

Conceptualising Addiction as Disability in Discrimination Law: A Situated Comparison

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Abstract

People labelled as having an addiction and people with disabilities face significant discrimination in their daily lives. In countries where targeted disability discrimination law is applied, it is often assumed that including addiction in the definition of disability will protect those labelled as having an addiction from discrimination. Several scholars have considered the effects of excluding addiction from the remit of discrimination law, but there has been less work examining the consequences – both positive and negative – of including addiction. Using the method of ‘situated comparisons’ developed by intersectionality scholars, this article interrogates how addiction and disability are co-constituted in two contrasting legal and geographical contexts, where people labelled as having an addiction have sought to assert their right to equality before the law. By comparing the application of targeted discrimination law in Australia with a human rights charter in Canada, it demonstrates how systems of power such as ableism and neoliberalism work through the law to co-constitute addiction and disability in ways that are stigmatising, even within legal approaches that aim to eliminate discrimination. Furthermore, the law, in both contexts, fails to recognise the intersectional nature of discrimination often experienced by these groups. The article contends that conceptualising addiction as a disability will not necessarily reduce the discrimination faced by people labelled as having an addiction; and concludes with recommendations for both policy and legal practice.

Keywords: addiction, disability, discrimination, human rights, intersectionality

Introduction

People with disabilities and people labelled as having an addiction are widely recognised as two of the most stigmatised groups in society. Both are frequently subjected to discrimination and exclusion from various social, cultural and political spaces, and face the judgment, disgust or pity of others on a daily basis (Garland-Thomson, 2005; Lloyd, 2013). For those labelled as having an addiction, this stigma is often attributed to their actual or perceived use of illicit drugs, which invites further moral condemnation (Seear et al., 2017). Such discrimination can undermine their fundamental human dignity, and deny both groups the recognition of equality before the law (Jürgens et al., 2010).

The right of every individual to enjoy equality before the law is a key tenet of liberal democratic thought, and is also a ‘primary element’ of the modern human rights movement (Gaze, 2002). The Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights establish that individuals have a right not to be discriminated against on the basis of ‘race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status’ (UDHR, 1948, Art. 2). The domestic application of the right to equality before the law can be said to adopt one of two approaches. The first is discrimination law, which is a targeted approach to enforcing the right to non-discrimination. This approach usually seeks to define particular groups at risk of discrimination, before then reaffirming their right to equality and offering legal remedies and mechanisms for protection. An alternative approach is the use of a bill or charter of rights. These instruments seek to give domestic expression to the broad range of rights included in international human rights law; not simply the right to non-discrimination alone. Furthermore, they start from the premise that rights confer to every individual on the basis of their inherent human dignity.

In countries where targeted discrimination law is applied, such as Australia, specific disability discrimination legislation is usually used to render discrimination against people with disabilities unlawful, and to promote their right to equality before the law (Basser and Jones, 2002). However in order to identify who can benefit from such legislation, they must inevitably define ‘disability’, and the question of how to do so has been the subject of some debate (Kaplan, 2000). Furthermore, some commentators often assume that addiction can be categorised as a mental disorder, and can thus be included within the remit of disability discrimination legislation (Flacks, 2012). However, like disability, the definition of addiction is heavily contested (Fraser et al., 2017), making its framing as a disability for the purposes of law controversial.

This article considers whether addiction should be conceptualised as a disability for the purposes of discrimination law. I begin by briefly introducing the critical addiction and disability studies literature, before proposing that intersectionality theory provides a valuable framework for understanding the interaction of these two categories. I draw on intersectionality theory to interrogate the ways in which addiction and disability are co-constituted in two contrasting legal and geographical contexts: targeted discrimination legislation in Australia, and via a human rights charter in Canada, where people labelled as having an addiction have sought to achieve equality before the law. The purpose of this comparison is not to illustrate which legal approach is ‘preferable’, but to demonstrate how particular systems of power – such as neoliberalism and ableism – work through seemingly different legal approaches to achieve similar goals, and how presumably beneficial laws may have problematic effects for the subjects they claim to protect.

Addiction, disease and disability

While addiction can be ascribed to a range of different behaviours and activities, this article will use the term ‘addiction’ only as it refers to alcohol and other drugs (AOD). Two main models of addiction have been dominant in Western societies over time: addiction as a moral failure, and addiction as a medical condition or disease (Clark, 2011). The moral or ‘deviance’ model conceptualises addiction as a personal and immoral choice for which people who use drugs are ultimately to blame. Alternatively, a medicalised approach views addiction as a disease, disorder or condition requiring medical treatment. This model is considered by a range of scholars and practitioners to be the current prevailing model of addiction, exemplified by its classification in the *International Classification of Diseases: ICD-10* (WHO, 2004) and the *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (APA, 2013).

While the conceptualisation of addiction in these medicalised terms is often unquestionably accepted within public discourse and practice (Reinarman, 2005), a growing number of commentators are challenging the assumed hegemony of the biomedical model by exposing its deep cultural, historical and political undertones. According to Clark (2011, p. 56) what is really at stake when considering how addiction should be defined, is what each model represents: fundamental ideas about ‘free will, autonomy, self-control, rationality, responsibility and blame.’ For example, some have argued that concerns about habitual drug use are associated with the rise of post-enlightenment ideas about ‘reason’ and ‘rationality’, or that key concepts of addiction (such as concerns that drug use inhibits one’s ability to function as a ‘productive’ member of society) align with capitalist and neoliberal ideals (Fraser and Moore, 2008; O’Malley and Valverde, 2004). Under a neo-liberal frame, the individual exemplified in classical liberalism becomes an entrepreneurial, self-governing,

autonomous actor (Zibbell, 2004), who is considered solely responsible (and thus blameworthy) for the management of their own health care (Fraser, 2004). In line with these various critiques, there is debate about whether framing addiction as a form of impairment, disease or disability is indeed beneficial for people labelled as having an addiction (Wasserman, 2004).

By framing people labelled as having an addiction as ‘sick’ and in need of care, the biomedical model has been positioned as antithetical to its moral/deviance counterpart which seeks, instead, to punish people who use drugs (Clark, 2011). Indeed there may be benefits in framing addiction in biomedical terms, such as the potential for a greater focus on access to treatment. However there are also a number of shortcomings, such as the increased use of coercive and mandatory treatment, and claims that the model has failed to curb the stigma around addiction (Seear and Fraser, 2014; Hall et al., 2015). Ultimately, the biomedical model is characterised by a central paradox: that while it encourages compassion in treatment and policy, it simultaneously pathologises and stigmatises those labelled as having an addiction. In short, the model ‘comes with a price’ (Buchman et al., 2010, p. 75).

The law is widely recognised as contributing to or exacerbating the stigma created by these models of addiction (Seear et al., 2017). For example, the law may offer formal protection from discrimination, while also relying on stigmatising labels to describe the category of person afforded such protection (Room, 2005). Alternatively, the law may offer protection on the basis of certain attributes in one area of law, while simultaneously criminalising those same attributes elsewhere (Seear et al., 2017). Regardless of the approach, the stigmatising and fundamentally negative category of ‘addict’ is ultimately reinforced.

Similar observations have been developing in disability scholarship with respect to concepts of disability and disease (Flacks, 2012). Recent decades have seen a growing disability rights movement challenge a medical model that viewed disability as individual pathology, instead promoting a social model of disability that sought to differentiate between the concepts of ‘impairment’ and ‘disability.’ Proponents of this model argued that a range of structural factors combined to produce an environment in which people with impairments were systematically excluded from society, and that experiences of disability could largely be eradicated were adequate social, economic and environmental supports provided to people with impairments (Oliver, 1983).

The social model had a significant effect on how disability was understood on a global scale. It also had an influence on global conceptions of disease and its relationship with disability. According to the *International Classification of Functioning, Disability and Health* (ICF) (WHO, 2001) disability is often seen as an *outcome* of disease, characterised by a ‘disablement process’ whereby the disease reduces or otherwise affects bodily functioning, and broader social and environmental factors influence the way it is experienced (Verbrugge and Jette, 1994). However, the ICF still faces a number of criticisms, including that it seeks to label and therefore stigmatise people with disabilities, and that negative terminology is still used to describe people’s impairments (Wade and Halligan, 2003). As Newell (1999, p. 173) argues, people with disabilities are still represented ‘as the objectified other.’

In response to these emerging criticisms, the field of critical disability studies arose to challenge the strict separation of impairment and disability that the social model promoted. It advocated instead that the biological body and cultural discourses around disablement be understood as intrinsically *interrelated*, though not *conflated* in the way the medical model had imagined (Goodley, 2013; Campbell, 2012). Critical disability scholars were also

instrumental in challenging the assumption that to have a disability is an essentially negative experience. The dominant system of thought that established this narrative is known as ‘ableism’, which refers to the framing of disability as fundamentally negative; locating it outside the realm of what is normal, or even human (Campbell, 2012). According to this view, both the medical and social models of disability are deficient because they fixate on the so-called ‘problems’ of disability, rather than the question of whether being able-bodied is normal and inherently more favourable than being ‘disabled’ (Campbell, 2012; Hughes, 2015). Under this disablist framework, the term ‘disability’ is used to describe a whole class of people whose main commonalities are that they are ‘designated as defective’ and socially stigmatised (Garland-Thomson, 2005, p. 1558). Comparable rhetoric is also evident in discourses around disease; with chronic illnesses, mental disorders and ‘challenging’ behaviours all tending to be collectively classed as ‘abnormal’ and thus as subordinate states of existence (Garland-Thomson, 2005; Williams, 1999).

As such, many have argued that the way disability is constructed in law matters (Jones and Marks, 1999; Campbell, 2012). For example, people with disabilities are often required to identify with stigmatising definitions of disability in law, whether or not they wish to do so (Karpin and O’Connell, 2015). Protection is thus ‘predicated on subordination to the...intrinsically disablist statutory framework’ (Flacks, 2012, p. 406). In this way, critical disability studies and studies of ableism have exposed the limits of the law in protecting people with disabilities from harm (Campbell, 2001). In fact the law has been accused of committing violence upon people with disabilities through its complicity with biomedicine (Steele, 2017), the underlying objective being the imposition of ‘compulsory able-bodiedness’ (McRuer, 2006, p. 9).

Conceptualising addiction and disability in discrimination law

The question of whether addiction can be understood as a disability in law is arguably contingent upon the definitions adopted. Applying only a limited, medical model of disability to addiction would see it as a biomedical impairment that limits activity and consequently results in disability (Wasserman, 2004). In addition, applying a social model of disability to addiction may prompt examination of ‘the links between “brute” impairments and “institutional” responses’ to addiction, as Flacks has suggested (Flacks, 2012, p. 408).

Alternatively, critical disability studies and studies of ableism offer us ways of understanding disability as the *meanings* ascribed to bodies, rather than the essence or functionality of those bodies themselves (Williams, 1999). Using this same approach, we can critique the *meanings* attributed to the experience of addiction in the context of discrimination law, rather than simply taking for granted its ‘forms, functions and behaviours’ (Garland-Thomson, 2005, p. 1558). Likewise, the critical addiction literature suggests that despite the perceived dominance of the biomedical model of addiction, there is a clear discursive shift in thinking about addiction as a more nuanced, contingent and contested experience (Seear and Moore, 2014), which has implications for how the condition should be understood in law.

A handful of scholars have considered the question of whether addiction should be considered a disability for the purposes of discrimination law (O’Flaherty, 2016; Flacks, 2012; Wasserman, 2004). The argument for *excluding* addiction where it relates to the use of illicit drugs has so far been made on the basis that the protection of both illicit drug use and the consequences flowing from it, undermines the ‘legitimacy of a liberal-democratic state’ (Wasserman, 2004, p. 484). As Flacks (2012) identifies, this argument holds currency only insofar as it operates within a prohibitionist model that criminalises illicit drug use, and views the perceived loss of self-control resulting from such use as a threat to the concept of a

rational, autonomous liberal subject. According to this view, it is ‘reasonable’ not to protect people who use illicit drugs from discrimination, because doing so would contradict existing laws that criminalise that same group (Flacks, 2012; Fraser and Moore, 2008). Alternatively, the more common argument for *including* addiction as a disability centres around two related purposes. First, that its inclusion would protect a group of people who are heavily discriminated against, and second, that it would help reduce the stigma attributed to drug addiction (Flacks, 2012; O’Flaherty, 2016). According to these arguments, including addiction as a disability in discrimination law is preferable because it will afford the same benefits to people labelled as having an addiction, as people with disabilities are assumed to enjoy. However this argument assumes that disability is positively constructed, and that people with disabilities derive significant benefits from discrimination law – a point heavily disputed in disability studies (Campbell, 2001; 2012). In addition, it fails to thoroughly interrogate the concept of addiction-as-disorder, which is similarly contested in the critical addiction literature (Fraser et al., 2017), and which predicates its link to disability for the purposes of this argument. Thus while it may appear beneficial to widen the protection promised by discrimination law, it may also unintentionally ‘expand legal categories with negative applications’ (Karpin and O’Connell, 2015, p. 1462). In light of this, I argue that the consequences of *including* addiction in the category of disability for the purposes of such protection have not been thoroughly considered, in light of what such inclusion would ultimately *mean* for those being ‘protected’.

An intersectional approach

In pursuit of this goal, I propose that intersectionality theory can be valuable for interrogating how concepts of addiction and disability interact with each other in various contexts, and what this ultimately means for their enactment in law. Specifically, I will argue that

intersectionality theory can help to illuminate how addiction and disability – at both an experiential and systemic level – reciprocally construct and reproduce each other, so that discrimination against one attribute is intricately connected to discrimination against the other.

The origins of intersectionality can be traced back through the histories of both critical race and feminist epistemologies, where social identities such as gender and race began to be understood as ‘analytical categories’ (McCall, 2005). The term ‘intersectionality’ itself was coined by critical race theorist Kimberlé Crenshaw in two groundbreaking interrogations of discrimination law in the United States (1989; 1991). Her main contention was that the law was unable to conceptualise discrimination as occurring across multiple axes of difference, because it treated social identities as mutually exclusive constructs. Intersectionality’s central principle is that all social identities – including race, gender, sexuality, disability, class and others – are not experienced as distinct categories but as intersecting pathways that are complex, fluid, historically situated and contextual (Hancock, 2007). Importantly, however, it is both the intersections of identities at the micro-level *and* the ‘interlocking’ systems of power at the macro-level, which simultaneously and contingently produce inequality (Collins, 1990; Yuval-Davis, 2006).

Scholars within the field of critical disability studies have long argued that disability should be understood as an intersectional category (Erevelles and Minear, 2010; Garland-Thomson, 2005). On the other hand, addiction has been considered sparingly in the intersectional literature, and does not appear to have been approached specifically as a form of identity or category of difference for the purposes of an intersectional analysis. I argue that conceptualising addiction as a category of difference can help us to understand the ways in

which this socially stigmatised form of behaviour is differentiated from the mainstream and constituted in particular ways, for particular reasons.

Hae Yeon Choo and Myra Marx Ferree (2010) and Rita Dhamoon (2011) describe three different types of intersectional analysis. A ‘group-centred’ analysis focuses primarily on “giving voice” to those who are located at particular points of intersection within the social matrix. This type of analysis tends to be concerned with the intersections of social identities or categories, seeking to achieve the inclusion of those who are typically marginalised (Choo and Ferree, 2010). In contrast, a ‘process-centred’ approach is concerned with the *interaction* between categories, and more importantly, ‘what the interaction reveals about power’ (Dhamoon, 2011, p. 234). As a result, the focus shifts from the experience of the multiply-marginalised subject, to the *ways* in which the inequality they experience is produced. Finally, a ‘system-centred’ approach draws attention to the institutions of power that produce inequality. These systems are seen as ‘mutually constitutive’ (Yuval-Davis, 2016, p. 369), ‘overlapping’ (Choo and Ferree, 2010) or ‘interlocking’ (Collins, 1990) in that they *rely on each other* to function (Dhamoon, 2011). In this way, systems of power such as ableism, neo-liberalism and sexism, *make* each other, work *through* each other, and are effective precisely *because of* each other. Ultimately, this assemblage of power structures works to subordinate particular ways of being, by simultaneously reinforcing that which is considered ‘normal’ across multiple social categories. It follows that one cannot fully understand or address one system of power, without recognising its entanglement with others (Dhamoon, 2011).

Following these authors, an intersectional analysis is enriched where it moves beyond the level of intersecting identities or categories where social inequalities are experienced, to consider the *processes* and *systems* that work in tandem to create those inequalities. In order to deal with the complexity that this entails, Dhamoon (2011) has introduced the method of

‘situated comparisons.’ This approach recognises that while all social categories, processes and systems of power are co-constitutive, it is impossible and unnecessary to focus upon the interactions of all of them in every instance. Instead, a comparison can be made between two or more similar contexts to identify ‘which interactions are salient in a specific set of historically constituted social relations’ (Dhamoon, 2011, p. 236). Situated comparisons can therefore help us to understand *how* salient systems of power work dynamically across different sites, and how these, in turn, influence the constitution of social identities.

In the following sections I analyse and compare two contexts in which people labelled as having an addiction have sought redress from discrimination under the law. Australia and Canada are both western liberal democracies with similar systems of government, and similar histories of Indigenous dispossession and multiculturalism. However, one major difference between the legal systems of the two countries is that Canada has a constitutional bill of rights, which confers a number of fundamental freedoms and democratic rights on Canadian citizens, while Australia does not. Comparing the two countries thus allows us to consider how potentially similar values operate through different legal approaches. In the Australian context, I consider targeted discrimination legislation and associated law reform in both the Commonwealth and New South Wales (NSW) jurisdictions, as well as the authoritative case of *Marsden v Human Rights Equal Opportunity Commission & Coffs Harbour & District Ex-Servicemen & Women’s Memorial Club Ltd* (2000), which applied the Commonwealth legislation to the question of addiction. I also draw upon reports by the Australian Injecting and Illicit Drug Users League (AIVL) and the Anti-Discrimination Board of NSW, who have investigated addiction- and disability-related discrimination within these jurisdictions. In the Canadian context, I analyse the cases of *PHS Community Services Society v Attorney General of Canada* (2008) and *Canada (Attorney General) v PHS Community Services Society* (2011) (hereafter referred to collectively as *Insite*), which relied on the *Canadian Charter of Rights*

and Freedoms to make a number of constitutional findings, but in the process, framed addiction as a disease. I also consider the implications for the local community affected by the *Insite* decision, where a significant number of people labelled as having an addiction and people with disabilities reside.

Marsden and addiction in Australian disability discrimination law

Ableist foundations in disability discrimination law

In Australia, the *Disability Discrimination Act 1992* (Cth) aims to eradicate discrimination ‘as far as possible’ (s3(a)) to ‘ensure, as far as practicable’ that people with disabilities enjoy equal treatment under the law and to promote the rights of people with disabilities within the community (s3(c)). Section 4 of that Act defines ‘disability’ as:

- (a) total or partial loss of the person’s bodily or mental functions; or
- (b) total or partial loss of a part of the body; or
- (c) the presence in the body of organisms causing disease or illness; or
- (d) the presence in the body of organisms capable of causing disease or illness; or
- (e) the malfunction, malformation or disfigurement of a part of the person’s body; or
- (f) a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction; or
- (g) a disorder, illness or disease that affects a person’s thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour.

The *Anti-Discrimination Act 1977* (NSW) includes similar aims, and defines disability in almost identical terms (s4). According to Bassar and Jones (2002, p. 261), the definition espoused by both jurisdictions adopts a ‘broad approach’ to disability and is advantageous because it avoids ‘complicated discussions about the relationship between impairment and

disability.’ In contrast, I argue that this definition is nothing more than a list of impairments. There is limited consideration, for example, of the social or environmental factors that shape disability, and which could help to alleviate it. Thus, rather than avoiding a discussion about impairment and disability, it reinforces a distinct view of disability *as* impairment. This is a clear embodiment of the medical model (Oliver, 1983). Furthermore, as Arnold and colleagues argue, this definition is ‘presumptively negative’ (Arnold et al., 2010, p. 384) because it is concerned only with aspects of disability that are unwanted, malfunctioning or absent altogether. Indeed the attributes of disability in all cases are described as resulting from a ‘defect’, ‘disorder’, ‘illness’ or ‘malfunction’ of some sort. Both Acts thus conflate disability with impairment and frame them in fundamentally negative terms. Paradoxically, it is only upon acceptance of this narrow definition of disability that those discriminated against on such grounds are eligible to seek redress under discrimination law – exemplifying what scholars have described as the complicity of biomedicine and law in perpetuating ‘compulsory able-bodiedness’ (McRuer, 2006; Campbell, 2001).

Marsden and associated law reform

The case of *Marsden* is one of the most important cases relating to addiction discrimination in Australia. This case concerned Wayne Marsden, who was denied service of alcohol and later evicted from a club he was a member of, on the grounds of perceived intoxication. Marsden disputed this, claiming instead that he was dependent on methadone (a medication he was lawfully prescribed as treatment for heroin dependence) and that this constituted a disability for which he had been discriminated against. He brought a claim on this basis to the NSW Human Rights and Equal Opportunity Commission (The Commission), which was rejected at first instance. Upon appeal to the Federal Court, Branson J set aside the Commission’s decision, finding that

[i]n ordinary usage, the words "disorder, illness or disease" encompass a medical condition the symptoms of which can be, and are, alleviated by treatment. Certain disorders are amenable to treatment such that, while taking appropriate treatment, the person suffering from the disorder feels normal and is able to lead a normal life...Nonetheless, in ordinary parlance, the person still suffers the disorder. (para 55)

Importantly, Branson's findings imply that those experiencing a dependence are abnormal, and that they do not 'lead a normal life'. The court thus reinforced a biomedical view of addiction as a form of disorder requiring medical treatment and as amenable to cure.

Crucially, this conceptualisation was made possible precisely because the legislation itself constructed disability as abnormal, vulnerable, sick and ontologically problematic. The underlying assumption was thus that to be able-bodied, fully-functioning and rationally-minded is the 'normal' to which those seeking protection under such laws should aspire (Campbell, 2012). Crucially, Branson J did not explicitly find that methadone dependence was a disability in this case, however she did hold that it was 'open to [The Commission] to find that, prima facie' (Marsden, para. 54). This ultimately attracted considerable public outrage (Gibson, 2009), and two main legal implications followed.

First, the *Marsden* decision led to the enactment of the *Anti-Discrimination Amendment (Drug Addiction) Act 2002* (NSW) in the state of NSW, which specifically *excluded* addiction to illicit drugs from protection as a disability in the area of employment (s49PA). As a result, employers gained the right to actively discriminate against employees who were deemed to be addicted to a prohibited drug at the time of the discrimination. Importantly, the amendments only excluded drug addiction from protection where it related to the use of *illicit* substances. The result is that the Act makes an exception for a certain *type* of disability (so defined) that it considers unworthy of protection. It is thus not addiction or dependence *per se* that is precluded, but addiction to substances that the State does not control, and behaviour

interpreted as an affront to normative ideals of order, rationality and productivity, and thus undeserving of State protection (O'Malley and Valverde, 2004; Room, 2005). By contrast, the use of regulated substances such as pharmacotherapy are afforded protection from discrimination under the Act, because they are seen as evidence of a person's desire to cease using illicit substances and to become a compliant subject, insofar as they are prepared to engage with biomedical interventions. Furthermore, while the Act does not mention alcohol, as a legal substance, its use would appear to be protected under the Act. The result is that where a person consumes illicit substances they are denied recognition as a person with dignity, irrespective of whether they identify as a person with a disability. Alternatively, where they 'choose' to reject this status and submit to treatment or pharmacotherapy in order to restore 'order' to their lives, they are once again afforded protection. Curiously then, this approach is based on the assumption that a person deliberately chooses to become addicted and can subsequently choose to stop, or can choose to seek treatment for the purposes of eradicating their addiction. This ultimately demonstrates a paradox whereby a moral model of addiction is operating surreptitiously within an Act adopting a biomedical definition of disability. Others have similarly described this contradiction in traditional addiction narratives (see Weinberg, 2013; Keane, 2001).

Shortly after the passage of the NSW amendments, the Commonwealth government attempted to pass similar legislation in the form of the Disability Discrimination Amendment Bill 2003 (Cth) (the Bill). Controversially, this Bill sought to make it *lawful* to discriminate against people labelled as having an addiction, and did not limit its remit to the area of employment. Like in NSW, the Commonwealth government stated that the Bill was not intended to punish 'people with drug problems' but rather to protect the broader community 'from the harms and risks posed by another person's illicit drug addiction' (Commonwealth of Australia, 2003, 23541). Despite these assertions, however, the comments express a clear

view that ‘people with drug problems’ are unworthy of the recognition of human dignity that discrimination law might afford. This inevitably reinforces beliefs about people labelled as having an addiction (to illicit substances only) as inherently dangerous and deviant. As Keane (2003, p. 3) has noted, such approaches are often employed to justify the exclusion of people who use illicit drugs ‘from normative categories of citizenship, such as the “general public”.’ Ultimately, these approaches serve only to further stigmatise people who use illicit drugs, reinforcing their marginalisation and exclusion from the wider community (Moore et al., 2015). Furthermore, like its NSW counterpart, the Bill sought to use discrimination law as a mechanism to incentivise people with certain *types* of addiction to submit to normative expectations around self-regulation, rationality and able-bodiedness in return for equality before the law. Due to strong opposition from a coalition of service providers, medical experts and advocacy bodies, the Bill was never passed and ultimately lapsed (Lynch and Wodak, 2004). However, the failure of the *Marsden* case to definitively define addiction as a disability makes it unclear whether all kinds of addiction constitute a disability in Commonwealth discrimination law (Seear and Fraser, 2014).

The effects of the amendments passed in NSW and those attempted in the Commonwealth jurisdiction, ultimately demonstrate how concepts of addiction and disability are ‘enmeshed’ (Yuval-Davis, 2006, p. 205) in Australian disability discrimination law. At the level of social categories where addiction and disability intersect, we can observe how in legislation designed to protect people with disabilities from discrimination, a particular group is carved out of the disability category for deliberate exclusion. Within this group, ‘addicts’ and ‘non-addicts’ are then further differentiated not because of the nature of their apparent disease or disability, but because of the legality of the substances they consume and associated moral judgments about their behaviour. This can most aptly be described as a demarcation ‘between

“addicts” and “normal” in neurological identity’, which in turn facilitates increased social distance, a known component of stigma (Buchman et al., 2010, p. 66). Importantly, this division is made possible because the two Acts already make such a distinction between able-bodied people and people with disabilities (Karpin and O’Connell, 2015). Ultimately, the promise of protection is held out as an incentive for people labelled as having an addiction to modify their behaviour and submit to the same negative labels applied to people with disabilities.

In addition, the explicit aims of the NSW amendments and the unsuccessful federal Bill demonstrate how interlocking systems of power can work together through the law to impose neoliberal and ableist values on its subjects. For example, while employment and consumption are usually held out as desirable facets of neoliberal subjectivity (Fraser and Moore, 2008), the NSW amendments ensure that people labelled as having an addiction to illicit drugs can be excluded from employment on the basis of addiction alone – rather than on their ability or desire to work. Indeed as citizens, they are expected to conform with particular social norms around work (informed by values of utility and economic production) (Fraser and Moore, 2008) as well as social norms around behaviour (informed by values of individual autonomy and able-bodiedness) (McRuer, 2006). Yet even where they may abide by the former, the amended legislation facilitates their exclusion from employment on the basis of the latter. Thus rather than being separately constituted, social norms around work and behaviour effectively rely on each other in this context to exclude people labelled as having an addiction from the full benefits of liberal subjecthood, unless they submit to a framing of their drug use as ‘disordered’ and enter into treatment. These two normative systems are therefore co-constitutive and successful insofar as they rely on each other to achieve their goals (Dhamoon, 2011).

The lived experience of addiction- and disability-related discrimination in Australia

What legislation and case law cannot show us is a deeper understanding of the lived experience of discrimination against people labelled as having an addiction and people with disabilities. The following section draws on key work in this area by AIVL and the Anti-Discrimination Board of NSW, to show how experiences of discrimination on the basis of drug use, addiction and illnesses such as the hepatitis C virus (HCV) are interrelated, and intersectionally constructed, so that redress under discrimination law on such grounds is extremely difficult to achieve.

AIVL is the peak representative body for people who use or have used illicit drugs in Australia. They argue that the definition of disability adopted in the *Disability Discrimination Act* is so narrow that it ‘excludes the majority of people who use/have used illicit drugs’ (AIVL, 2012, p. 2). While people labelled as having an addiction may be a deliberately targeted group within this larger category, AIVL contends that the boundaries of such internal groups are arbitrary and questionable:

The majority of drug users do not experience their drug using behaviour as problematic in either physical or emotional terms and/or do not wish to classify their drug use as a ‘disability’ or ‘illness.’
(AIVL, 2012, p. 12)

This accords with the critical addiction literature, which notes that there is significant within-group diversity among people who use drugs, and that the experience of ‘addiction’ is highly contested, fluid across time and space, and often at odds with biomedical definitions found in diagnostic tools (Fraser, 2016). As a result, those seeking redress against drug-related discrimination must ultimately submit to a framing of their drug use as a ‘disease’ or ‘disorder’ whether or not this accords with their lived experience. Notably, this same dilemma faces many people who may not wish to identify as ‘disabled’, but who are required

to do so in return for protection against discrimination (Karpin and O'Connell, 2015). In the case of addiction, this consequence is significant because it reserves protection from discrimination only for those who accept that their 'thought processes, perception of reality, emotions or judgment' (*Disability Discrimination Act* s.4) are compromised. A recognition of reduced capacity is thus traded for equality before the law, and a person's dignity is recognised only insofar as they accept a view of their drug use as chaotic and disabling. This echoes what Campbell (2001) has described as a process through which people with disabilities are often expected to 'submit to... ableist renderings of disability in law' which construct disability as a 'tragedy' (p. 50). Further to this, it represents a paradox whereby dignity and autonomy are undermined by a legal framework that is meant to facilitate them. Many would argue, of course, that where a person does not believe they have an illness or disability, their need for protection under discrimination law is negated. However as AIVL (2012, p.13-14) asserts, it is often not addiction (actual or perceived) that forms the basis of discrimination commonly experienced by this group:

AIVL would argue that it is a person's 'drug use' (presumed or otherwise) that is most often at the core of such discrimination, rather than the presence of...illness.

This is a crucial distinction because even for those who *do* accept a definition of their addiction as a 'disease' or 'disorder', their discrimination is nonetheless extremely difficult to prove on such grounds.

Protection under Australian discrimination law is further complicated by the intersectional nature of the discrimination experienced. Some people who use drugs – and particularly many people labelled as having an addiction – may experience multiple forms of disadvantage which obscure the discrimination they face and make it difficult to prove (AIVL, 2011; 2012). For example, discrimination based on a person's HCV status is often related to discrimination based on (actual or perceived) drug use or addiction (Anti-

Discrimination Board of NSW, 2001). This may reflect the fact that hepatitis C is commonly spread through intravenous drug use, but also that the two issues are often conflated (Harris, 2005). For many people who are members of such groups, the basis of discrimination they are subjected to is thus unclear:

Drug users are often left guessing themselves as to what the discrimination was based on. Were they discriminated against because of their drug use or because of their hep C [*sic*] status or because of their methadone treatment? Often they're not sure... they either don't fall into the categories outlined in the antidiscrimination law, or they can't be specifically defined as being a hep C [*sic*] related problem. (Anti-Discrimination Board of NSW, 2001, p. 33)

The consequence of the law failing to understand the complicated relationship between these categories is that people whose experiences span multiple categories are prevented from utilising Australian discrimination law effectively. For example, a person who used illicit drugs and also had a positive HCV status described to the Anti-Discrimination Board of NSW the deep emotional stigma they experienced due to the intersection of both attributes:

[I got] the virus through drug use, drug use is a criminal activity, therefore (they would think) I'm no good. I don't feel self-respect, I don't feel half the person anyone else does...one I'm a drug user, two I've got this disease. (Anti-Discrimination Board of NSW, 2001, p. 19)

These excerpts demonstrate that the burdens of discrimination based on illicit drug use, addiction and HCV status are not experienced separately, nor simply cumulatively. Rather, the two forms of discrimination are intricately bound up in each other (Dhamoon, 2011; Yuval-Davis, 2006). As a result, efforts to provide protection from discrimination to people who have HCV alone, or people who are labelled as having an addiction alone, fail to protect those who are – or are perceived to be – situated in both groups (Crenshaw, 1989).

This kind of exclusion has significant consequences, even in contexts where people with illnesses or disabilities are supposed to receive the highest levels of support. Both AIVL

(2012) and the Anti-Discrimination Board of NSW (2001) found, for example, that people who use illicit drugs anecdotally experience the most discrimination when accessing health services such as hospitals, pharmacies, and general practitioners. As a result, they are denied the same level of health and quality of life as people who do not use illicit drugs. Crucially, this is not simply due to their drug use per se, but their systematic discrimination and exclusion from social institutions on the mere basis of such use. Furthermore, people who use illicit drugs face such contemptuous social exclusion that they are very likely to be ‘discredited, disbelieved or ignored’ even within the discrimination redress process itself (AIVL, 2012, p. 3-4). Keane and colleagues (2011, p. 875) have similarly contended that the label of ‘addict’ is frequently used to ‘dismiss the validity of [people’s] claims and the significance of their suffering.’ Publicly admitting to the use of illicit drugs, or disclosing one’s HCV status can also have dire consequences for people’s employment, custody of children and social relationships; and thus may have greater consequences for women, people living in remote or regional communities, or other social groups (AIVL, 2012; 2011). It is thus unsurprising that most cases of discrimination go unreported (Anti-Discrimination Board of NSW, 2001; AIVL, 2012). Through these examples we can understand how the intersection of disability and addiction leads to complicated experiences of discrimination, in ways which render their use as grounds for protection under Australian discrimination law effectively impossible.

There are thus multiple ‘processes of differentiation’ (Dhamoon, 2011, p. 232) occurring at once within the administration of disability discrimination law in Australia. In its framing of both addiction and disability as fundamentally negative biomedical impairments, the law in this area either pathologises those who submit to such depictions, stigmatises those who reject them, or responsabilises those who may be persuaded to cease their drug use in return

for protection. People labelled as having an addiction are thus required to acquiesce to neoliberal and ableist interpretations of their capacity as diminished and compromised, or are excluded from the remit of discrimination law altogether. At the same time, the law encourages uniformity and erases difference among those who embrace such representations (Moore et al., 2015). This renders the intersectional nature of discrimination experienced by people labelled as having an addiction and people with disabilities invisible. I now demonstrate how such processes are not unique to the architecture of targeted discrimination law, but equally visible in a different legal and geographical context where people labelled as having an addiction have sought to assert their right to equality under the law.

Insite and addiction in Canadian human rights law

Insite is a medically-supervised injection facility located in the Down Town East Side (DTES) of Vancouver, Canada, jointly operated by the Portland Hotel Society Community Services Society (PHS) and Vancouver Coastal Health. It opened in 2003 after sustained, grassroots community pressure and the eventual support of three levels of government (Lessard, 2011). The purpose of Insite is to provide a space whereby people who inject drugs can do so under medical supervision, without the threat of arrest. The facility thus adopts a harm reduction model, which attempts to reduce the harms associated with drug use, without expecting abstinence as a condition of access (Young, 2011).

Initially, Insite was able to obtain an exemption from prosecution under Canada's *Controlled Drugs and Substances Act* (1996), which criminalises the possession of illicit drugs. However in 2006, following a change of federal government which saw the Conservative Party come to power, a further exemption for Insite was denied. This decision ultimately risked the possibility of arrest and incarceration of Insite users and staff, and thus most probably, the

closure of the facility (Small, 2012). In light of this risk, PHS, two Insite clients and the Vancouver Area Network of Drug Users (VANDU) launched legal action in the British Columbia Supreme Court. They were successful, upon appeal, in arguing that the criminalisation of illicit drug possession at Insite would prevent access to an important healthcare facility, thereby violating the right to life, liberty and security of the person for Insite users and staff under s7 of the *Charter* (Insite (2008) para. 5). In short, Insite was able to remain open.

The geographical, historical and social landscape of the DTES was critical to the success of *Insite* (Young, 2011; Lessard, 2011). The DTES has been described as one of the poorest communities in Canada (Young, 2012), known for its high levels of homelessness, displacement and poverty (Elliott, 2014). It is estimated that approximately 5,000 of its residents inject drugs (McNeil et al., 2014), with rates of HIV and HCV at times seen at epidemic proportions (Young, 2011). However despite such disadvantage, the community that resides there should be recognised as much for its rich ‘history of social activism’ (Elliott, 2014, p. 13) as for its marginalisation. The long, collective action of current and former drug users in the DTES – including the establishment of VANDU – was instrumental in bringing the fight for harm reduction services such as Insite into the public consciousness, and to the attention of government (Boyd et al, 2009). Furthermore, the struggle for Insite was intricately connected to the broader struggles of its community against interconnected systems of oppression including drug prohibition, colonisation and poverty (Boyd et al., 2009; Lessard, 2011).

At the same time, the campaign to keep Insite open has been criticised for adopting neoliberal values and relying on medicalised notions of addiction to win public support (Elliott, 2014; Ben-Ishai, 2012). However, while notions of neo-liberal subjectivity have traditionally been

considered harmful to people who use drugs, they have also been described as ‘potentially empowering’, in circumstances where this group seeks recognition from the mainstream community (Moore and Fraser, 2006, p. 3036). Thus, while the disempowering effects of neo-liberal discourse remain ripe for interrogation more generally, the struggle for harm reduction services like Insite in a punitive context of drug prohibition and socio-political marginalisation, demonstrates a compelling and enduring example of political resistance (Lessard, 2011).

In this broader context, the *Charter* provided a crucial avenue to recourse against discrimination for the DTES community. Indeed, the fact that the rights of Insite users were affirmed on the basis of s7 rather than s15 (non-discrimination) is telling. It shows that principles of non-discrimination are not the only avenues for people labelled as having an addiction to effectively assert their right to equality before the law. However, I argue that a closer look at the judgements and commentary surrounding the *Insite* case exposes other important consequences. In what follows, I focus on two implications that I argue this case has for questions around the mutual construction of addiction and disability in law.

Addiction as disease within a social model of disability

The accepted wisdom following the *Insite* decision is that the court upheld the ‘legal fact’ that addiction is an illness or disease (Small, 2012, p. 35; Young, 2011). The trial judge, Pitfield J, noted for example the ‘incontrovertible conclusion’ that ‘addiction is an illness’ (*Insite* (2008) para. 87). I argue however, that a more nuanced interpretation of addiction can be drawn from his findings— one which goes some way toward acknowledging the complexity of drug use and addiction (Seear and Moore, 2014). At trial, Pitfield J relied upon

the following definition of addiction provided by the Canadian Society of Addiction

Medicine:

A primary, chronic disease, characterized by impaired control over the use of a psychoactive substance and/ or behaviour. Clinically, the manifestations occur along biological, psychological, sociological and spiritual dimensions. Common features are change in mood, relief from negative emotions, provision of pleasure, pre-occupation with the use of substance(s) or ritualistic behaviour(s); and continued use of the substance(s) ...despite adverse physical, psychological and/or social consequences. (*Insite* (2008) para. 48)

In addition, Pitfield J accepted the evidence of an addiction medicine specialist employed by the local health authority who spoke of the varied ‘psychological and social determinants’ of addiction, alongside the ‘neuro-chemical effects’ of substances (*Insite* (2008) para. 22).

Interestingly, while still including core biomedical concepts such as impaired choice and the framing of addiction as a ‘chronic disease’, this definition also incorporates concepts such as pleasure, ‘relief from negative emotions’ and an acknowledgement of the ‘sociological and spiritual dimensions’ of the condition, which are often omitted from strictly biomedical accounts (Clark, 2011). Thus, while the court in this case accepted the framing of addiction as an ‘illness’, the definition of ‘illness’ relied upon differs from pure biomedical definitions such as those found in Australian discrimination law.

In a similar way, the case of *Insite* demonstrates a shift away from a medical model of disability to a social model. The second significant finding of *Insite* was that the spread of diseases such as HCV and HIV/AIDS was not inherently caused by illicit substance use, but the use of such substances in unsafe environments and with unsanitary instruments (*Insite* (2011) para. 93). Likewise the court found that overdose and death associated with intravenous drug use could be ‘ameliorated’ where injection was performed in the presence of medical professionals (para. 93). Thus, rather than regarding blood-borne diseases,

overdose and death as pathologically intrinsic to drug use or addiction, as a medical model of disability would espouse, the court acknowledged that legal, social and environmental factors can aggravate the illnesses or impairments of people who inject drugs in the DTES, effectively separating the nature of their impairments from their social context. According to Small (2012), this social model approach within a human rights framework is one in which people labelled as having an addiction and people with disabilities are able to effectively assert and enjoy their inherent rights to healthcare, to the same degree as others in the community. I argue, however, that the way in which access to such rights was achieved simultaneously undermines them.

Addiction and disability as fundamentally disordered

As has been observed in the critical addiction literature, the framing of addiction as an illness is not without its consequences (Buchman et al., 2010). One such consequence is that it predicates access to the benefits just described, on the condition that the ‘illness’ is couched in negative and potentially stigmatising terms. At the same time as the court in *Insite* accepted the complex nature, causes and manifestations of addiction, it simultaneously depicted addiction to illicit drugs as fundamentally risky, dangerous and disordered. This is not to suggest that people who use illicit drugs do not experience harm associated with such use; but to draw attention to the way in which this case depicts illicit drug use and addiction as *unquestionably* and *inherently* tragic, as it does both disease and disability. Furthermore, this depiction is transposed upon a whole community of people whose very existence the Supreme Court of Canada described as ‘bleak’ (*Insite* (2011) para. 8). For example, in describing the lives of DTES residents labelled as having an addiction, the court held that:

For injection drug users, the nature of addiction makes for a *desperate* and *dangerous* existence. (*Insite* (2011) para. 10)

The court also described both disease and disability in similarly alarmist terms:

Insite was widely hailed as an effective response to the *catastrophic* spread of infectious diseases
(*Insite* (2011) para. 1)

...

The DTES is one of the few places where Vancouver's poorest people, *crippled* by disability and addiction, can afford to live. (*Insite* (2011) para. 8)

Ultimately, these findings frame the residents of the DTES as fundamentally damaged (Garland-Thomson, 2005) and as unable to function in ways considered by the law to be safe and orderly. Structural factors such as poverty, displacement and discrimination are consequently depoliticised; with little consideration as to the ways in which they may co-create the health risks associated with addiction, facilitate the spread of infectious diseases, or mediate what it *means* to be a person with a disability and/or a person labelled as having an addiction in the DTES. Both addiction and disability are still framed as 'problems' existing independently of their environment. This ultimately allows them to be depicted as *naturally* problematic or vulnerable (Ben-Ishai, 2012) and thus in need of 'saving' and control by harm reduction interventions such as Insite (Elliott, 2014). Indeed as Lessard (2011, p. 104) notes, while the vulnerability of individual DTES residents features prominently in the courts' reasoning to allow Insite to remain open, the 'autonomy of the relevant political community' that led the struggle for Insite, does not.

Central to the depiction of addiction as naturally problematic and vulnerable is the idea of impaired choice, or a 'lack of free will' (Clark, 2011; Weinberg, 2013). According to this concept, the seemingly compulsive behaviour of people labelled as having an addiction is used as evidence of their lack of autonomy and capacity to make rational, reasoned decisions (Weinberg, 2013). This parallels starkly with the disability literature, where the capacity and

autonomy of people with disabilities is so often in question (Weller, 2008; 2014). An example of how the court grappled with the concept of choice in *Insite* is as follows:

[A]ddiction is an illness, characterized by a loss of control over the need to consume the substance to which the addiction relates... This does not negate the fact that some addicts [*sic*] may retain some power of choice. *Insite* is premised on the assumption that at least some addicts [*sic*] will be capable of making the choice to consume drugs in the safety of the facility and under the supervision of its staff. (*Insite* (2011) para. 99-100)

The reasoning provided in this excerpt is interesting, for it seems to suggest that the choice to consume substances to which one might be addicted is an impaired choice, while the choice to consume such substances under the ‘safety’ and ‘supervision’ of *Insite* is an autonomous one. In this way, the notion of ‘choice’ is used to steer people labelled as having an addiction into behaviours considered by the law to be responsible and orderly (O’Malley and Valverde, 2004). In *Insite*, this means the use of drugs within the legally-sanctioned space of *Insite*, where the assumed vulnerability of addiction can be managed and the ‘catastrophic spread’ of diseases can be contained. Thus, as was similarly evident in the political response to the *Marsden* decision in Australia, the way in which *Insite* grapples with the notion of ‘choice’ demonstrates how benchmarks of capacity and autonomy are modelled upon able-bodied and neoliberal conceptions of what is normal, rational and reasonable (O’Malley and Valverde, 2004; Campbell, 2012). In the process, broader structural influences on addiction and disability are obscured (Ben-Ishai, 2012, Moore and Fraser, 2006).

Alternatively, applying an intersectional lens can reveal how the construction of identities and social categories are intrinsically interconnected to the structural factors present in any given context; which are themselves ‘enmeshed’ and interdependent (Yuval-Davis, 2006, p. 205). In *Insite*, both neoliberal and ableist expectations around drug using practices work through each other to inform the kinds of ‘choices’ the court recognises as being worthy of

protection. Importantly, the interaction of these and other factors such as poverty, displacement and the criminalisation of drug use, are all implicated in the ‘political and subjective’ (Yuval-Davis, 2006, p. 205) experience of being a person labelled as having an addiction in the DTES. They are not – as the social model of disability would assume – factors which simply exacerbate the intrinsic vulnerability or ‘crippling’ effects of addiction. A more recent empirical study of a separate ‘unsanctioned’ supervised injection centre operated by the Vancouver Area Network of Drug Users (VANDU) in the DTES, lends weight to the argument that such processes can be found in spaces least expected: such as the operation of the Insite facility itself. At Insite, assisted injections by staff are prohibited because of legal liability concerns (McNeil et al., 2014). This means, however, that people who use drugs intravenously and are unwilling or unable to self-inject, are excluded from the service. Through interviews with users and peer workers of the ‘unsanctioned’ facility, McNeil and colleagues (2014) found that women and people with disabilities were significantly more likely to require assistance when injecting, and thus disproportionately affected by Insite’s prohibition on assisted injecting practices. Many women reported, for example, that they relied upon intimate partners to inject, while people with disabilities cited difficulty self-injecting due to physical impairments (McNeil et al., 2014, p. 6). As a result, these two groups were exposed to serious risks of violence, exploitation and intimidation within the local drug scene due to the ‘embodied subjectivities’ of their gender or disability status, and the ‘intersubjective injection practices’ which saw them excluded from Insite (McNeil et al., 2014, p. 13). The authors concluded:

Our study suggests supervised injection services promulgate neoliberal subjects (i.e. autonomous, responsible individuals capable of self-injecting) to the detriment of alternate drug-using subjects (i.e. people who require help injecting). (p. 12)

Keane (2003) has similarly argued that harm reduction interventions – even when pursued within a human rights framework – are capable of reinforcing morally-imbued concepts of

drug use and addiction into spaces otherwise expected to be empowering. This may explain how, in this case, *Insite* inadvertently works to ‘emphasize *particular bodies* at the expense of others’ (McNeil et al., 2014, p. 13) and reserves the full enjoyment of rights for a narrowly conceived rights-bearing subject. It is important to note, however, that these exclusionary practices are in no way indicative of the desires or efforts of harm reduction advocates in the DTES community. In fact, the popularity of *Insite*, and the continued efforts of VANDU and others to establish peer-led overdose response units in the face of the recent North American overdose crisis (Kerr et al., 2017), is testament to their ongoing struggle against the criminalisation of addiction and the marginalisation of DTES residents. Instead, such exclusionary practices are symbolic of the ways in which the law – in this case, human rights law – co-opts the broader struggle for equality at the same time as it allows for certain expressions of such equality to be recognised. For while the court in *Insite* affirmed the right to life, liberty and security of the person for DTES residents labelled as having an addiction, the very remedy the judgement endorsed excludes certain members of that group, such as people with disabilities, from realising such rights in practice. In so doing, it leaves conceptions of able-bodied and neo-liberal subjectivity, and the overarching regime of drug prohibition, intact.

In *Insite*, the framing of addiction as an illness (with complex social, psychological, biological and spiritual elements) within a social model of disability, arguably produced some clear practical benefits. However, like in Australian discrimination law, the vulnerable and tragic ontology attributed to people labelled as having an addiction and people with disabilities remains. Moreover, this vulnerability is perceived as intrinsic to addiction and disability, rather than as deeply intertwined and shaped by the political, social and economic milieu that is the DTES. This artificial division between addiction and disability, and the environments which co-constitute them, ultimately lends itself to the erasure of complexity

and difference in addiction and disability discourses. It also allows both addiction and disability to be positioned as oppositional to concepts such as autonomy, capacity, rationality and utility – all of which, under both neoliberal and ableist frameworks, constitute one's humanity. Through the deployment of 'choice', the court in *Insite* thus inadvertently reinforced these questionable divisions; it recognised that people labelled as having an addiction in the DTES were entitled to life, liberty and security of the person, only insofar as they embodied the image of the rational, (most likely male) able-bodied person who was willing and able to self-inject in a medically-supervised facility. The irony in this outcome is that human rights instruments such as the *Charter* hold that citizens are entitled to such rights simply by way of their being human, rather than on the basis of any disability or disadvantage.

Conclusion

The situated comparison of these two contexts ultimately invites us to question how particular forms of law may reinforce dominant ideas about normality and difference, while simultaneously purporting to protect those labelled as different (Karpin and O'Connell, 2015). As all human rights are interdependent and indivisible (*Vienna Declaration and Programme of Action*, 1993, Art.5), rights such as the right to health, or to life, liberty and security of the person, are 'inherently guaranteed in a non-discriminatory way' (Jürgens et al., 2010, p. 476). Thus the benefit of a human rights approach – as compared with targeted discrimination law – is that it potentially broadens the avenues for particular groups to assert their rights. More importantly, it may allow them to assert such rights on the basis that they are human beings with inherent dignity, rather than on the basis of them being 'designated as defective' (Garland-Thomson, 2005, p. 1558). Crucially, however, neither legal framework

guarantees freedom from the strictures of neoliberalism and ‘compulsory able-bodiedness’ (McRuer, 2006, p. 9) that construct both addiction and disability as profoundly dangerous, tragic or disordered. My analysis demonstrates that a rights-based approach is as susceptible as targeted discrimination law to being used as a tool through which such processes may be actualised. In this way, the inclusion of addiction in the definition of disability, under either framework, may be equally harmful. It is arguably less a question of which legal framework inherently provides more equality, but how all frameworks must question the latent assumptions and values which work through them to achieve particular normative aims.

The pursuit of equality before the law for people labelled as having an addiction cannot be achieved simply by way of their inclusion in the category of disability, or by the use of any particular legal approach. This is because, as Spade (2013, p. 1032) has contended, ‘legal equality or rights strategies not only fail to address the harms facing intersectionally targeted populations but also often shore up and expand systems of violence and control.’ Instead, true equality before the law for these groups will require a change in how addiction and disability are conceptualised socially, culturally and politically, and how such concepts are then manifested in law and legal practice. Policy- and law-makers must consider the effects of conceptualising addiction and disability in ways that undermine the inherent human dignity of the people affected by them. Furthermore, they must reconsider laws and policies that criminalise or stigmatise people who use drugs, and which contribute to the material, social and political disadvantage of people with disabilities, and must do so in a way that unconditionally embraces difference, rather than divides people on the basis of presumed deservedness.

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