforded to mental health problems generally. Mulvany notes that: “People with mental disorders have been excluded from generic disability programmes in areas such as employment and training, housing and accommodation support, generic social support, recreation and disability services” (Mulvany, 2000: 586).

And yet, substance dependence offers interesting insights into the study of disability. At the same time, viewing dependence as a disability might be fruitful for reconceptualising our understanding of it. The ‘brute’ impairment – the mental ‘illness’ resulting from dependence – may be both physically and mentally incapacitating, but substance dependence differs from other (although not all) forms of disability because the impairment is also reversible, which if successful is contingent on at least some level of personal will – the very characteristic that

contributes to the lack of public sympathy for stigmatised ‘addicts’. Nonetheless, this aspect of dependence, as has already been demonstrated, does not lead to its disqualification from being classified as a disability, and as such reinforces the argument that the presence of some level of personal autonomy or even responsibility should not mean that people are not able to enjoy protection from disability discrimination. Furthermore, the ‘institutional’ response to the ‘addict’ inverts the paradigm of the historically subordinated disabled person on which the social model of disability rests. This response has not been interested in the rights and welfare of the drug or alcohol dependent, concerned with, say, eliminating barriers, promoting participation and educating. Stigma has been deliberately attached to dependence through the deployment of an exclusion clause within discrimination law, as well as through the criminal law in the case of illegal drug users. Drug ‘addicts’, in particular, are arrested, incarcerated and subjected to stringent regulation. Beyond the mental ‘disorder’, knowledge that such disorder results from drug taking results in further stigmatisation, discrimination and disabling barriers. A social model approach that is more consistent with the one applied to people with other, in some cases more socially acceptable, disabilities might recognise, as discussed above, that attitudes to drug and alcohol dependence may be based on fragile stereotypes and moralistic assumptions that correlate poorly with the reality for those people affected.

Reconceiving ‘addiction’ as a mental health problem rather than a moral failure would therefore be a first step in redressing some of the stigma directed towards people whose drug and/or alcohol use has led to some form of debilitation. Many of us experience mental health problems at some point in our lives (WHO, 2001), and this might include difficulties with drug and alcohol use. Whatever the nature of the ‘problem’, our social responsibility is to offer support, and guard against discrimination. Public campaigns highlighting the prevalence of mental health problems,

and the stigma associated with them, have furnished a greater understanding of mental illness in recent years (see, for example, BBC, 2009), and similar campaigns in respect of drug dependence would be welcome. However, such efforts would also be met with resistance, particularly since any campaign must assist with decoupling the causal links between drug problems and any manner of social ills, particularly crime, even though such uncritical associations continue to be nurtured by the government (Drug Strategy, 2010).

More broadly, a nuanced understanding of drug and alcohol ‘problems’ is required beyond the recreation/dependence binary. The invocation of a social model approach to substance dependence might encourage the appreciation that mental health problems, particularly when classified according to medical or legal hegemony, have always been, and should remain, open to interrogation. Bolton has critiqued the duality of order/disorder, arguing “there is no natural, principled boundary between normal and abnormal conditions of suffering” (Bolton, 2008: 194). He argues that for many people with ‘disorders’, a term he in fact rejects, life remains ordered and meaningful. Similarly, Room contends: “While there is an element of social construction and definition in all illness, the threshold of what becomes defined as a mental disorder is often set by the reactions of others to behaviours which they are defining as ‘strange’ and ‘odd’” (2005: 144). As such, writes Room, “an alcoholism or addiction concept exists precisely as an apparent explanation of the otherwise mysterious and inexplicable” (2006: 284). This would explain the diversity of terms referring to people who are identified as having issues with drugs, whether they are ‘problematic drug users’, ‘misusers’, ‘addicts’, and so on. Rigid understandings of impairment and disability, such as those found in UK discrimination legislation, support Campbell’s assertion that “there is no space or place for subaltern or previously unarticulated

experiences of impairment/disability that diverge from the predominant biomedically defined interpretations of it” (2005: 121).

Returning to the debate within disability studies over the very meaning of disability, consideration of substance dependence more generally supports the argument that disability is not a purely social construction. While understandings of substance use, dependence and intoxication contribute to the infringement of the rights of those classified as disabled as a result of substance dependence, as evidenced by the refusal of successive UK governments, in the face of strong contrary evidence, to include substance dependence with disability discrimination legislation, the barriers faced by so-called ‘addicts’ cannot be attributed only to the social. The impairment caused by dependence may cause some degree of incapacity and vulnerability as with any other form of disability, but the ability of the person to extrapolate herself from the barriers imposed by her mental dependence is evidence itself of a separation, contra Barnes, between the individual and the social. Mulvany’s (2000) apt call for the adoption of the notion of ‘embodied irrationality’ in respect of mental disabilities, which addresses both the bodily experience of mental illness and the social constructions of such illnesses, thereby avoiding biological determinism and the reification of medical solutions to mental problems, applies equally to the management, treatment and understanding of substance dependence. Until now, dependence has largely been the preserve of treatment agencies and medical personnel. But it is time for a broader approach to drug and alcohol use that registers the social and environmental factors that construct barriers and entrench stigma and discrimination.

## **Discrimination, the law and beyond**

There are other challenges involved in removing the addiction exclusion clause. Disability activists worry that ever-expanding definitions of impairments trivialise disability and fail to distinguish between illnesses and more debilitating, long-term conditions, thus weakening legislative provisions (Mulvany, 2000; Oliver 1996). Incorporating substance dependence into one, broad disability ontology will fuel the debate over whether different types of disability should be incorporated into one monolithic understanding of ‘disablement’ anyway. Indeed, a failure to acknowledge difference has been equated with a “disinterest in people’s perceptions of living with impairment and disability” (Mulvany 2000: 587). Moreover, people with disabilities may object to being identified with people who are dependent on substances, and people who are dependent on drugs and/or alcohol may well not wish to identify as disabled – even if substance dependence is already understood as a disability for the purposes of international systems of disease classification and the Convention on the Rights of Persons with Disabilities.

Understandings of, and self-identification with, disability are already highly complex. Pearson and Watson cite a study in which less than half of the applicants interviewed originally defined themselves as being disabled, including many of those who would be protected by disability discrimination legislation. They write that: “Many thought that disabled people were those who used wheelchairs or who had sensory impairment. People with mental health problems, diabetes, a bad back, cancer, or other health problems did not consider themselves covered by the Act” (2007: 113).<sup>xiii</sup> Negative identities are also ascribed within drug user groups. For example, those using crack may positively differentiate themselves from other users on the basis that, for example, they are on the street, or are injecting rather than inhaling, and so on (Mateu-Gelabert

et al., 2005). Research on heroin users has uncovered similar attempts to differentiate themselves from other ‘junkies’ (Stevens and Radcliffe, 2008:1068).

The likely ‘success’ of the removal of the exclusion clause on, say, the employment prospects of people who are dependent is questionable, particularly given that it is unlikely their inclusion will yield a torrent of litigation. Indeed, some empirical research has suggested that the UK Disability Discrimination Act in fact *worsened* the employment rate of people with disabilities (Bell and Heitmueller, 2009). Others have argued that discrimination law perpetuates fixed, subordinating understandings of disability, and in fact reinforces marginalisation. Cambell contends that ‘negative ontologies’ of disability consider disabilities as inherently problematic, with the result that poorer outcomes are inevitable for the individuals concerned. She writes: “The evolution of antidiscrimination law has in fact led to the codification of inquiry, victimhood and dependency within an overall context of docile subject positions” (2005: 114). She claims that legal recognition equates with a “language of unfreedom” so that the lives of disabled people become “regulated within the confines of juridical formations, which ultimately foreclose any alternative perspectives.” As such, she continues, “in order to be free within neoliberal societies, disabled people must submit to the strictures of ableist renderings of disability in law, that is, renderings of disability as personal tragedy” (p.115). She even goes so far as to suggest that the well-intentioned promotion of such “social injury strategies” could result in unintended consequences “such as an increase in disability resentment and hate crimes” (p.116). Moreover, other authors question any attempt to seek social, political or economic parity via the law. Nancy Fraser (1995) insists that *affirmative* solutions that recognise rights or identity claims fail to transform underlying inequalities because they are predicated on subordination to the (for our

purposes, intrinsically *disablist*) statutory framework. On the other hand, she argues, truly *transformative* solutions must in same way overcome or destabilise existing structures.

Nevertheless, alternative perspectives suggest that the removal of the omission clause could have beneficial effects, for example in respect of positive identity. Pearson and Watson argue that disability rights can be beneficial in a number of ways: “First, they can change self perceptions. Such rights make people believe that more is possible. Further, such rights affect and individual’s identity, giving them a basic understanding of who they are and where they belong...if a person believes they have a right to a job or an education then they are more likely to attempt to achieve these aspirations” (Pearson and Watson, 2007: 117). Not only, argue the authors, does anti-discrimination legislation challenge cultural and societal expectation, but, following philosophers Axel Honneth and Charles Taylor, “being recognised as rights-bearing citizen is a necessary condition for achieving subjectivity, self-realisation and self-identity” (p.118). While Fraser, among others, and in keeping with feminist legal critiques,<sup>xiv</sup> has cautioned against the pursuit of affirmative solutions to social exclusion, others have argued that ‘failing to make the grade’ in itself fuels the belief that there might be good reason for such exclusion. This has been observed, for example, in light of repeated, failed attempts to pass a resolution relating to sexual orientation at the United Nations (Heinze 2000). In other jurisdictions, courts focus on the discriminatory behaviour, rather than the subject of discrimination, in disability discrimination cases. It seems reasonable, given the fluid nature of mental disorder, that judicial interpretations of impairment should give way to a focus on the injustice suffered, rather than a rigid categorisation of a changing and malleable condition that the law may be slow to understand or define.

There are other legal measures that could be invoked in order to address the social and structural factors that impact negatively on the lives of people who are substance dependent. Such measures might, for example, include the express identification of people dependent on drugs within hate crime legislation. There are no statistics on the prevalence of such crimes for this section of the population, but given the pervasiveness of cases among disabled people generally, despite a lack of figures and expected underreporting (Perry, 2008), and the evidence on stigma exhibited towards ‘addicts’, the numbers are likely to be high. While the victim’s ‘disability’ as motivation for a criminal offence is already considered an aggravating factor in sentencing (Criminal Justice Act 2003, ss.145 (2) and 146(2), recent guidance from the Crown Prosecution Services, following lobbying from the National AIDS Trust, emphasised that people with HIV fall under the definition of disability under section 146 of the legislation (CPO, 2010; NAT, 2010). It is perhaps time that guidance also recognise the specific vulnerabilities of people who are dependent on substances.

## **Conclusion**

The removal of the addiction exclusion clause in the Equality Act 2010, which expressly stigmatises conditions elsewhere characterised as mental disabilities, might have been a first step in redressing an approach to substance dependence that has thus far focused on either medical or criminal interventions. Instead, the continued, express exclusion of drug and alcohol addicts from UK disability discrimination legislation reinforces their marginalised status, and reproduces

their inhumanity in the same way that others excluded from human rights legislation, such as refugees or those seeking asylum, are similarly dehumanized (Douzinas, 2000). Both systems of disease classification and human rights law support the inclusion of substance dependence within disability rights legislation, although the sociology of substance use and dependence sheds light on the reasons for the exclusion. Examining substance dependence, and use, from the perspective of disability studies, meanwhile, helps further in forging an understanding of the social factors that construct substance dependence and contribute to the marginalisation of those affected.

Buchanan (2004), among others, has called for a new conceptual framework for addressing problematic drug use that incorporates such structural and social factors, and does not rest exclusively on a treatment and recovery model. This would correspond with a social model of disability by which other factors, beyond a concern with physical impairments, contribute to constructions of disadvantage in society. Some bodies and organisations are attempting to draw attention to the exclusions faced by people with drug and alcohol problems (UKDPC, 2010), but a new conceptual framework remains, for the most part, elusive. Where the social and environmental exclusions stemming from dependence have been addressed in drug policy and human rights literature, the overarching focus is generally on access to health services, and health outcomes, rather than on broader exclusions experienced by people with drug and alcohol problems. A key message of the harm reduction movement, for example, has been to switch the basis for drug policy from criminal control to health treatment, but broader structural harms tend to garner less attention and advocacy has mostly focused on *physical* health policy issues such as encouraging the establishment of needle exchange programmes – a focus that has been fuelled by the HIV epidemic which has accounted for much of the movement’s political currency.<sup>xv</sup> The

harm reduction movement's pragmatic exigencies – namely, to work within existing structural frameworks without, say, advocating for a right to use drugs, or the liberalisation of drug laws – are informed by the need for political expediency. But this approach, while successful and arguably necessary in many respects,<sup>xvi</sup> may have invited a cautious approach to challenging stigmatising legislative developments such as those contained in the UK Equality Act.

Issues relating to drug and alcohol dependence are furthermore almost completely absent from discourse on disability, whereas the issue of discrimination in law for people with drug and alcohol problems has been largely neglected across the academic spectrum. In keeping with theoretical and political standpoints pertaining to disability, a holistic, 'embodied irrational' approach requires not only legislative change, but broader interventions that focus on discrimination and stigma expressed in public services and actively pursued in the media.

Disability activism has challenged social constructions of disability and impairment, but it has been much harder for 'deviants' dependent on drugs and alcohol to escape their marginalised and highly stigmatised status and accrue political influence. Accepting that substance dependence lawfully constitutes a mental disability could provide the opportunity for redressing such exclusion. Problems do remain, such as defining 'dependence' and differentiating non-problematic drug and alcohol use from behaviours considered harmful or dependent. But closer consideration of substance dependence as a disability offers the opportunity to further examine the links between 'brute' impairments and 'institutional' responses for those deemed dependent on substances, as well as the implications for legislative developments beyond the current focus on the system of drug classification.

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<sup>i</sup> In a House of Commons debate, Liberal Democrat Dr Evan Harris noted, for example, that the bill had been “hardly opposed” by parliament (*Hansard* (series 5) vol.492, col 625 (11 May 2009)).

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<sup>ii</sup> The ‘addiction’ and ‘dependence’ concepts have been heavily critiqued and this will be discussed in due course. The terms may be used interchangeably during the course of the article depending on the context. For example, since the Equality Act uses the term ‘addiction’, the term ‘addict’ is used when discussing the Act directly. In other situations, the term ‘dependence’ is preferred since, as will be discussed, it is perceived as less stigmatising than ‘addiction’ and is the favoured expression in international systems of disease classification.

<sup>iii</sup> It should be noted that problems also persist with the term ‘dependence’ as described under the *DSM*. See, for example, Goode (2000).

<sup>iv</sup> There is potentially a lot to be said about the different forms of ‘dependence’ induced by different substances, and of course the differing social constructions of, and responses to, different types of substances – legal and illegal. However, given that the Equality Act groups alcohol and drug ‘addiction’ together, this article attempts to focus on the addiction or dependence concept in general.

<sup>v</sup> This emphasis is explored at length detail below.

<sup>vi</sup> It also leaves open the question of whether drugs that were medically-prescribed at one stage, but subsequently illegally obtained, would fall within the purview of the Act.

<sup>vii</sup> Methadone is a drug usually administered to help users come off heroin, although it is an ‘addictive’ drug in its own right.

<sup>viii</sup> See HM Government Office for Disability Issues (2010). Indeed, people with cancer, multiple sclerosis and HIV, originally excluded under the DDA 1995, were protected as a result of changes in the Disability Discrimination Act 2005, c.13, 18(6)(a).

<sup>ix</sup> This has also been apparent in the differences in welfare provisions for ‘undeserving’ asylum seekers and ‘deserving’ refugees. See Sales (2002).

<sup>x</sup> Pearson and Watson note that such rigid parameters are absent from both the Sex Discrimination Act of 1975, and the Race Relations Act of 1976, and that “failure to prove that a claimant is disabled is the single most common reasons for claims under the DDA to fail” (2007: 107).

<sup>xi</sup> It is possible that authors do not aim to exclude dependent behaviours, but that, they simply consider such conditions to be part of a broader mental illness ontology – if indeed they consider them at all.

<sup>xii</sup> It is worth noting that HIV/AIDS may also be classified as a disability for the purposes of the Equality Act 2010 (see HM Office for Disability Issues, 2010: 9). People with cancer, multiple sclerosis and HIV, originally excluded under the DDA 1995, were protected as a result of changes in the Disability Discrimination Act 2005, c.13, 18(6)(a).

<sup>xiii</sup> The study in question is Hurstfield, 2004.

<sup>xiv</sup> See, for example, MacKinnon (1989); West (1988).

<sup>xv</sup> See, for example, International Harm Reduction Association (2010).

<sup>xvi</sup> Although Hathaway (2001) has, for one, questioned this assertion.