Addicted to the ADA? Disability Antidiscrimination Law and the Problem of Addiction

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To date, efforts to apply the Americans with Disabilities Act ("ADA") to people with addiction have largely failed due to several provisions that restrict the ADA's reach. In denying potentially beneficial legal protections to those with addictions, these provisions create what I call "the addiction outlier" problem. In recent years, largely in response to the opioid epidemic, a number of scholars have tried to address the addiction outlier problem, either by calling for legislative amendment or by identifying other ADA provisions that could be used to protect addicts within the confines of current law. Such attempts, however, failed to address fundamental questions concerning the nature of addiction, whether addiction should qualify as a disability, and whether addicts should be entitled to the same protections as people with other disabilities given their distinctive features.

Situated in this ongoing debate, this Article is the first to offer an alternative construction of the addiction outlier that will expand ADA protection for addicts and give rise to a principled justification for applying the ADA to addiction more generally. The Article argues that the addiction outlier emanates from a conception of addiction as a compulsive disorder. But an alternative conception of addiction put forth by philosopher Hanna Pickard, which recognizes the choice in addiction, would instead require the reinterpretation of the addiction outlier provisions and expand the ADA coverage to apply to addicts. Moreover, this Article contends that the analysis of addiction along these lines calls for reevaluation of the category of disability. Specifically, drawing on recent philosophical work in social metaphysics, this Article suggests that the category of disability should cover any feature of the body or mind that society generally views as an impairment

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and is typically associated with socially caused disadvantages in a wide range of domains. Thus, the theoretical analysis put forth in this Article has implications far beyond addiction, as calls to expand the legal category of disability—and consequently the ADA's reach—continue to emerge.

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INTRODUCTION

As the opioid epidemic continued to devastate lives, families, and communities,[1] legal scholars and practitioners have joined medical experts in seeking ways to improve the social response to this unprecedented crisis. There is a growing group of scholars advocating for decriminalization of drug use and an end to the "war on drugs," highlighting the adverse consequences such policies have on stigma and consequently recovery and social reintegration.[2] From a different angle, other scholars seek to utilize disability antidiscrimination law, particularly the Americans with Disabilities Act ("ADA"), to assist people with addiction by improving the availability and equity of healthcare services,[3] protecting recovering addicts who use prescribed medications in their treatment,[4] strengthening confidentiality of healthcare records in treating addictions,[5] and increasing access to harm-reduction services.[6]

Indeed, people with addictions have been seeking protection under the ADA and its predecessor, the Rehabilitation Act, for decades.[7] However, these efforts have had limited success due to several provisions that deny the

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1. *See Drug Overdose Deaths: Facts and Figures*, NAT'L INST. ON DRUG ABUSE, https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates [https://perma.cc/WZ3K-4HE6] (data demonstrating an increase in drug-related deaths over the past decades, with a sharp increase in cases of opioid-related deaths, reaching 81,806 deaths in 2022).

2. *See, e.g.*, Teneille R. Brown, *Treating Addiction in the Clinic, Not the Courtroom: Using Neuroscience and Genetics to Abandon the Failed War on Drugs*, 54 IND. L. REV. 29 (2021) (claiming that addiction is a disease and should be treated as such, by allocation of federal funding to healthcare services in lieu of criminalization which reinforces stigma and thus hinders treatment and recovery); Brian D. Earp et al., *Racial Justice Requires Ending the War on Drugs*, 21 AM. J. BIOETHICS 4 (2021).

3. *See, e.g.*, Kelly K. Dineen & Elizabeth Pendo, *Engaging Disability Rights Law to Address the Distinct Harms at the Intersection of Race and Disability for People with Substance Use Disorder*, 50 J.L. MED. & ETHICS 38 (2022) (discussing the potential of the ADA to address different forms of discrimination in healthcare against people with substance use disorder, particularly due to the racism characterizing such treatment); Elizabeth Pendo & Jennifer Oliva, *Disability Discrimination by Clinical Algorithm*, 103 N.C. L. Rev. (forthcoming 2024) (criticizing prescription drug monitoring programs that rely on algorithms as discriminatory under disability rights laws).

4. *See, e.g.*, U.S. DEP'T OF JUST., THE AMERICANS WITH DISABILITIES ACT AND THE OPIOID CRISIS: COMBATING DISCRIMINATION AGAINST PEOPLE IN TREATMENT OR RECOVERY (2022).

5. *See, e.g.*, Kelly K. Dineen & Elizabeth Pendo, *Substance Use Disorder Discrimination and the CARES Act: Using Disability Law to Inform Part 2 Rulemaking*, 52 ARIZ. ST. L.J. 1143 (2021).

6. *See, e.g.*, Abigail Fletes et al., *Advancing Harm Reduction Services in the United States: The Untapped Role of the Americans with Disabilities Act*, 21 YALE J. HEALTH POL'Y L. & ETHICS 61 (2022).

7. *See infra* Part I.

protections of the law to people with addictions. These include the definition of disability under the ADA; the exclusion from coverage of people currently using illegal drugs; the ADA's specific exclusion regarding addiction-related misconduct; and rules regarding employee drug and alcohol tests.[8] Taken together, these provisions generate what I call the "addiction outlier problem," which hinders ADA protection to people with addiction in the United States.[9]

One way of addressing the addiction outlier problem would involve a series of legislative amendments to the ADA. As Leslie Francis argues, removing ADA provisions excluding people currently using drugs from ADA's coverage would go a long way in mitigating the disadvantages facing addicts and providing them ADA protection on par with other disabilities.[10] Other legislative changes to mitigate the addiction outlier problem could involve explicitly including people with addictions in the category of disability,[11] equalizing the ADA's treatment of misconduct regardless of its cause,[12] or disallowing drug testing in workplaces and other places of public accommodations.[13]

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8. *See infra* Part I.

9. The question of whether addiction qualifies as a disability for purposes of protection under antidiscrimination law also occupies disability law scholars and practitioners oversees. *E.g.*, Frances Gibson, *Drugs, Discrimination and Disability*, 17 J.L. & MED. 400 (2009) (detailing the debate on addiction as a disability in Australia); Simon Flacks, *Deviant Disabilities: The Exclusion of Drug and Alcohol Addiction from the Equality Act 2010*, 21 SOC. & LEGAL STUD. 395 (2012) (discussing the justification for excluding people with drug and alcohol addictions from the United Kingdom's Equality Act 2010).

10. *See* Leslie Francis, *Illegal Substance Abuse and Protection from Discrimination in Housing and Employment: Reversing the Exclusion of Illegal Substance Abuse as a Disability*, 4 UTAH L. REV. 891 (2019) (claiming that we should do away with the exclusion of illegal substance use in the definition of disability, and instead examine whether people with substance abuse disorder are qualified and do not pose a direct threat on others, like people with other disabilities); *see also* Elie G. Aoun & Paul S. Appelbaum, *Ten Years After the ADA Amendment Act (2008): The Relationship Between ADA Employment Discrimination and Substance Use Disorders*, 70 PSYCHIATRIC SERVS. 596 (2019).

11. Indeed, this was partly already accomplished through the 2008 ADA Amendments Act, which included a general instruction about ADA construction. *See infra* notes 30, 73–74 and accompanying text.

12. *See* Kelly Cahill Timmons, *Accommodating Misconduct Under the Americans with Disabilities Act*, 57 FLA. L. REV. 187, 205–11 (2005) (analyzing the ADA's treatment of misconduct and demonstrating that the exception regarding drug and alcohol was expanded to misconduct related to other disabilities too).

13. *See* Walker Newell, *Tax Dollars Earmarked for Drugs? The Policy and Constitutionality of Drug Testing Welfare Recipients*, 43 COLUM. HUM. RTS. L. REV. 215 (2011) (claiming that laws permitting drug testing of welfare recipients without prior suspicion may be unconstitutional).

This Article puts forth an alternative way to mitigate the addiction outlier problem, which involves reinterpreting the Act. Specifically, this Article argues that the addiction outlier problem is exacerbated by the expansive interpretation of relevant ADA provisions, resting on a conception of addiction as compulsive disorder. Following Hanna Pickard, I refer to this conception as the "orthodox" conception of addiction.[14] By contrast, reinterpreting the addiction outlier provisions along the lines of Pickard's alternative view—which recognizes addicts' ability to choose, and locates the reasons for continued usage in a variety of personal and social factors—would extend more protection to drug and alcohol addicts under the ADA. This Article argues that reinterpreting the ADA's addiction outlier provisions in line with this view, which I call the "multifactorial" conception of addiction, would facilitate an appropriate social response to the crisis of addiction.[15]

However, both calls to amend the ADA and attempts to reinterpret the Act raise a fundamental question of whether disability antidiscrimination law *should* afford protection to people with addiction. The concern is that people with addictions are not disabled and therefore should not be entitled to ADA protection—even if such protections could benefit them. This is because their condition is arguably not a clinical condition that amounts to an impairment and a disability. By framing addiction as a pathology of impulse control, the orthodox conception of addiction is less susceptible to such a concern. But the multifactorial view, which emphasizes the role of social factors in generating addiction, is more vulnerable to this worry.[16]

To address this fundamental issue, this Article also delves into the philosophical debate on the concept of disability. Building on recent developments in social metaphysics, this Article puts forth a novel conception of disability applicable to the antidiscrimination context. More specifically, it advances the claim that, for the purpose of antidiscrimination law, a person is disabled if that person has or then had a feature of the body or mind—pathological or not—that society generally views as an impairment and is associated with socially caused disadvantages in a wide range of domains.

This conception of disability explains why applying the ADA to people with addiction is not only instrumentally valuable but also principally warranted. Yet the value of this conception extends further by providing conceptual resources to resolve similar debates over the limits of the category

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14. *See infra* Section II.A.
15. *See infra* Section III.D.
16. *See infra* Part II.

of disability.[17] For instance, debates continue to arise regarding the ADA's coverage (or lack thereof) of other conditions, including pregnancy,[18] HIV/AIDS,[19] obesity,[20] and gender nonconformity.[21]

This Article proceeds in three parts. Part I describes the legal provisions and case law that make up the addiction outlier problem. Part II outlines the orthodox and multifactorial conceptions of addiction. This Part argues that the addiction outlier is generated and exacerbated by the orthodox conception of addiction. However, it contends that adopting the alternative multifactorial view would lead to a different interpretation of the ADA which would afford more protection to people with addiction. Part III then addresses the more general objection toward applying disability antidiscrimination law to addicts, arguing that the category of disability in the context of antidiscrimination law is best understood as including non-clinical conditions. Taking addiction as just one example, it claims that people with addiction should be entitled to ADA protection even if addiction is not a pathology.

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17. *See e.g.*, Doron Dorfman, *Disability as Metaphor in American Law*, 170 U. PA. L. REV. 1757, 1759 (2022) (referring to advocacy efforts using disability rights law to "strategically argue for protection of marginalized groups that do not live with impairments" as "disability frame advocacy"). *See generally* Craig Konnoth, *Medicalization and the New Civil Rights*, 72 STAN. L. REV. 1165 (2020) (defending the notion of "medical civil rights," which refers to the advancement of civil rights by using medical language).

18. Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 670–78 (1999).

19. *See generally* Arthur S. Leonard, *Employment Discrimination Against Persons with AIDS*, 10 U. DAYTONA L. REV. 681 (1984) (arguing that AIDS should be protected under the law as a physical disability). Bragdon v. Abbott, 524 U.S. 624 (1998) (holding that since HIV "substantially limits" major life activities, such as reproduction, the infection is a "disability" that entitles its victims to ADA protections).

20. *See generally* Jane Byeff Korn, *Fat*, 77 B.U. L. REV. 25 (1997) (arguing that obesity should be recognized as a disability under the Americans with Disabilities Act); Karen M. Kramer & Arlene B. Mayerson, *Obesity Discrimination in the Workplace: Protection Through a Perceived Disability Claim Under the Rehabilitation Act and the Americans with Disabilities Act*, 31 CAL. W. L. REV. 41, 52–64 (1994); Bruce I. Shapiro, Comment, *The Heavy Burden of Establishing Weight as a Handicap Under Anti-Discrimination Statutes*, 18 W. ST. U. L. REV. 565 (1991).

21. *See generally* Kevin M. Barry, *Disabilityqueer: Federal Disability Rights Protection for Transgender People*, 16 YALE HUM. RTS. & DEV. L.J. 1 (2013) (criticizing the ADA's exclusion of Gender Identity Disorder). For a critical perspective on the medicalization of transgender identity, see Maayan Sudai, *Revisiting the Limits of Professional Autonomy: The Intersex Rights Movement's Path to De-Medicalization*, 41 HARV. J.L. & GENDER 1 (2018).

I. THE ADA ADDICTION OUTLIER

This Part sketches in greater detail five ADA provisions most relevant for addiction:[22] the definition of disability,[23] the current illegal drug use exception,[24] the safe harbor provision,[25] as well as the explicit permissions to hold people with drug and alcohol addiction to the same standards of behavior as nondisabled people[26] and to administer drug and alcohol testing in the workplace.[27] I call these provisions and their judicial construction the addiction outlier problem because they restrict the protection afforded to people with addiction. Some of these provisions explicitly exclude people with drug and alcohol addiction from entitlements that are otherwise available to people with disabilities. Other provisions have been construed broadly by courts, generating additional restriction in the Act's coverage of addiction.

A. Qualifying as Disabled Under the ADA

Under the ADA, only people who qualify as having a "disability" are covered by the Act.[28] The ADA provides a three-prong definition of disability: "(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.[29] Qualifying as disabled under the first two prongs of the ADA thus involves first establishing that one has or had an impairment, and then proving that the impairment substantially limits a major life activity. Qualifying as disabled under the third prong requires proving that the plaintiff was subject to an adverse action on the basis of a real or perceived impairment.[30] Accordingly,

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22. Other provisions that may also impede ADA protection for people with addiction, but which do not apply directly and exclusively to them, include the requirement that a person would be "otherwise qualified" for the job or service and the "direct threat." 42 U.S.C. §§ 12112(b)(5)(A), 12113(b).

23. *See infra* Section I.A.

24. *See infra* Section I.B.

25. *See infra* Section I.C.

26. *See infra* Section I.D.

27. *See infra* Section I.E.

28. *See* 42 U.S.C. § 12101(b).

29. *Id.* § 12102(1).

30. *See id.* § 12102(3)(A) (applying equally "whether or not the impairment limits or is perceived to limit a major life activity"); Sutton v. United Air Lines, Inc., 527 U.S. 471 (1999). For a review of legislative predecessors, the original Act, judicial construction, and the advocacy efforts and negotiations leading to the new interpretation of the third prong under the ADAAA,

whether addiction is a disability is contingent on two interconnected questions: first, whether it is an impairment, and second, whether it is a disability.

1. Addiction as an Impairment

The ADA does not define "impairment," but related regulations stipulate that impairment is "[a]ny physiological disorder or condition" or "[a]ny mental or psychological disorder, such as . . . emotional or mental illness."[31] As Christopher Boorse rightly observed, the meaning of "impairment" under the ADA, is nearly the same as a "clinically evident pathological condition" that is a biological dysfunction.[32]

Over the years, courts found that certain addictions do not qualify as impairments under the ADA because specific provisions exclude them from the statutory definition. Thus, addiction to gambling is explicitly excluded from the ADA's definition of impairment.[33] A more complicated case concerns sex-love addiction. The ADA explicitly excludes disorders of sexual behavior from the category of disability, including "transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, [and] gender identity disorders."[34] Courts have found that a sex-love addiction is not an impairment because it is a sexual behavior disorder which the Act explicitly excludes.[35] In *Manson v. Carelington International Corp.*, the plaintiff tried to challenge

see generally Kevin Barry, Toward Universalism: *What the ADA Amendments Act of 2008 Can and Can't Do for Disability Rights*, 31 BERKLEY J. EMP. & LAB. L. 203, 233–36, 262–66, 272–74, 278 (2010) (claiming that the ADAAA's mandate regarding the third prong "harmonize[d] the concept of impairment with race, sex, and other protected characteristics," and that it introduces a broader conception of the social model of disability for recognizing that limitations may arise from social attitudes towards some people, not from impairments themselves).

31. 29 C.F.R. § 1630.2(h) (2024).

32. Christopher Boorse, *Disability and Medical Theory*, *in* PHILOSOPHICAL REFLECTIONS ON DISABILITY 55, 71–76 (D. Christopher Ralston & Justin Ho eds., 2009) (claiming that all impairments under the ADA are either pathological conditions, or pathological conditions and nonpathological disfigurements); *see also id.* at 61 (explaining his interpretation of a pathological condition).

33. For a critique of this statutory exclusion, see Kathleen V. Wade, *Challenging the Exclusion of Gambling Disorder as a Disability Under the Americans with Disabilities Act*, 64 DUKE L.J. 947 (2015).

34. 42 U.S.C. § 12211(b)(1); *see also* 29 C.F.R. § 1630.3(d)(1) (2024).

35. *See, e.g.*, Chaniott v. DCI Donor Servs., Inc., 481 F. Supp. 3d 712, 723 (M.D. Tenn. 2020). The plaintiff in *Chaniott* kept his precise behavioral addiction under seal, but the court gave enough information to help infer the relevance of his addiction to his employment. *See id.* at 717 n.2*; see also* Pacenza v. IBM Corp., No. 04 CIV. 5831, 2009 WL 890060, at *10 n.11 (S.D.N.Y. Apr. 2, 2009) (citing the ADA's exclusion of "sexual behavior disorders" to explain why the plaintiff didn't argue his sex addiction was a disability).

this merging of sex addiction with a disorder of sexual behavior.[36] She argued that her addiction does not affect her actions, only the manner in which she perceives others, but the court rejected the plaintiff's claim.[37]

By contrast, both alcoholism and drug addictions are recognized impairments under the ADA.[38] This designation is plausibly rooted in the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-V"), which recognizes substance use disorders as psychiatric disorders.[39] At the most basic level, recognizing that addiction is an impairment indicates a transformation in the social perception of addiction, from a moral failure and social deviance to clinical issue or pathology.[40]

Because alcohol or drug use only qualifies as an impairment if it amounts to a clinical condition (i.e., disorder), a major issue arises over the distinction between *using* a particular substance and *having an addiction* to it. Put simply: recognizing addiction as impairment requires discerning under what circumstances using alcohol or drugs persistently qualifies as a clinical condition. In practice, the question is what kind of evidence is needed to establish the claim that one's persistent usage of alcohol or drugs amounts to an addiction that warrants ADA protection.

Case law suggests that self-identification is not enough to establish one has an addiction. The case of *Rhoads v. Board of Education* nicely illustrates this point.[41] In that case, an Ohio woman employed for over twenty years as

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36. No. 20-CV-00916, 2021 WL 3912536 (E.D. Tex. Aug. 6, 2021) (recommending dismissal of a disability discrimination claim filed by an employee who was terminated after disclosing her sex-love addiction diagnosis on the grounds that the ADA does not cover sex-love addictions as a disability).

37. *Id.* at *3.

38. *See* Nielsen v. Moroni Feed Co., 162 F.3d 604, 609 (10th Cir. 1998); Williams v. Windall, 79 F.3d 1003, 1005 (10th Cir. 1996) (discussing alcoholism covered under the Rehabilitation Act); Duda v. Bd. of Educ. of Franklin Park Pub. Sch. Dist. No. 84, 133 F.3d 1054, 1059 n.10 (7th Cir. 1998) (citing cases finding alcoholism covered under the ADA); Evans v. Fed. Express Corp., 133 F.3d 137, 139 (1st Cir. 1998) (citing cases finding alcoholism covered under both statutes); Buckley v. Consol. Edison Co. of N.Y., Inc., 127 F.3d 270, 273–74 (2d Cir. 1997) (holding that alcoholism and drug addiction are covered under ADA), *vacated en banc on other grounds*, 155 F.3d 150 (2d Cir. 1998); Mararri v. WCI Steel, Inc., 130 F.3d 1180, 1185 (6th Cir. 1997) ("There is no dispute that alcoholism is a disability within the protection of the ADA."); Bailey v. Ga.-Pac. Corp., 306 F.3d 1162, 1167 (1st Cir. 2002) (holding that alcoholism is an impairment under the ADA).

39. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 483–85 (5th ed. 2013).

40. On the progression of characterizing addiction as a disease rather than a moral failure, see PETER CONRAD & JOSEPH W. SCHNEIDER, DEVIANCE AND MEDICALIZATION: FROM BADNESS TO SICKNESS, 73–109, 110–44 (2010) (concerning alcoholism and opiate addiction).

41. 103 F. App'x 888, 893 (6th Cir. 2004).

a school bus driver failed a random drug test and consequently resigned.[42] Her requests to withdraw her resignation or to reapply for her old job were later rejected, despite the fact she was seeking counselling for her drug problem.[43] The Court of Appeals for the Sixth Circuit nevertheless rejected her claim that she had a disability, because it was only supported by her own testimony.[44] Specifically, she testified that she believed she was an addict, as she started smoking at the age of sixteen and sometimes smoked marijuana all day long.[45]

The *Rhoads* court's approach aligns with the general trend in the interpretation of disability antidiscrimination law, which requires medical proof to establish that one has a disability. As Diedre Smith and Katharine Macfarlane demonstrated, this approach is rooted in court rulings as well as EEOC agency guidance, which in turn shaped employers' policies.[46]

However, disability law scholars often criticize the deference to medical knowledge for the purpose of establishing one's disability and claiming various entitlements. As Macfarlane notes, in circumstances of limited access to healthcare provisions, requiring medical proof may hinder access to various legal protections and entitlements that people deserve by law.[47] She also contends that requiring documentation counteracts the ADA's legislative intent of rejecting the medical model of disability.[48] Accordingly, Macfarlane argues that people claiming disabled status based on their own assessments and needs deserve deference irrespective of medical documentation.[49]

Laura Rovner similarly argued that requiring medical proof sometimes hinders people from claiming their disability rights due to stigma associated

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42. *Id.* at 889; *see also infra* Section I.E (detailing more information on drug testing at the workplace).

43. *Rhoads*, 103 F. App'x at 891.

44. *Id.* at 893.

45. *Id.*

46. *See* Deirdre M. Smith, *Who Says You're Disabled?: The Role of Medical Evidence in the ADA Definition of Disability*, 82 TUL. L. REV. 1, 3 (2007) (claiming that courts typically require plaintiffs to introduce medical evidence to prove they are disabled within the meaning of the ADA); *see also* Katherine A. Macfarlane, *Disability Without Documentation*, 90 FORDHAM L. REV. 59, 70–84 (2021) (summarizing court rulings affirming the requirement of medical documentation in the "interactive process" leading to reasonable workplace accommodations, and tracing back such decisions to EEOC agency guidance that not only permit employers to require documentation but also encourage such requirements and set demanding standards).

47. Macfarlane, *supra* note 46, at 87–88.

48. *Id.* at 81–83. For a discussion of the medicalization of disability under the ADA, see *infra* Part III.

49. Macfarlane, *supra* note 46, at 95–100.

with disability and their reluctance to self-identify as such.[50] This concern applies even more forcefully in the context of addiction given its negative stigma.[51] As in other stigmatized conditions, fear of social stigma could hinder people's willingness to seek an official diagnosis, and instead try to deal with their addiction by themselves.

Notably, however, in the case of addiction, medical proof need not necessarily be a formal diagnosis. Participation in a rehabilitation program could also be sufficient proof, as the early case of *Andriacchi v. City of Chicago* nicely demonstrates.[52] There, an employee was arrested and convicted for possession of cocaine, and subsequently entered a drug treatment program.[53] The employee was later dismissed from his job because of his arrest, and he then filed a claim for discrimination under the ADA.[54] The court found that the employee was disabled due to his addiction to drugs and his eligibility to participate in a treatment program that was only open to drug offenders whose substance abuse problems qualify as addictions.[55] In such circumstances, courts may rely on the assumed judgment of healthcare professionals who originally admitted the individual to the rehabilitation program. Importantly, however, the challenges indicated by both Macfarlane and Rovner, vis-à-vis access to healthcare provisions and stigma, are far from mitigated in such circumstances.

2. Addiction as a Disability

Although both drug addictions and alcoholism are recognized as impairments under the ADA, these conditions only qualify as disabilities if certain other criteria are met.[56] As mentioned at the outset of Part I, this is

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50. *See* Laura L. Rovner, *Perpetuating Stigma: Client Identity in Disability Rights Legislation*, 2 UTAH L. REV. 247, 251 (2001) (exploring the process of self-identifying as disabled for filing claims under federal law); *see also* Katie Eyer, *Claiming Disability*, 101 B.U. L. REV. 547, 568 (2021) ("[T]hese and other obstacles to claiming disability identity are very real and pose substantial challenges to a project aimed at increasing disability self-identification. Nevertheless, the current confluence of a number of factors . . . mean that the opportunities for shaping the meaning of disability identity around a positive self-concept are uniquely promising.").

51. *See infra* notes 178–81 and accompanying text.

52. No. 96 C 4378, 1996 WL 685458, at *2 (N.D. Ill. Nov. 22, 1996).

53. *Id.*

54. *Id.*

55. *Id.*

56. This discrepancy rests on a principled distinction between impairment, understood as a clinical condition or disease, and disability. *See* Adi Goldiner, *Understanding Disability as a*

because qualifying as disabled under the ADA also requires proving that one has had, or is regarded as having, an impairment that substantially limits one or more of the individual's major life activities.[57]

In the first decade following the enactment of the ADA, courts interpreted the definition of disability narrowly, consequently limiting the class of individuals protected by the Act.[58] This jurisprudence has become known as the ADA "backlash."[59] In unison with the interpretation of the term "impairment," and despite the stated purpose of the ADA to address the social discrimination facing disabled people, the judicial interpretation of the definition of disability manifested a medicalized view of disability.[60] Specifically, federal courts interpreted the ADA as requiring that an impairment only qualifies as a disability if it is the cause of substantial limitation on a major life activity.[61] In addition, it set a high threshold for such limitations to qualify as substantial for the purpose of qualifying as disabilities.[62]

Cluster of Disability Models, 2 J. PHIL. DISABILITY 28 (2022) (explaining the relation between impairment and disability on various models of disability).

57. 42 U.S.C. § 12102(1).

58. *See* Chai R. Feldblum, *Definition of Disability Under Federal Anti-Discrimination Law: What Happened? Why? And What Can We Do About It?*, 21 BERKELEY J. EMP. & LAB. L. 91, 93 (2000); Linda Hamilton Krieger, *Introduction* to BACKLASH AGAINST THE ADA: REINTERPRETING DISABILITY RIGHTS 1, 10–13 (Linda Hamilton Krieger ed., 2003) (reviewing Supreme Court decisions narrowing the ADA's coverage).

59. The term "judicial backlash" was used to describe court-led resistance to a successful civil rights initiative. *See* Krieger, *supra* note 58, at 5 ("[B]y 1996, many in the disability community were speaking of an emerging *judicial* backlash against the ADA." (emphasis added)). This term also implies rejection of explanations unrelated to the subject matter, such as cases brought to court were inherently weak, that the statute was poorly drafted, or that the enactment of major legislation typically leads to confusion in implementation and interpretation. Matthew Diller, *Judicial Backlash, the ADA, and the Civil Rights Model of Disability*, *in* BACKLASH AGAINST THE ADA: REINTERPRETING DISABILITY RIGHTS 62, 62–64 (Linda Hamilton Krieger ed., 2003). For explanations of the judicial backlash against the ADA, see *id.* at 78–82, which claims that courts interpreted the ADA at a time when they were "inhospitable" to expansive interpretations of civil rights protection more broadly, specifically with regards to differential treatment as a way of securing equal opportunities; and Nicole Buonocore Porter, *The New ADA Backlash*, 82 TENN. L. REV. 1, 13 (2014), which argues that courts interpreted the term "disability" narrowly to ensure that the ADA's reasonable accommodations provisions, viewed as conferring special treatment, were only given to those who were truly deserving.

60. *See* Bradley A. Areheart, *When Disability Isn't "Just Right": The Entrenchment of the Medical Model of Disability and the Goldilocks Dilemma*, 83 IND. L.J. 181, 232 (2008) (arguing that the medical model of disability reigns in public perceptions of disability and federal courts' ADA jurisprudence).

61. *Id.* at 212 (reviewing and analyzing federal court cases that disregarded social attitudes towards plaintiffs and held they were not "disabled enough" under the ADA due to the extent to which their impairments limited their functionality and life activities).

62. *Id.*

Often, people struggling with addictions were similarly excluded from the Act's coverage on the grounds that addictions did not limit people's abilities permanently, but only episodically, and therefore could not be considered substantially limiting.[63] Along these lines, in *Burch v. Coca-Cola Co.*, the court found that an alcoholic plaintiff was not disabled because he did not prove that his alcohol addiction significantly limited him in a major life activity.[64] The court reasoned that "[p]ermanency, not frequency, is the touchstone of a substantially limiting impairment," and that the plaintiff established his usage was frequent, not permanent.[65]

In other instances, courts excluded people whose addiction was continuous but did not significantly limit plaintiffs in their major life activities.[66] This was the reasoning in *Rhoads v. Board of Education*.[67] There, the court held that, even assuming the plaintiff could show she had a drug addiction, no evidence indicated the extent to which the addiction affected her ability to perform a major life activity, as she was working at her job for over twenty years despite smoking marijuana every day.[68] And in *Skinner v. City of Amsterdam*, the court held that a former employee struggling with a drug addiction for fifteen years was not disabled, and therefore not entitled to ADA protection, because his drug addiction did not impact his work performance.[69] Similarly, in *Sullivan v. Neiman Marcus Group., Inc.*, the Court of Appeals for the First Circuit held that a retail employee's alcohol addiction of two decades did not significantly limit his major life activities.[70]

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63. *E.g.*, Bailey v. Ga.-Pac. Corp., 306 F.3d 1162, 1169 (1st Cir. 2002) (stating that the plaintiff's inability to work due alcohol-related incarceration was only short-term in nature and therefore not a substantial limitation); Roig v. Mia. Fed. Credit Union, 353 F. Supp. 2d 1213, 1216 (S.D. Fla. 2005) (holding that an alcoholic employee was not disabled nor regarded as such because she was not permanently limited by her alcoholism).

64. 119 F.3d 305, 316 (5th Cir. 1997); *see also* Mueck v. La Grange Acquisitions, L.P., 75 F.4th 468, 481–82 (5th Cir. 2023) (suggesting that even after episodic impairments began to be recognized as disabilities, the plaintiff's disability in *Burch* was a less severe impairment due to the typical effects that coincide with overconsuming alcohol).

65. *Burch*, 119 F.3d at 316.

66. Toyota Motor Mfg., Inc. v. Williams, 534 U.S. 184, 201–02 (2002) (interpreting the term "substantially limiting" to require a high degree of limitation on major life activities), *superseded by statute*, ADA Amendments Act of 2008, Pub. L. No. 110–325, § 3, 122 Stat. 3553, 3555–56 (codified at 49 U.S.C. § 12102).

67. *See* 103 F. App'x 888 (6th Cir. 2004).

68. *Id.* at 893.

69. 824 F. Supp. 2d 317, 321, 331 (N.D.N.Y. 2010).

70. 358 F.3d 110, 112–13, 116 (1st Cir. 2004) (noting the plaintiff challenged his job termination after drinking alcohol during lunch with his colleagues, which violated company policies concerning the use of alcohol on the job); *see also* Bailey v. Ga.-Pac. Corp., 306 F.3d

The court based its decision on the plaintiff's claims that his alcoholism did not interfere with his ability to work (claims which the plaintiff stressed in order to be found qualified for the job).[71] Ultimately, the court put it succinctly by stating that "[a]lcoholics can be fully functioning and productive employees who do not experience any substantial limitation in their ability to work."[72]

In 2008, Congress passed the ADA Amendments Act ("ADAAA") in response to widespread criticism of how courts construed "disability."[73] The ADAAA superseded the courts' interpretation and mandated that "the question of whether an individual's impairment is a disability under the ADA should not demand extensive analysis."[74] In explicitly rejecting the strict interpretation of the "substantially limits" requirement, it stipulated that an episodic impairment would be considered a disability if it is substantially limiting when active.[75]

Since the ADAAA, qualifying as "disabled" is more straightforward and addicts can more easily obtain ADA protection. In fact, courts are beginning to draw an analogy between addictions and other disabilities. For instance, in *Jones v. City of Boston,* the First Circuit held that "[i]ndividuals who are recovering from an addiction to drugs may be disabled in the meaning of the ADA, as the statute aims to protect them from the stigma associated with their addiction."[76] More recently, the Court of Appeals for the Fifth Circuit joined other appellate courts in holding that alcoholism can qualify as a disability within the meaning of the ADA like other episodic impairments that substantially limit major life activities while active.[77]

1162, 1168 (1st Cir. 2002) (holding that experiencing isolated difficulties on the job, such as not being able to accept overtime shifts due to alcoholism does not amount to a substantial limitation in one's ability to work).

71. *Sullivan*, 358 F.3d at 116.

72. *Id.* at 117.

73. ADA Amendments Act of 2008, Pub. L. No. 110–325, 122 Stat. 3553 (codified in scattered sections of 42 U.S.C.). For an overview of ADA enactment, judicial construction of the third prong, and the advocacy efforts and negotiations leading to the legislation of the ADAAA, see generally Barry, *supra* note 30.

74. 42 U.S.C. § 12101(b)(4)).

75. *Id.* § 12102 (4)(D).

76. 752 F.3d 38, 58 (1st Cir. 2014).

77. Mueck v. La Grange Acquisitions, L.P., 75 F.4th 469, 479–84 (5th Cir. 2023) (accepting an employee's claim that, given his binge drinking, his alcoholism was substantially limiting his major life activities while he was not at work, and finding the question of employee's disability a triable issue). Notably, the *Mueck* court ruled in favor of the employer, explaining that it had a "legitimate, non-discriminatory reason" to dismiss the employee because of his inability to attend his shifts due to substance-use classes and his failure to request for reasonable disability accommodations. *Id.* at 484–88.

However, the effects of the ADAAA must be qualified, both in the context of addiction and more broadly. As Nicole Porter showed, even ten years after Congress superseded judicial interpretation of the ADA, courts sometimes mistakenly disregard the ADAAA and reject ADA claims based on outdated law.[78] Such errors persist in cases of addictions to this very day, fifteen years after the statutory amendment.[79]

In addition, even after the ADAAA, not all impairments, including addictions, automatically qualify as disabilities. This is a persistent problem that faces those "functioning" addicts, who have an ongoing addiction but are not functionally limited by it. In particular, some addicts manage their personal lives and perform satisfactorily at their jobs. They might struggle to demonstrate the manner in which their addiction limits any major life activity, such as caring for themselves or working.[80]

B. Current Illegal-Use-of-Drugs Exception

In addition to the hurdles for people with additions to qualify as disabled, the ADA also explicitly limits the Act's protection of people with an addiction *to drugs*. It does so by excluding from ADA protection individuals who are "currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use."[81] Historically, the ADA was introduced at the peak of the American-led global "war on drugs" campaign, and just two years following the enactment of the Drug-Free Workplace Act.[82] The current illegal-use-of-drugs exception plausibly reflects the social climate at the time.

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78. *See* Nicole Buonocore Porter, *Explaining "Not Disabled" Cases Ten Years After the ADAAA: A Story of Ignorance, Incompetence, and Possibly Animus*, 26 GEO. J. POVERTY L. & POL'Y 383, 385, 392–93 (2019) (arguing that many courts still erroneously find plaintiffs "not disabled" while disregarding or wrongly applying the ADAAA).

79. *Mueck*, 75 F.4th at 481 (overturning the district court's ruling on the question of the plaintiff's disability, noting the ADAAA legislative change).

80. *E.g.*, Marshall v. Eyecare Specialties, P.C., 876 N.W.2d 372, 386–87 (Neb. 2016) (holding that a former addict did not prove she was disabled on the basis of her past addiction because she did not explain how her addiction limited major activities in her life today). Notably, the *Marshall* court seemed to have misapplied the second prong of "record of impairment" by requiring that the plaintiff show how past impairment limited her major life activities at the time of litigation. *See id.*

81. 42 U.S.C. §§ 12210(a), 12114(a). Unless the individual was erroneously regarded as engaging in such use when in fact they were not. §§ 12210(b)(3), 12114(b)(3). Importantly, this does not apply to health services, or services provided in connection with drug rehabilitation. § 12210(c).

82. 41 U.S.C. § 8102(a)(1) (requiring certain employers who are federal contractors and grantees to make good faith efforts to keep a drug-free workplace).

In practice, applying the current drug use exception has given rise to a host of interpretive questions. One question concerns the meaning of using drugs *illegally*, and whether using prescribed medications that are otherwise used for medical treatment amounts to such illegal usage. Another set of questions revolve around the relevant time frame for determining whether one is currently using, namely currently relative to what, and how recent one's usage should be to qualify as "current." Taken as a whole, courts' interpretation of these terms tended to expand the exception, thus restricting ADA's coverage in cases of drug addiction. As I now turn to explain, courts' approach, at least with regard to the latter set of questions, was predicated on the orthodox conception of addiction as a chronic medical condition of compulsive use.

1. Illegally Using Drugs

The ADA defines the "illegal use of drugs" as "the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act."[83] Based on the ADA's definition, courts have held that the current drug-use exception applies not only to the use of illegal drugs, but also to the misuse of controlled drugs that can be legally prescribed by doctors. For instance, it applies to circumstances where an individual "knowingly or intentionally . . . acquire[s] or obtain[s] possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge" in violation of the Controlled Substance Act.[84] Thus, the Court of Appeals for the Tenth Circuit held that the illegal-use-of-drugs exception applies to the usage of drugs that can be legally prescribed, if the prescription was obtained fraudulently.[85] Similarly, district courts in New York and in Georgia found that "doctor shopping" for prescriptions, while failing to inform physicians that one is currently receiving the same drugs from other doctors, amounts to the illegal use of drugs.[86]

This interpretation is key to understanding why people addicted to opioids might also be excluded from ADA protection, even though they often become

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83. 42 U.S.C. § 12111(6)(A).
84. 21 U.S.C. § 843(a)(3).
85. Nielsen v. Moroni Feed Co., 162 F.3d 604, 611 n.12 (10th Cir. 1998).
86. Scoggins v. Floyd Healthcare Mgmt. Inc., No. 14-CV-00274, 2016 WL 11544774, at *25 (N.D. Ga. June 10, 2016) (holding that an administrator and chief nursing officer who obtained prescriptions from multiple doctors simultaneously was engaging in illegal use of drugs); *see also* Pierce v. Highland Falls-Fort Montgomery Cent. Sch. Dist., No. 08-CIV-1948, 2011 WL 4526520, at *7 (S.D.N.Y. Sept. 28, 2011) (holding that a teacher who misused prescription drugs was engaging in illegal use of drugs).

addicted to drugs that were initially—or indeed, even continuously—prescribed to them.[87] According to the Centers for Disease Control and Prevention, anyone who takes prescription opioids can become addicted to them; studies show that as many as one in four patients receiving long-term opioid therapy in a primary care setting will later struggle with an opioid addiction.[88] The not-so-bright line between using and abusing drugs, and between compulsion and choice, is even blurrier.[89]

More generally, the current illegal-use-of-drugs exception is best understood as a manifestation of the distinction between impairment and its symptoms. Broadly speaking, the ADA only prohibits adverse actions on the basis of one's disability—namely, it does not prohibit adverse actions that had a legitimate reason unrelated to one's disability.[90] And a major issue in determining whether the cause of the adverse action was the disability, or some other legitimate reason, concerns the distinction between impairment and its symptoms.[91]

As Michelle Travis describes, a public debate ensued surrounding this issue following the proposed regulation for implementing Title I of the ADA.[92] On the one hand, the business community objected to equating adverse action based on symptoms with discrimination on the basis of impairment, claiming this proposal exceeded statutory text and legislative intent by imposing liability on a wide range of everyday managerial decisions, such as disciplining employees for unproductive and disruptive

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87. *Pierce*, 2011 WL 4526520, at *2, *16–17.

88. *About Prescription Opioids*, CDC, https://www.cdc.gov/overdose-prevention/about/prescription-opioids.html [https://perma.cc/HV7P-4359].

89. *See id.*

90. The ADA uses the phrases "on the basis of" and "because of" disability interchangeably. *See* 42 U.S.C. § 12112(b)(1) ("[T]he term 'discriminate against a qualified individual on the basis of disability' includes . . . limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee *because of* the disability of such applicant or employee . . . ." (emphasis added)).

91. *See* Michelle A. Travis, *The Part and Parcel of Impairment Discrimination*, 17 EMP. RTS. & EMP. POL'Y J. 35, 41–43 (2013) (discussing the backlash to the EEOC's proposed definition of symptom-based discrimination that would have applied "regardless of whether an employer is aware of an individual's underlying condition" (citing Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act, as Amended, 74 Fed. Reg. 48431, 48443 (proposed Sept. 23, 2009) (to be codified at 29 C.F.R. § 1630.1(*l*)(2)))); *see also* Sch. Bd. of Nassau Cnty. v. Arline, 480 U.S. 273, 282–85 (1987) (rejecting the distinction between a disease's contagiousness and its effects on the person with the disability); Travis, *supra*, at 54–55 (analyzing *Arline*'s applicability to ADA regulations regarding the impairment-symptom distinction).

92. Travis, *supra* note 91, at 42–44.

behavior.[93] On the other hand, disability rights activists claimed that adverse action on the basis of symptoms related to one's impairment is akin to discrimination on the basis of impairment itself, as targeting people because of a symptom related to their impairments is "part and parcel" of impairment-based discrimination.[94] The regulations ultimately failed to resolve this debate, and so whether the ADA proscribes adverse actions on the basis of symptoms was left an open question for courts, who remained split on this issue.[95]

Denying protection to people currently using illegal drugs amounts to an acceptance of the distinction between impairment and its symptoms vis-à-vis drug addicts. Obviously, using drugs is a fundamental symptom of the diagnosis. The exclusion of people currently using drugs denies protection from many people struggling with addiction.

If other impairment-related symptoms are not protected under the ADA, the exclusion of current drug use is best understood as an instance of a more general problem in ADA judicial construction. As I argued elsewhere, drawing the distinction between impairment and its symptoms is particularly problematic in cases of mental disorders, where the clinical conditions are defined as the accumulations of symptoms.[96] Excluding protection of all symptoms would thus be unjustifiably disadvantageous.

By contrast, if other impairment-related symptoms *are* protected under the ADA, the question then becomes whether there is a valid justification for singling out illegal drug use altogether. As Elie Aoun and Paul Appelbaum

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93. *See id.* at 52–63, 77 (arguing that the proposed regulations were compatible with legislative intent and explaining that the concern about impeding everyday managerial decisions were unfounded as the trait and impairment distinction was relevant only to the first threshold of qualifying plaintiffs as persons with disabilities, whereas they still had to be "otherwise qualified").

94. *See id.* at 46–47; Susan D. Carle, *Analyzing Social Impairments Under Title I of the Americans with Disability Act*, 50 U.C. DAVIS L. REV. 1109, 1177 (arguing that one indirect implication of the distinction between impairment and symptoms might be that employers will be disincentivized from educating themselves on the symptoms of specific impairments, contrary to the purpose of the ADA of fighting prejudice and stigma).

95. *See* Travis, *supra* note 91, at 64–68 (arguing that prior to the ADAAA, defendants' claims that their adverse actions were in response to employees' symptoms, and not their underlying mental disorder, brought mixed results). Some courts rejected employers' claims that they suspended or dismissed employees not because of their disorder but because of their related uncooperative and disruptive behavior; other courts found no causation between the adverse act and the underlying impairment, although the adverse act was a response to an impairment-related outburst. *See id.*

96. *See* Adi Goldiner, *Moral Accommodations: Tolerating Impairment-Related Misconduct Under the Americans with Disabilities Act*, 54 COLUM. HUM. RTS. L. REV. 171 (2022); *see also* AM. PSYCHIATRIC ASS'N, *supra* note 39, at 31–32.

claim, such differential treatment lacks justification for it would be based on a moralizing perspective on drug and alcohol use, which disadvantages people with addictions compared to people with other disabilities.[97]

Importantly, however, accepting Aoun and Appelbaum's critique does not necessarily call for a legislative amendment to remove the current illegal-use-of-drugs exception, as some scholars suggest.[98] Even if it is granted that possessing or using drugs or alcohol is a symptom of addiction, and that adverse action on the basis of such actions amounts to discrimination on the basis of disability, and that there is no justification to excluding addicts categorically from such protection, it is still possible that the current drug-use exception is justified. This is due to the significant burden that employers, service providers, and places of public accommodations would face if they were required to retain employees and keep serving clients who are illegally using drugs.[99] On this view, illegal drug use constitutes a legitimate reason for adverse action, but not because such use is not a symptom of an addiction or because symptoms are not protected under the ADA. Rather it is because tolerating ongoing drug use imposes an undue burden on employers, service providers, and places of public accommodations.

2. Current Relative to What?

Regarding the timeframe relevant for "current" usage, a key question is: what is the relevant *date* by which the individual can be said to be currently using drugs? This issue underpins an old—and yet unresolved—circuit split.

One approach is found in one of the earlier cases, *Teahan v. Metro-North,* that was brought under the ADA's predecessor, § 504 of the Rehabilitation

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97. *See* Aoun & Appelbaum, *supra* note 10, at 596.

98. *See generally* Francis, *supra* note 10.

99. The issue of cost is central to the statutory delineation of the duty to provide reasonable accommodations to persons with disabilities, which are a common feature of disability antidiscrimination law worldwide. *Compare, e.g.*, 42 U.S.C. § 12112(b)(5) (stipulating the duty to provide reasonable accommodations within the meaning of the ADA), *and* Equality Act 2010, c. 15, §§ 20–22 (UK) (describing the duties to make adjustments for persons with disabilities, failures to comply with duties to make adjustments, and regulations regarding adjustments for persons with disabilities under the Act), *with* Council Directive 2000/78 art. 5, 2000 O.J. (L 303) 16–22 (EC) (establishing a general framework for equal treatment in employment and occupation and explaining the duty to provide reasonable accommodations to persons with disabilities), *and* U.N. Convention on the Rights of Persons with Disabilities arts. 2, 27, *opened for signature* Mar. 30, 2007, 112 U.S.T. 7, 2515 U.N.T.S. 3 (entered into force May 3, 2008) (defining reasonable accommodations and establishing duties of State Parties to the Convention to provide reasonable accommodations to persons with disabilities).

Act.[100] There, the employer was a railroad company that dismissed the plaintiff, a telephone and telegraph maintainer, because of his absenteeism from work related to his alcohol and drug abuse.[101] The question arose due to the four-month gap between the time of the decision to dismiss the employee and the time where the termination process concluded in his termination letter, which he received after completing a successful rehabilitation program.[102] In those circumstances the Court of Appeals for the Second Circuit held that "currently" using drugs means using on the day of the adverse action, namely the actual dismissal, explaining that this interpretation "best comports with the legislative purpose of ensuring that rehabilitated or rehabilitating individuals are not discriminated against on the basis of past substance abuse."[103] The court reasoned that allowing otherwise would create a loophole that exposes recovering substance abusers to retroactive punishment.[104]

A competing approach was adopted by the Fifth Circuit Court of Appeals in *McDaniel v. Mississippi Baptist Medical Center*.[105] There, a former addict who worked as a marketing representative for a substance abuse recovery program relapsed.[106] The employer notified him that he could not return to his current position, but that he might be transferred within the company.[107] Just days later the plaintiff entered a rehabilitation program, and he was terminated three weeks after that.[108] The court found that the relevant time for inquiry was the day the decision was conveyed to the employee, not the later date when the formal dismissal took place.[109] Under these circumstances, the court found that the employee was currently using illegal drugs.[110]

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100. *See* 951 F.2d 511, 514 (2d Cir. 1991).

101. *Id.* at 513. A related issue emanating from the facts of this case is whether adverse action on the basis of behavior associated with a disability is akin to dismissal because of a disability. The ADA explicitly excludes this equation when the underlying disability is an addiction to drugs or alcohol. *See* Kelly, *supra* note 12, at 204, 211–22 (analyzing cases revolving around various kinds of employees' impairment-related misconduct and explaining that, under the ADA, employers may hold people addicted to drugs or alcohol under the same standards as nondisabled employees).

102. *Teahan,* 951 F.2d at 518.

103. *Id.*

104. *Id.* at 519.

105. *See* 877 F. Supp. 321 (S.D. Miss. 1995), *aff'd*, 74 F.3d 1238 (5th Cir. 1995) (unpublished table opinion).

106. *Id.* at 324–25.

107. *Id.* at 325.

108. *Id.* at 324.

109. *Id.* at 326–27.

110. *Id.*

3. When Is One "Currently" Using Drugs?

The court in *Teahan* also addressed the second question in interpreting the illegal-use-of-drugs exception: how recent should drug use be in order to qualify as "current"?[111] The Court of Appeals for the Second Circuit explained that the term "current" is to be determined by "whether the employee's substance abuse problem is severe and recent enough so that the employer is justified in believing that the employee is unable to perform the essential duties of his job."[112] This, the court explained, will turn on other factors related to the job responsibilities and performance of the employee, namely "the level of responsibility entrusted to the employee; the employer's applicable job and performance requirements; the level of competence ordinarily required to adequately perform the task in question; and the employee's past performance record."[113] In other words, rather than focusing solely on the timing of the employee's drug use, the court determined that the issue should be whether an employer could reasonably conclude that the employee's substance abuse prohibited the employee from performing the essential job duties.[114] Based on this logic, the court interpreted the clause "currently engaging in the illegal use of drugs" as applying to persons who have illegally used drugs in the weeks and months preceding an adverse employment action, thus significantly limiting the scope of ADA protection.[115]

One obvious problem with this interpretation is that it generates a double threshold of qualification for plaintiffs with addictions, disadvantaging them relative to other plaintiffs with disabilities. Plaintiffs must show that they are otherwise qualified for the job to be entitled to ADA protection in the first place, regardless of whether their impairment is an addiction or not. Reading the qualification requirement into the construction of the current drug-use exception permits defendants to voice their concern about qualification requirements yet again.

111. 951 F.2d 511, 518 (2d Cir. 1991).

112. *Id.* at 520.

113. *Id.*; *see* D'Amico v. City of New York, 132 F.3d 145, 151 (2d Cir. 1998).

114. *See Teahan*, 951 F.2d at 520; *see also* 29 C.F.R. app. § 1630.3 (2024) (reiterating that "currently" means that the drug use was sufficiently recent to justify the employer's reasonable belief that the drug abuse remained an ongoing problem).

115. *E.g.*, Collings v. Longview Fibre Co., 63 F.3d 828, 833 (9th Cir. 1995) ("[T]he fact that the employees may have been drug-free on the day of their discharge is not dispositive. Their own admissions of drug involvement during the weeks and months prior to their discharge indicated that they were recently involved in drug-related misconduct.").

C. Safe Harbor Provision

The broad construction of the "current" illegal-drug-use exception was further augmented by the narrow interpretation of the so-called "safe harbor" provision. Despite the exclusion of people currently engaging in illegal drug use, the ADA *does* protect a qualified individual with a disability who is or was in a rehabilitation program. Under the Act, a person who *was* engaging in the illegal use of drugs is not excluded from the category of disability if that person "is no longer engaging in the illegal use of drugs," either because one is currently undergoing rehabilitation or because they successfully completed a rehabilitation program.[116] This protection involves two conditions: participating or completing a rehabilitation program, and refraining from illegal drug use.[117] This safe harbor provision allows people who previously used illegal drugs to obtain ADA protection.

The Fifth Circuit addressed the safe harbor provision in *McDaniel*.[118] There, a relapsed employee entered a rehabilitation program but was nonetheless dismissed several weeks later.[119] He claimed that his dismissal was unlawful because he was protected under the ADA's safe harbor provision.[120] Relying on legislative history, the court held that the safe harbor provision comes into effect only after a person has had a "drug free period of some considerable length . . . [and] that the person had been in recovery long enough to have become stable."[121] The court held that, under the circumstances of the case, the six weeks in which the plaintiff had not used drugs (including his time in recovery) was not a sufficiently long time to find that he was no longer engaging in drug use.[122]

The *McDaniel* court's approach was adopted by courts around the country, giving way to an even broader interpretation of the current illegal-drug-use exception. To name a few examples, in the years following *McDaniel*, the Court of Appeals for the Fourth Circuit found that a nurse who was illegally using drugs during the weeks and months prior to her discharge was a *current*

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116. 42 U.S.C. § 12114(b)(1)–(2).

117. *Id.*

118. McDaniel v. Miss. Baptist Med. Ctr., 877 F. Supp. 321, 325–26 (S.D. Miss. 1995), *aff'd*, 74 F.3d 1238 (5th Cir. 1995) (unpublished table decision).

119. *Id.* at 324–25.

120. *Id.* at 326–27.

121. *Id.* at 327–28.

122. *Id.* (stating an alternative ruling to avoid retrial because, although the court found the plaintiff was terminated before he went to rehab, there was significant disagreement between the parties as to whether the plaintiff was dismissed before or after he went to rehab); *see also* Zenor v. El Paso Healthcare Sys., Ltd., 176 F.3d 847, 858–59 (5th Cir. 1999) (adopting the same alternative ruling approach used in *McDaniel*).

drug user, even though she was dismissed while in a rehabilitation facility.[123] The Court of Appeals for the Fifth Circuit also later held that a pharmacist who was addicted to cocaine for several years, but was otherwise an adequate employee receiving favorable employment evaluations, was still "currently engaging" in illegal drug use, even though he was in detox and rehabilitation center for five weeks prior to the decision to terminate his employment.[124] The Court of Appeals for the Ninth Circuit found that a checker at Lucky Stores was "currently" using drugs at the time of her dismissal, although she was then in a court-directed rehabilitation program following her arrest and incarceration for alcohol and drug related offenses.[125] The Court of Appeals for the Tenth Circuit held that a sales representative was still "currently using drugs," even though he completed a thirty-day rehabilitation program and was no longer using drugs.[126] In the latter case, the court also emphasized that there is no formula to determine "if an individual qualifies for the safe harbor for former drug users or is 'currently' using drugs," but rather eligibility for ADA protection in such cases must be determined on a case-by-case basis.[127]

Meeting the two conditions of the safe harbor provision is even more complicated in cases involving addictions to opioids, as ongoing drug use is arguably treatment-related. In *Shirley v. Precision Castparts Corp.*, the Fifth Circuit grappled with such circumstances.[128] There, an employee with an addiction to pain killers, which were initially prescribed to him to manage pain from various work-related injuries, refused to complete an inpatient treatment program after detox and insisted on using the opiate pain reliever Vicodin.[129] The court found that under these facts, the employer was reasonable in thinking that the employee's drug use was still an ongoing

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123. Shafer v. Preston Mem'l Hosp. Corp., 107 F.3d 274, 275, 280–81 (4th Cir. 1997). In *Shafer*, the court used plain language interpretation and appealed to legislative history. *See id.* at 277–79. The court explained that Congress's safe harbor provision intended to protect individuals who have illegally used drugs in the past, recognizing that many continue to participate in drug treatment programs long after they stopped using drugs. *Id.* at 279–80.

124. *Zenor*, 176 F.3d at 856–59. In making its decision, the court noted that "[s]uch a short period of abstinence, particularly following such a severe drug problem, does not remove from the employer's mind a reasonable belief that the drug use remains a problem. Zenor's position as a pharmacist required a great deal of care and skill." *Id.* at 857. Furthermore, there was "substantial testimony about the extremely high relapse rate of cocaine addiction." *Id.*

125. Brown v. Lucky Stores, 246 F.3d 1182, 1186–89 (9th Cir. 2001) (employee was dismissed for absenteeism after missing work due to her arrest and subsequent assignment to a rehabilitation program).

126. Mauerhan v. Wagner Corp., 649 F.3d 1180, 1183, 1189 (10th Cir. 2011).

127. *Id.* at 1188.

128. 726 F.3d 675 (5th Cir. 2013).

129. *Id.* at 677, 681.

problem upon his termination, and therefore the employee was not protected under the safe harbor provision.[130]

Courts' narrow construction of the safe harbor provision and the subsequent expansion of the "currently engaging in the illegal use of drugs" exception motivate plaintiffs with addictions to ground their ADA claims in other provisions. Specifically, some plaintiffs with addictions seek ADA protection by invoking employers' duty to provide reasonable accommodations to employees with disabilities.[131] Thus, in a recent case, a Las Vegas salesman with prescription drug addiction challenged his dismissal while at a detox-and-rehabilitation program.[132] He argued that his termination was a violation of his employer's duty under the ADA to provide reasonable accommodations in the form of extended leave of absence for medical treatment.[133] Given the dispute regarding the duration of the plaintiff's sought-after leave of absence, the Nevada district court denied summary judgment to the employer.[134] Yet it is far from clear whether the duty to provide accommodations applies to individuals who are excluded from ADA protection on the basis of their illegal use of drugs. In addition, plaintiffs taking this approach may face several practical challenges, including asking for accommodations explicitly and in advance—which is not always possible[135]—and having to specify the duration of the extended leave they seek, to avoid the impression that it will be an indefinite one.[136]

D. Other Addiction-Related Misconduct

The ADA also carves out an explicit exception wherein people with drug or alcohol addictions may be held to the same standards of behavior as nondisabled employees.[137] This exception, too, should be understood in the broader context of the ADA mandate, which only prohibits adverse actions

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130. *Id.* at 681.

131. 42 U.S.C. § 12112(b)(5).

132. LeBarron v. Interstate Grp., LLC, 529 F. Supp. 3d 1163 (D. Nev. 2021).

133. *Id.* at 1168, 1171–72 (considering whether terminating an employee who checked into a rehabilitation program violated the ADA, specifically the duty to provide reasonable accommodations by extending leave of absence for medical treatment).

134. *Id.* at 1173.

135. Brown v. Lucky Stores, 246 F.3d 1182, 1188 (9th Cir. 2001).

136. *LeBarron*, 529 F. Supp. 3d at 1174.

137. *See* Timmons, *supra* note 12, at 204. And still today, courts are split on this issue. *See* Goldiner, *supra* note 96, at 200–02; *see also* Raytheon Co. v. Hernandez, 540 U.S. 44 (2003) (holding that a refusal to rehire a former employee who previously resigned after failing a drug test was not in violation of the ADA).

on the basis of one's disability but not on the basis of a legitimate reason unrelated to one's disability.[138] As discussed earlier, a major issue in determining whether the cause of the adverse action was the disability or some other legitimate reason concerns the distinction between impairment and its symptoms.[139] When related symptoms amount to misconduct, the challenge becomes all the more acute.[140] To date, it remains an open question as to whether the ADA protects against adverse action on the basis of impairment itself or also its symptoms.[141] As I argued elsewhere, there is no reason to exclude impairment-related misconduct from ADA protection, and indeed, accommodating misconduct to various degrees is supported by the moral justifications of disability accommodations more broadly.[142] However, addiction-related misconduct, unlike other impairment-related misconduct, is explicitly excluded from ADA protection.[143] Accordingly, even if misconduct is directly related to the addiction, it would not be protected under the ADA.

Surprisingly, however, when deciding cases involving addiction-related misconduct (other than illegal drug use), courts tend to ground their decisions in a distinction between the addiction and the misconduct, thereby justifying the adverse action based on the latter and not the former. In one of the early ADA cases, *Despears v. Milwaukee County*, an alcoholic employee brought a claim challenging his demotion after losing his license due to driving under the influence of alcohol.[144] The Court of Appeals for the Seventh Circuit rejected his claim, explaining that "a cause is not a compulsion (or sole cause); and we think the latter is necessary to form the bridge that Despears seeks to construct between his alcoholism and his demotion."[145] A few years later, the same court drew a similar distinction regarding drug possession in *Pernice v. City of Chicago*.[146] There, the plaintiff was an employee of the City of Chicago's Department of Aviation who was arrested for disorderly conduct and possession of drugs.[147] Shortly after his arrest, he sought treatment for his "'self-acknowledged drug addiction,'" but several months later, he was discharged on the basis of his misconduct, including possessing

138. *See supra* note 90.
139. Carle, *supra* note 94, at 1177; *see also* discussion *supra* Section I.B.1.
140. Goldiner, *supra* note 96, at 201–02.
141. *Id.* at 200.
142. *Id.* at 175.
143. 42 U.S.C. § 12114(a).
144. 63 F.3d 635, 636 (7th Cir. 1995).
145. *Id.*
146. 237 F.3d 783 (7th Cir. 2001).
147. *Id.* at 784.

drugs.[148] He challenged his dismissal, making various claims linking his drug possession to his disability and arguing he was wrongfully terminated on the basis of his drug addiction in violation of the ADA.[149] The Court of Appeals for the Seventh Circuit held that even if addiction is a disease that includes an involuntary need to possess some substance, acting on that need is the outcome of a conscious decision to actually possess that substance.[150]

E. Drug Testing and Post-Recovery Issues

Finally, the ADA allows covered entities to prohibit drug-related misconduct at the workplace,[151] and to adopt or administer reasonable policies or procedures, including but not limited to drug testing, in order to ensure that individuals are not engaging in such illegal use.[152] This is permissible both in the pre-employment stage and during employment, again reflecting the social climate of the "war on drugs" at the time of the ADA enactment.[153]

While seemingly straightforward, the administration of such drug tests presents pragmatic and legal challenges on the ground. One such issue concerns employees' refusal to submit to routine alcohol and drug tests, or to previously agreed-upon tests of this sort. At least one court held that an adverse employment action following such a refusal does not amount to disability discrimination.[154] Another issue concerns the type of test administered and the manner in which it renders some people more susceptible to failure than others. This issue arose in *Buckley v. Consolidated Edison Co. of N.Y.*, where a recovering drug addict was dismissed after failing

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148. *Id.*

149. *Id.* at 784–85.

150. *Id.* at 787.

151. 42 U.S.C. § 12114(c).

152. *Id.*; *see also* Coffey v. Norfolk S. Ry. Co., 23 F.4th 332, 339 (4th Cir. 2022) (holding that a railway company's medical inquiry into its employed locomotive engineer's medical records following a positive drug test was job-related and consistent with business necessity and therefore did not violate the ADA); *cf.* Irving Pulp & Paper Ltd. v. CEP, Local 30, [2013] 34 S.C.R. 275 (Can.) (holding that universal random alcohol-testing policies are overreaching unless an employer can demonstrate evidence of an alcohol problem).

153. *See* Connolly v. First Pers. Bank, 623 F. Supp. 2d 928 (N.D. Ill. 2008) (discussing pre-employment drug test); *see also* EEOC v. Grane Healthcare Co., Civil No. 10-250, 2015 WL 5439052, at *39, *40 (W.D. Pa. Sept. 15, 2015) (discussing drug testing before and during employment).

154. *See* Skinner v. Amsterdam, 824 F. Supp. 2d 317, 333 (N.D.N.Y. 2010) (granting summary judgement to employer in claim brought by an employee who was addicted to drugs and failed to give an illegal drug test while on probation).

to provide a routine urine sample due to his medical condition of neurogenic bladder.[155] Specifically, his condition meant providing urine often took him a long time, and the employer refused to grant him extra time to provide the sample.[156] A divided Court of Appeals for the Second Circuit held that the requested accommodation of extra time to provide the urine sample was not linked to his disability of drug addiction, and therefore there was no legal duty to accommodate it.[157] In the more recent case of *Jones v. Boston*, plaintiffs argued that the hair test used to detect illegal drugs in employees generated false-positive results in processing the type of hair common to many black individuals and was therefore racially discriminatory.[158]

The permissibility of drug testing further blurs the distinction between drug use and drug addiction, which is critical for qualifying as disabled under the ADA.[159] Indeed, in *Jones*, the Court of Appeals for the First Circuit held that the dismissal of plaintiffs from the Boston Police Department after failing a drug test was not discriminatory, because they were dismissed on the basis of their drug use, not addiction.[160] Similarly, the Court of Appeals for the Tenth Circuit held that dismissal of an employee who failed a drug test does not amount to direct evidence of disability discrimination and accordingly rejected the plaintiff's ADA claim.[161] Additionally, the Court of Appeals for the Fifth Circuit found that dismissing an employee for arriving to work under the influence of alcohol did not amount to dismissal on the basis of actual or perceived alcoholism.[162]

The permissibility of drug testing poses a fundamental challenge for the reintegration of recovered opioid addicts.[163] The treatment for opioid use disorder ("OUD") often involves taking prescribed medication, which are also opiates. And accordingly, people taking such treatment come up positive in drug tests. However, in recent years, the U.S. Department of Justice focused its efforts against such adverse actions taken against people using

155. 155 F.3d 150, 156 (2d Cir. 1998).

156. *Id.* at 152.

157. *Id.* at 157.

158. 752 F.3d 38, 41 (1st Cir. 2014).

159. *See supra* Section I.A.1; *see also* Rhoads v. Bd. of Educ., 103 F. App'x 888, 893 (6th Cir. 2004).

160. 752 F.3d at 59.

161. Turner v. Phillips 66 Co., 791 F. App'x 699, 711 (10th Cir. 2019).

162. Kitchen v. BASF, 952 F.3d 247, 252–53 (5th Cir. 2020).

163. A related question concerns the legal usage of drugs as treatment for other clinical conditions. *See, e.g.*, Turner, 791 F. App'x at 708.

medications for OUD.[164] For example, the DOJ found that the Indiana State Board of Nursing violated the ADA in denying a nurse the opportunity to participate in a rehab program because she took OUD medications.[165] The DOJ also filed claims against a Colorado-based program for people experiencing homelessness that denied admission to an individual who took OUD medications, and against the Unified Judicial System of Pennsylvania that allegedly prohibited participants in its court supervision programs from using OUD medications.[166]

II. REINTERPRETING THE ADDICTION OUTLIER

Having laid out the addiction outlier problem in detail, this Part turns to analyze its root cause and puts forward a way of addressing it. The Part begins by describing the two competing conceptions of addiction that this Article focuses on: the orthodox and multifactorial conceptions of addiction.[167] It then demonstrates how the orthodox conception underpins current legal construction of the ADA regarding people with addictions, and how accepting the multifactorial conception of addiction in lieu of the orthodox conception would revert the expansive interpretation of the addiction outlier provisions, thus mitigating the major obstacles to utilizing ADA protection for addicts.[168] The following Section addresses a potentially key objection to this proposed shift: that endorsing the multifactorial view of addiction in lieu of the orthodox conception renders addiction even further removed from paradigmatic cases of disability. Accordingly, regardless of its foreseeable benefits, applying the ADA to addiction is arguably not warranted because addiction is not a disability.

A. Two Conceptions of Addiction

The DSM-V defines a "substance use disorder" as a condition whose essential feature is "a cluster of cognitive, behavioral, and physiological

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164. U.S. DEP'T OF JUST. C.R. DIV., THE AMERICANS WITH DISABILITIES ACT AND THE OPIOID CRISIS: COMBATING DISCRIMINATION AGAINST PEOPLE IN TREATMENT OR RECOVERY (2022), https://archive.ada.gov/opioid_guidance.pdf [https://perma.cc/PKK7-ZWLE].

165. Press Release, U.S. Dep't of Just. C.R. Div., Justice Department Issues Guidance on Protections for People with Opioid Use Disorder Under the Americans with Disabilities Act (Nov. 29, 2022), https://www.justice.gov/opa/pr/justice-department-issues-guidance-protections-people-opioid-use-disorder-under-americans [https://perma.cc/5GC2-5ZKP].

166. *Id.*

167. *See infra* Section II.A.

168. *See infra* Section II.B.

symptoms indicating that the individual continues using the substance despite significant substance-related problems."[169] The crux of addiction then, which distinguishes it from mere usage, lies in continuous usage despite related problems. Accordingly, understanding the nature of addiction requires understanding the mechanisms leading to such continuous usage. As Pickard incisively puts it, the question of why people keep using drugs despite negative consequences is the "puzzle of addiction."[170]

The orthodox view of addiction responds to the puzzle of addiction by equating addiction with compulsion to use.[171] To be an addict, on this view, is to use certain substances despite negative consequences because of an irresistible desire to do so.[172] There is little to no choice involved in addicts' continued usage, and this is what singles them out from non-addicted users.[173]

Importantly, the orthodox view of addiction characterizes addiction more broadly as a disease. A prominent view of addiction characterizes it as a brain disease, namely a disease involving some underlying dysfunction of the brain that causes a pattern of substance abuse and addiction.[174] Other views of addiction as a disease do not commit to it being a disease of the brain and rather focus on the behavioral aspects of this condition. Thus, the DSM-V characterizes substance use disorders—including addiction—as "a cluster of cognitive, behavioral, and physiological symptoms" without defining it as a disease of the brain.[175] As Pickard explains, this definition fits with a minimal model that treats diseases as syndromes, namely as "collections of observable signs and experienced symptoms that co-occur and unfold over

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169. AM. PSYCHIATRIC ASS'N, *supra* note 39, at 483.

170. Hanna Pickard, *The Puzzle of Addiction*, *in* THE ROUTLEDGE HANDBOOK OF PHILOSOPHY AND SCIENCE OF ADDICTION 9, 10 (Hanna Pickard & Serge Ahmed eds., 2018).

171. *Id.*

172. *Id.*

173. *Id.*

174. *See* Alan Leshner et al., *Addiction Is a Brain Disease, and It Matters*, 278 SCI. 45, 46 (1997). For a recent defense of the brain disease model, see Markus Heilig et al., *Addiction as a Brain Disease Revised: Why It Still Matters, and the Need for Consilience*, 46 NEUROPSYCHOPHARMACOLOGY 1715, 1715 (2021). Given obvious differences between addiction and other paradigmatic brain diseases, some accounts of addiction view it as a disease not necessarily of the brain. For example, the American Society for Addiction Medicine defines addiction as a "treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences," and the DSM-V adopts a behavioral model of addiction. JOHN T. MAIER, THE DISABLED WILL 10, 14 (2024). Maier draws a conceptual distinction between behavioral views of addiction and disease views of addiction, but this distinction is less important for our purposes, so I will not get into it here.

175. *See* AM. PSYCHIATRIC ASS'N, *supra* note 39, at 483.

time in a characteristic way."[176] On this view, addiction is a disease because it involves compromised choice faculties leading to a pattern of drug choices, regardless of whether it results from an underlying brain dysfunction or not.[177]

Interestingly, characterizing addiction as a disease, primarily as a compulsive disorder, was intended to combat stigma against addicts and to facilitate more healthcare services.[178] This was based on the assumption that viewing addiction as a disease would shift public perceptions of addicts from "bad persons" to "chronically ill sufferers" and thereby reduce stigma against them.[179] The thought was that if people are addicted to drugs, then they have no choice vis-à-vis their drug use; and if they are not responsible for using, they cannot be blamed for doing so. This would, in turn, harness support to provide addicts with the assistance that they need.

Characterizing addiction as a disease would clearly facilitate more healthcare for people with addictions, including the development of effective interventions. However, the thought that associating addiction with disease will reduce stigma against addicts did not prove true. Stigma against drug addicts remains more-or-less steady and closely intertwined with racial and class prejudices.[180] Even more so, perceiving addiction as a disease was associated with increased social rejection and attribution of dangerousness, unpredictability, and fear.[181]

An alternative view of addiction, which I call the multifactorial conception, was developed by Hanna Pickard in a series of influential articles.[182] As a starting point, Pickard doubts the orthodox premise that addiction involves some compulsion resulting from brain dysfunction.[183] She

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176. Hanna Pickard, *Addiction and the Meaning of Disease*, *in* EVALUATING THE BRAIN DISORDER MODEL OF ADDICTION 321, 323 (Nick Heather et al. eds., 2022) (reviewing the compatibility of addiction with philosophical models of disease).

177. *See id.* at 324.

178. *Id.* at 321–22.

179. *Id.* It is interesting in this regard that the first edition of the Diagnostic and Statistical Manual of 1952 grouped alcohol and drug abuse under Sociopathic Personality Disturbances, which were thought to be symptoms of deeper psychological disorders or moral weakness. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 85 (1st ed. 1952).

180. Sonia Mendoza et al., *Race, Stigma, and Addiction*, *in* THE STIGMA OF ADDICTION 131, 147 (Jonathan D. Avery & Joseph J. Avery eds., 2019).

181. Pickard, *supra* note 176, at 322.

182. *See* Hanna Pickard, *The Purpose in Chronic Addiction*, AJOB NEUROSCIENCE, Apr.–June 2012, at 40 [hereinafter Pickard, *Chronic Addiction*]; Pickard, *supra* note 170; Hanna Pickard, *What We're Not Talking About When We Talk About Addiction*, HASTINGS CTR. REP., July–Aug. 2020, at 37 [hereinafter Pickard, *What We're Not Talking About*]; Hanna Pickard, *Addiction and the Self*, 55 NOÛS 737 (2021); Pickard, *supra* note 176.

183. Pickard, *Chronic Addiction*, *supra* note 182, at 41.

highlights data regarding patterns of use, indicating that people tend to "mature out" of addictions, and this often occurs spontaneously and without medical treatment.[184] From this data, she infers that addiction is a state of purposeful choices to use drugs despite negative consequences, and it occurs for several reasons.[185]

Pickard provides a rich and nuanced account of the factors motivating the continuous usage of drugs and other substances.[186] She claims that some people continue to use drugs and other substances out of a desire to self-harm due to other psychiatric disorders or past trauma; some continuously use drugs and other substances to relieve suffering generated by extremely limited socioeconomic opportunities and poor mental health, particularly when there are no realistic incentives to quit; still others continue using due to temporary myopic decision-making, namely an extreme tendency to discard future consequences relative to present gains; some are in denial about the negative consequences of continued usage; and, finally, some are attached to a self-identity connected with substance use, under circumstances in which continuous use has alas become the only life they know.[187] Pickard concludes that there is no single and unified explanation of addiction. Rather, it is the upshot of many interacting factors, many of which are based on social practices and plausibly none of which is pathological.[188]

Coming to terms with the multifactorial nature of addiction is necessary, Pickard argues, for effectively addressing it.[189] Specifically, recognizing the various factors leading to addiction calls for diversifying the social response to the problem of addiction.[190] As Pickard explains, addiction neuroscience and the search for pharmacological treatment receive significant funding and attention.[191] Doing away with the brain disease model of addiction mandates addressing the diverse causes of addiction by investing in psychological, behavioral, social, and economic interventions—which we know help many people recover.[192] Such nonmedical interventions would arguably aim to reinforce what has been called people's "stake in conventional life," which

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184. *Id.* at 40–41.

185. *Id.* at 44–46 (highlighting five folk psychological factors explaining chronic addiction: strong and habitual desire, faculties of willpower, motivation stemming from lower socioeconomic status, functional role in managing stress, and failure to believe in one's ability to quit using).

186. Pickard, *supra* note 170, at 14–19.

187. *Id.*

188. *Id.* at 19.

189. *Id.*

190. *See* Pickard, *What We're Not Talking About*, *supra* note 182, at 42–43.

191. Pickard, *supra* note 176, at 333.

192. *Id.*

Pickard takes to be "the things that give life meaning and weigh heavily in the balance as a counter to the value of drugs."[193]

B. Conceptions of Addiction and the Addiction Outlier

Recognizing the two competing conceptions of addiction outlined in the previous Section can play a key role in reshaping the protection afforded to people with addiction under the ADA. As this Section turns to show, endorsing an orthodox conception would widen the exclusion of people with addiction from the category of disability. Indeed, much of the current judicial approach can be explained through the orthodox lens. By contrast, accepting Pickard's conceptualization of addiction would allow for a much narrower interpretation of the ADA's addiction outlier, thereby permitting a broader coverage of addicts under the ADA. Thus, accepting a multifactorial view of addiction would generate a pivotal shift in the construction of the addiction outlier.

First, the judicial tendency to exclude addicts from the category of disability within the meaning of the ADA seemingly rests on the orthodox view of addiction. On the one hand, conceived as a compulsive use disorder, addiction easily qualifies as a pathology and, in turn, an impairment.[194] It also easily qualifies as a disability because if one cannot control his use of substances due to an addiction, it will foreseeably significantly limit his ability to function in various major life domains.[195] On the other hand, accepting the orthodox conception of addiction explains why courts tend to exclude from the category of "impaired" or "disabled" those people whose addictions are not limiting enough.[196] When a person's use does not sufficiently limit their ability to function all the time, they seemingly do not have an addiction under the orthodox view.

By contrast, a multifactorial view of addiction would expand the category of disability under the ADA to include more "functioning" people with addiction. If addicts retain the ability to choose whether, when, and how often to use, this view is compatible with their ability to maintain functioning at particular times and in certain life domains. This does not imply that they are not addicted or that they are not disabled in other major areas of life, such as in caring for themselves, maintaining healthy relationships, or generally struggling more than others to keep functioning.

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193. Pickard, *What We're Not Talking About*, *supra* note 182, at 43.
194. *See supra* Section I.A.1.
195. *See supra* Section I.A.2.
196. *See supra* Section I.A.2.

Next, consider the appropriate construction of the current drug-use exception.[197] The controversy manifested in *McDaniel* and *Teahan*, nicely maps onto the distinction between the two conceptions of addiction. If addiction involves compulsive use, as the orthodox view holds, then it makes little difference whether the decision to terminate an employee was only finalized months after his usage. What matters is that the person has an active addiction, which justifies the concern of continuous usage due to its compulsive element. This view lends support to the Fifth Circuit's decision in *McDaniel*, which took the earlier date to be the relevant day for exploring current usage.[198] By contrast, the multifactorial conception holds that addiction is a condition generated by various factors, both internal to the person and rooted in social circumstances, and so the addicted person chooses whether or not to continue using given those factors. The relevant time frame must then be the later date when the adverse action was finalized, along the lines of the Second Circuit's decision in *Teahan*.[199] This is because if addiction is responsive to incentives, an addict may well seek treatment following the threat of losing her job. The time between being notified of her dismissal and the time the employer finalized the termination is crucial in that regard.

A similar line of reasoning applies to the construction of the "currently engaging" prong. As mentioned earlier, current case law interprets the prong to include usage that occurred days, weeks, or months prior to the adverse action.[200] This approach seemingly rests on a view of addiction as a compulsive use disorder, for if a person was a using addict a few weeks or days ago it is very likely that one is still using. If addiction is driven by compulsion, quitting should be difficult—if not impossible—and addicts should face a very high evidentiary threshold to demonstrate that their illegal use is a thing of the past. By contrast, a multifactorial view of addiction would require courts to adopt a leaner approach when constructing "currently" in this context. Being caught using on the day of adverse action would plausibly qualify as current usage. However, a multifactorial conception would prompt courts to recognize the realistic possibility of people forgoing drug use. Courts would thus have to weigh the circumstances surrounding one's drug use, including the time that passed since last using, to assess whether the illegal drug use is still "current."

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197. *See supra* Section I.B.2.

198. McDaniel v. Miss. Baptist Med. Ctr., 877 F. Supp. 321 (S.D. Miss. 1994), *aff'd*, 74 F.3d 1238 (5th Cir. 1995) (unpublished table opinion).

199. Teahan v. Metro-N. Commuter R.R. Co., 951 F.2d 511 (2d Cir. 1991).

200. *See supra* Section I.B.3.

A crucial factor in determining whether usage is still current or not revolves around whether one went to a rehabilitation program to quit. The importance of this factor is manifested in the safe harbor exception.[201] However, its potential utilization was derailed by courts' strict construction of the provision to cover only those people that have long since recovered. The assumption seemingly underlying this view is that deciding to quit using drugs cannot be done at once, in line with the orthodox view of addiction. By contrast, accepting the multifactorial view of addiction would lead to a totally different construction of the safe harbor exception. A multifactorial conception of addiction recognizes people's ability to choose a different path. Rather than requiring people to be long recovered to gain ADA protection, the multifactorial approach would advocate for bolstering people's efforts to quit using drugs by utilizing ADA protection for people as soon as they seek treatment.

Importantly, expanding the safe harbor provision could be key for improving the social response to addiction generally and the opioid crisis in particular. One of the reasons why people with addiction keep choosing to use drugs, despite negative consequences, concerns what Pickard calls "temporally myopic decision-making."[202] This is the tendency—common to most humans but arguably exacerbated in addicts[203]—to value current desirable drug use and discount uncertain long-term undesirable consequences.[204] Yet those with addiction are not immune to incentives. Pickard explains that "[i]t is remarkable that a small amount of money or a prize can provide sufficient incentive for addicts to forgo drugs, when the consequences of their addiction do not."[205] Interestingly, studies show that in manufactured environments, remaining an active participant in social life and particularly in *employment* is an effective intervention for treating addiction.[206]

This insight is evident in the case law too. The chains of events depicted in court decisions reveal that people are worried about losing their jobs as a result of their addiction or related symptoms and consequences. They check

201. *See supra* Section I.C.

202. Pickard, *supra* note 170, at 15.

203. *Id.* Some view this as the pathology at the core of addiction, while Pickard attributes this myopia to life circumstances. *See id.* at 15–16.

204. *Id.* at 15.

205. *Id.*

206. *E.g.*, Kenneth Silverman et al., *The Therapeutic Utility of Employment in Treating Drug Addiction: Science to Application*, 2 TRANSLATIONAL ISSUES PSYCH. SCI. 203, 203 (2016) (discussing the effectiveness of the Therapeutic Workplace model for drug addiction intervention).

into rehabilitation programs when they see that their job is at risk, and even call their work from rehab or jail to make sure they will have a job when they are out and recovered. For example, in *LeBarron v. Interstate Group, LLC*, the plaintiff's wife texted with his direct supervisor and store manager throughout his time in rehab.[207] In *Brown v. Lucky Stores*, the plaintiff had someone contact her work on the day of her arrest.[208] And in *Zenor v. El Paso Healthcare Systems*, the plaintiff called his workplace several days after checking into a detox center.[209] Expanding the safe harbor provision could thus provide a valuable incentive for people to seek care and recover.

Considering the orthodox and multifactorial view also complicates the implementation of the ADA's exclusion of misconduct related to drug addiction and alcoholism. On the one hand, if addiction-related behaviors are not subject to choice, as the orthodox view holds, then perhaps related misconduct such as possession of drugs is properly understood as a symptom that warrants protection under the Act like other symptoms, even if they amount to misconduct.[210] Conversely, if unacceptable behaviors related to addiction are subject to choice, as the multifactorial view of addiction suggests, perhaps it is justly excluded from the Act's coverage because it is not a symptom at all?[211]

The first thing to note in this regard is that accepting the view that addicts retain the capacity to choose does not mean that their choices are categorically not symptoms of their addiction. On the contrary, even if it is granted that people can resist urges to possess or use in certain circumstances, a multifactorial approach realistically accepts that on many occasions they fail.[212] Those bad choices *are* the behavioral "symptoms" of their addiction. Therefore, prohibiting discrimination against impairment-related symptoms under the ADA could in principle extend to addiction as well.

Relatedly, a multifactorial conception of addiction would not necessarily undermine the permissibility of drug testing.[213] Routine drug testing can serve as an incentive for addicts not to use and seek treatment when needed. It could

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207. 529 F. Supp. 3d 1163, 1170 (D. Nev. 2021).

208. 246 F.3d 1182, 1186 (9th Cir. 2001).

209. 176 F.3d 847, 851 (5th Cir. 1999).

210. *See generally* Goldiner, *supra* note 96 (claiming that impairment-related misconduct should be tolerated to various degrees under the ADA).

211. *See supra* Section I.D. Interestingly, along these lines, the Seventh Circuit affirmed adverse action due to addiction-related misconduct by attributing it to the plaintiff's choice, notwithstanding the plaintiff's ongoing addiction. *See* Pernice v. City of Chicago, 237 F.3d 783 (7th Cir. 2001).

212. *See supra* Section II.A.

213. *See supra* Section I.E.

also be understood as a measure that helps employers single out employees who are continuously using drugs and take action only against them. Employers should be expected to retain employees who are recovering from addiction, but not those continuously engaging in illegal drug use. However, the legitimacy of such measures is contingent on the appropriate construction of other provisions relating to addiction, as detailed above.[214] Put simply, testing for drug and alcohol use is permissible if it is intended to encourage people to refrain from using and join a rehabilitation program when required. Testing is also plausibly legitimate for identifying continuous usage that places a heavy burden on the employer. By contrast, when accompanied by strict zero-tolerance policies, such as the one-strike rule, drug testing loses its legitimacy.[215]

To sum up, this Part analyzed the courts' application of the ADA to addiction in view of two competing conceptions of addiction. It demonstrated that ADA provisions limiting protection to addicts are often interpreted expansively in line with the orthodox conception of addiction. By contrast, a multifactorial conception of addiction recognizing that addiction involves choice would result in stricter interpretation of the addiction outlier provisions and lead to more expansive protection under the ADA.

III. ADDICTION AS A DISABILITY UNDER THE ADA

The claim that the ADA should be reinterpreted to afford greater protection to people with addictions, developed in the previous Part, is subject to an important objection. The concern is that people with addictions are not disabled and therefore should not be entitled to ADA protection—even if such protections could benefit them.

Importantly, the orthodox and multifactorial conceptions of addiction fare differently with regard to this charge. The orthodox conception of addiction is less susceptible to such objection, due to its framing of addiction as a pathology.[216] By contrast, denying that addiction is a compulsive use disorder is more susceptible to such critique because it emphasizes the role of social factors in generating addiction alongside certain psychological mechanisms.[217] Pickard herself remains agnostic as to the status of addiction

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214. *See supra* Part I.
215. *Id.*
216. *See supra* Section II.A.
217. *Id.*

as a clinical pathology, claiming that there is still much we do not know about the psychological mechanisms leading to addicted choices.[218]

One way to address this broader concern is found in John Maier's recent book, which explicitly defends the view that addiction is a disability.[219] Maier claims that addiction is what he calls a "volitional disability," which involves an atypical pattern of volitional tendencies to revise one's intentions with regard to a certain substance or activity.[220] While claiming that this atypical choice pattern is not itself a defect, Maier holds that addiction is a disability when (and because) it is subject to widespread patterns of discrimination and exploitation.[221]

However, the applicability of Maier's theory to my purpose here faces two concerns, both relating to his working definition of disability. First, Maier's view of disability seems overly broad, encompassing a myriad of disadvantaged groups marked by some atypical characteristic and subject to discrimination and exploitation. In his view, groups such as racialized minorities would be deemed disabled, and this is but one prominent example. Second, Maier's view of disability diverges significantly from the one adopted by the ADA. In previous work, I argued that disability is best understood as a cluster of different models of disability that are analytically compatible with one another.[222] Maier's view of disability reflects a cluster of two models: the social model of disability, which views disability as a disadvantage imposed on people with impairments by societies in which they live, and the affirmative model of disability, which views impairment as mere-difference with regard to well-being.[223] Moreover, the characteristic that lies at the heart of his account of disability is not a clinical pathology.[224] Despite the ADA's rhetoric and stated aim, which reflects the social model's view,[225] the ADA's definition of disability emerges from a cluster of two other models: the medical and personal tragedy models of disability,

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218. *See* Pickard, *supra* note 170, at 12–13. Addiction could still be a disease of choice, namely a clinical condition characterized by neural processes underlying drug choices. *See* Kent C. Berridge, *Is Addiction a Brain Disease?*, 10 NEUROETHICS 29, 29 (2017). But to date, there is little evidence to support the claim that such choice mechanisms are pathological. *See* Pickard, *supra* note 170, at 12–13.

219. *See* MAIER, *supra* note 174.

220. *Id.* at 60–61, 74.

221. *Id.* at 69.

222. *See* Goldiner, *supra* note 56 (characterizing different debates about the nature of disability, including the link between impairment and social participation, impairment and well-being, and the dichotomy or lack thereof between disabled and nondisabled people).

223. MAIER, *supra* note 174, at 56.

224. *See id.* at 31–54.

225. *See* Areheart, *supra* note 60, at 225–26.

according to which disability is an impairment that hinders social participation and adversely affects well-being.[226] As demonstrated earlier, the issue for addicts seeking to qualify as disabled hinges on the pathological nature of their usage and the effect of their addiction on their ability to function.[227] Therefore, even if we accept Maier's characterization of addiction at face value, its implications for the implementation of the ADA are only indirect. His view does not provide an argument—nor does he purport to do so—for adopting an alternative view of disability within the context of the ADA.[228]

To address the claim that the ADA's definition of disability is in tension with the nature of addiction, what is needed instead is a reevaluation of the definition of disability in this context. That task brings out fundamental questions regarding the concepts of impairment and disability within the meaning of the ADA. Attending to these conceptual issues, this Part will delve into the philosophical underpinnings of the concept of disability. It will begin by arguing that the category of disability is socially constructed,[229] and then put forth an account of disability applicable to antidiscrimination law.[230] Next, this Part will claim that addiction qualifies as a disability for the purpose of antidiscrimination law on that tailored conception of disability.[231]

A. The Social Construction of Disability

Historically, the concept of "disability" was often used to describe a limitation on one's ability to perform a legal act, such as voting or forming contracts, that was not tied to impairments.[232] "Disability" was employed beyond this original meaning predominantly due to the legislative need to

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226. *See id.* at 209 (emphasizing the entrenchment of the medical model in ADA jurisprudence); Goldiner, *supra* note 96, at 244–45 (suggesting that courts are also endorsing a tragedy model of disability in their decisions regarding impairment-related misconduct that harms other people).

227. *See supra* Section I.A.2.

228. *See* MAIER, *supra* note 174.

229. *See infra* Section III.A.

230. *See infra* Sections III.B–C.

231. *See infra* Section III.D.

232. *See* Wesley Newcomb Hohfeld, *Some Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 23 YALE L.J. 16, 30 (1913); Anita Silver, *An Essay on Modeling: The Social Model of Disability*, *in* 104 PHILOSOPHICAL REFLECTIONS ON DISABILITY 19, 23 (D. Christopher Ralston & Justin Ho eds., 2009) ("Someone with a legal disability suffers from an atypical or unusual or remarkable limitation that is legally imposed on her social participation, or at least is explicitly endorsed by the law. For example, prior to universal suffrage women had a disability in respect to exercising the franchise compared to men: they quite simply could not do so.").

find a suitable term to refer to people eligible for state benefits, such as payment of supplementary income.[233] Since then, the term "disability" has been commonly used in various laws and policy documents, ranging from social security benefits to antidiscrimination laws and healthcare policies.[234] While the concept of "disability" has outgrown its legal origins and is now a part of everyday discourse, it still lacks a universally accepted meaning.[235]

Drawing on these historical developments and the current state of affairs, my starting point is that disability is a socially constructed category. Broadly speaking, by saying that *X* is socially constructed, social constructionists are typically claiming that "*X* need not have existed, or need not be at all as it is. *X*, or *X* as it is at present, is not determined by the nature of things; it is not inevitable."[236] Applied to social categories, social constructivism suggests that certain features of persons, like gender, race, or disability, are descriptions that are at least partly determined by social practices and norms rather than natural properties.[237] Thus, in arguing that the concept of disability is socially constructed, I suggest that disability—as a category, a classification, or a kind of people—is not inevitable and it need not be as it is. The limits of "disability" as a property of people belonging to a specific

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233. Silver, *supra* note 232, at 24–25.

234. Disability can mean different things depending on the function the term is intended to serve. *Compare* 42 U.S.C. § 12102(1) (providing the definition of disability under the ADA), *with id.* § 416(i) (describing the determination of disability under the Social Security Act). Its meaning can differ depending on the jurisdiction in which it is adopted in connection with the same function. *E.g.*, LISA WADDINGTON & ANNA LAWSON, DISABILITY AND NON-DISCRIMINATION LAW IN THE EUROPEAN UNION: AN ANALYSIS OF DISABILITY DISCRIMINATION LAW WITHIN AND BEYOND THE EMPLOYMENT FIELD 18–24 (2009) (describing differences between European Union countries in defining disability under the Employment Equality Directive). The meaning of disability can also vary in the same context over time. *Compare International Classification of Impairments, Disabilities, and Handicaps*, WORLD HEALTH ORGANIZATION [WHO] (1980), https://iris.who.int/bitstream/handle/10665/41003/9241541261_eng.pdf [https://perma.cc/ES4D-ZEUT], *with International Classification of Functioning, Disability and Health*, WHO (2001), https://iris.who.int/bitstream/handle/10665/42407/9241545429.pdf?sequence=1 [https://perma.cc/RVA9-43ZL]; *compare* Americans with Disabilities Act of 1990, 42 U.S.C. § 12102(2) (2008), *with* ADA Amendments Act of 2008, 42 U.S.C. § 12102(4).

235. *See* Goldiner, *supra* note 56.

236. IAN HACKING, THE SOCIAL CONSTRUCTION OF WHAT? 6 (1999); *see also* Sally Haslanger, *Social Construction: The "Debunking" Project*, *in* SOCIALIZING METAPHYSICS: THE NATURE OF SOCIAL REALITY 301 (Frederick F. Schmitt ed., 2003) (drawing a distinction between causal social construction and constitutive social construction); E. Diaz-Leon, *What Is Social Construction?*, 23 EUR. J. PHIL. 1137 (2015) (arguing that the distinction between causal and constitutive social construction is the foundation for different types of political projects that arise from social constructivist theory; that some trait is not inevitable; that a certain trait is relational rather than intrinsic; and that a certain trait is not biologically real).

237. *See* HACKING, *supra* note 236, at 2.

group may shift independently of changes in natural properties of those classified as disabled.

In accepting that disability is socially constructed, I do not mean to suggest that disabled people's experiences are not real.[238] Nor do I suggest that these experiences do not have a significant impact on people's lives. For many people, being "disabled" is quite obviously a real experience—which I do not deny. The social construction thesis focuses on the designation of this real experience as a disability.

One could argue that disability is not socially constructed because in its core lies a natural property, namely impairment. Along these lines, Christopher Boorse famously argues that an impairment is a part of the body not performing its normal "species-typical" function.[239]

Conversely, many philosophers of disability and disability studies scholars criticize the naturalistic conception of impairment. Some claim that certain impairments are socially constructed in the sense that they are the consequences of people's actions, such as war or pollution, or social conditions, such as poverty.[240] Others claim that conditions classified as impairments are the result of social distinction concerning what constitutes "normal" functioning.[241]

Notwithstanding this ongoing debate concerning the nature of impairment, even if impairment is a natural property, it does not follow that *disability* is a natural property too. This is because the category of disability and the

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238. Ian Hacking, *The Looping Effects of Human Kinds*, *in* CAUSAL COGNITION: A MULTIDISCIPLINARY DEBATE 351, 366 (Dan Sperber et al. eds., 1996) (explaining that something can be "real" as well as "socially constructed," using the example of child abuse as real but also conceptually socially constructed in the sense that it develops and changes as a result of social classifications and knowledge). In these cases, "[n]either reality nor construction should be in question." *Id.*

239. Boorse developed his naturalistic account of "disease," which includes conditions that are commonly called "impairments," such as blindness and limb loss, based on the idea of value-free normal biological function in three articles. *See* Christopher Boorse, *On the Distinction Between Disease and Illness*, 5 PHIL. & PUB. AFFS. 49 (1975); Christopher Boorse, *Health as a Theoretical Concept*, 44 PHIL. SCI. 542 (1977); Christopher Boorse, *A Rebuttal on Health*, *in* WHAT IS DISEASE? 1 (J.M. Humber et al. eds., 1997).

240. *E.g.*, Paul Abberley, *The Concept of Oppression and the Development of a Social Theory of Disability*, 2 DISABILITY HANDICAP & SOC'Y 5 (1987).

241. LENNARD J. DAVIS, ENFORCING NORMALCY: DISABILITY, DEAFNESS, AND THE BODY (1995) (tracing the historical shift towards the valuation of normalcy in the nineteenth century); Ron Amundson, *Against Normal Function*, 31 STUD. HIST. & PHIL. BIOLOGICAL & BIOMED. SCIS. 33 (2000) (rejecting the idea of biological, value-free, normal function and instead arguing that assessments of "abnormal" derive not from biology, but rather from prejudice against certain forms of function); SIMI LINTON, CLAIMING DISABILITY: KNOWLEDGE AND IDENTITY 22–25 (1998); SUSAN WENDELL, THE REJECTED BODY: FEMINIST PHILOSOPHICAL REFLECTIONS ON DISABILITY 15–16 (1996).

category of impairments are not necessarily the same. Disability could be seen as the disadvantage imposed on people with impairments, as per the social model of disability, or indeed the kind of restriction on activity and social functioning that impairments cause.[242] Disability is thus not natural nor inevitable, even if impairment is a natural property. To illustrate, under the social model view, disability is determined by social practices that might disadvantage only *some* people with impairments, but not all. In the medical model, disability is determined by the extent to which impairment limits a person's ability to function and participate in society, which not all clinical pathologies do.

If disability is a socially constructed category, what are its limits and how should the law define it? The next Section outlines a response to the former question based on recent developments in social metaphysics,[243] and the Section that follows responds to the latter question by putting forth a novel account of disability applicable to antidiscrimination law.[244]

B. Conceptualizing Disability to Ameliorate Injustice

In a widely influential book, Elizabeth Barnes adopts an ameliorative approach in her theory of disability.[245] That is, she understands the project of conceptualizing disability as aiming to capture the legitimate purpose of dividing people into categories of disabled and non-disabled in order to promote social progress.[246]

According to Barnes, disability is a social category that people found useful when organizing themselves in a civil rights struggle to explain their shared experience of oppression and to work towards progress and social change.[247] To Barnes, disability is socially constructed from group solidarity, namely the process in which people with different experiences and bodies observed they had something in common, and organized themselves to promote justice for people with experiences and bodies that they judged to be importantly similar to their own.[248] Even though disabled people have very different bodies (and minds), their shared experiences made sense for them

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242. Goldiner, *supra* note 56 (describing different conceptions of disability that are distinctive from impairment).

243. *See infra* Section III.B.

244. *See infra* Section III.C.

245. ELIZABETH BARNES, THE MINORITY BODY: A THEORY OF DISABILITY (2016).

246. *Id.*

247. *Id.* at 41–42.

248. *Id.* at 44.

to think of themselves as being part of the same shared struggle, working together toward a common goal.[249]

Barnes's theory of disability as a minority group identity, therefore, postulates that "disability *just is* whatever the disability rights movement is promoting justice for."[250] Barnes emphasizes that the disability rights movement makes such judgments based on certain rules it adopts.[251] While she is less concerned with spelling out those rules, she explains that they need not pertain to types of physical conditions.[252] Rather, the relevance of the disability rights struggles to individuals' lives—namely efforts to promote accessibility, accommodations, acceptance, etc.—would determine whether they are indeed disabled.[253] In other words, something is a disability if it is "the kind of a thing that the disability rights movement is trying to make the world a better place to live with."[254]

Although Barnes explicitly limits her theory to physical disabilities,[255] her solidarity-based account is applicable to mental disabilities too. Mental disabilities, broadly construed as including psychological, developmental, and cognitive disabilities, are the kinds of conditions that give rise to shared experiences—including "being subject to social stigma and prejudice; being viewed as unusual or atypical; making ordinary daily tasks difficult or complicated; causing chronic pain; causing barriers to access of public spaces and employment; causing shame"—often requiring the use of medical care.[256]

Barnes's solidarity-based theory of disability is an invaluable contribution to the philosophical project of conceptualizing disability. In bringing a critical disability perspective into the philosophical debate, she refutes "common-sense" views of disability that rely on medical knowledge. She successfully brings to the fore people's experiential knowledge and defends their epistemic authority (e.g., regarding the impact of disability on well-being). In addition, by linking the delineation of disability with the demands of justice, Barnes reaffirms the link between the definition of disability and justice for disabled people.[257]

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249. *Id.* at 46.
250. *Id.* at 43.
251. *Id.* at 45–46.
252. *Id.* at 47.
253. *Id.*
254. *Id.* at 48.
255. *Id.* at 10.
256. *See id.* at 45.
257. For recent claims that the preoccupation with the definition of disability is not necessary for promoting justice for disabled people, see LINDA BARCLAY, DISABILITY WITH DIGNITY:

However, Barnes's account has at least one crucial disadvantage: her seemingly all-encompassing definition of disability.[258] Given the significant diversity of experiences associated with disability, why should the definition of disability be the same for all ends and purposes? Plausibly, injustice associated with disability differs depending on the context, be it participation in employment and public accommodations, welfare policies, access to justice, medical care and bioethics, or culture and disability pride. Accordingly, the delineation of disability under the ameliorative approach should also differ from one context to another.

Developing conceptions of disability for all ends and purposes and providing a rigorous defense of the pluralist ameliorative approach is beyond the scope of this Article. The next Section, however, takes a first step in this direction by exploring the ameliorative conceptualization of disability in the context of antidiscrimination law.

C. Conceptualizing Disability to Ameliorate Discrimination

Adopting an ameliorative approach to disability in the context of antidiscrimination law requires us to ask: what is the just purpose of categorizing people as disabled in the context of discrimination? Or, to put it even more broadly using Barnes's terminology: what is the thing that the disability rights movement is seeking justice for in promoting

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JUSTICE, HUMAN RIGHTS AND EQUAL STATUS 30 (2019); *see also* Jonas-Sébastien Beaudry, *Beyond (Models of) Disability?*, 41 J. MED. & PHIL. 210, 222–23 (2016). For a recent and more direct response to these claims, see Jesica Begon, DISABILITY THROUGH THE LENS OF JUSTICE 3 (2023) ("[W]e should understand disability as *the restriction in the ability to perform those tasks human beings are entitled to be able to perform as a matter of justice* (as the result of the interaction between an individual's impairment, their social, political, and material context, the resources they have access to, and their other internal characteristics).").

258. For other critiques concerning Barnes's theory, particularly challenging her deference to the disability rights movement in delimiting the category of disability, see Anita Silvers, *Philosophy and Disability: What Should Philosophy Do?*, 93 RES PHILOSOPHICA 843, 860 (2016), claiming that Barnes's deference to the disability rights movement could unjustly neglect people with bodies or minds that give rise to experiences that differ from their own; and David Wasserman, Book Review, 127 PHIL. REV. 251, 253 (2018) (reviewing BARNES, *supra* note 245), claiming that Barnes's theory provides little basis for objection against those rules, even if those rules are biased or arbitrary. Another critique of Barnes's account is that it flies in the face of key features of disability antidiscrimination law. *See* Leslie Francis, *Understanding Disability Civil Rights Non-Categorically: The Minority Body and the Americans with Disabilities Act*, 175 PHIL. STUD. 1135, 1135 (2018). It loses the force of the justification for antidiscrimination law, as we need not begin with an account of disability that the disability rights movement is seeking justice for, but rather with an account of the discrimination that a rights movement ought to seek to remedy. *Id.*

antidiscrimination norms? To answer this question, we must first have a clear grasp of the just aim of antidiscrimination law and the legitimate function of categorizing people into groups in this context.

Famously, there are different views on the aim of antidiscrimination law. For some, the justifying aim of antidiscrimination law is to secure people's freedom to pursue a good life by having access to basic goods of negative freedom, adequate range of valuable opportunities, and self-respect.[259] For others, antidiscrimination law aims to address the failure to treat people as equals on the basis of certain traits by subordinating them[260] or in other ways that prevent them from seeing themselves as and being seen as equal members of society.[261] For still others, antidiscrimination law has the just aim of promoting just relationships that manifest reciprocal respect based on the values of substantive equality and autonomy.[262]

Theorists also differ in how they view the legitimate purpose of dividing people into social groups in the context of antidiscrimination law.[263] For example, according to Kasper Lipper-Rasmussen, group membership is constitutive to the wrong of discrimination; discrimination *is* differential treatment against members of socially salient groups.[264] He explains that "a group is socially salient [when] perceived membership of it is important to the structure of social interactions across a wide range of social contexts."[265] To Lipper-Rasmussen, social salience is key to conceptualizing wrongful discrimination because differential treatment based on salient features has the

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259. *See* TARUNABH KHAITAN, A THEORY OF DISCRIMINATION LAW 92–112 (2015).

260. *See* DEBORAH HELLMAN, WHEN IS DISCRIMINATION WRONG? 29–31 (2008).

261. *See* SOPHIA MOREAU, FACES OF INEQUALITY: A THEORY OF WRONGFUL DISCRIMINATION 8–9 (2020).

262. *See* Hanoch Dagan & Avihay Dorfman, *The Tort of Discrimination*, 16 J. TORT L. 393, 404 (2023).

263. Notably, some theorists do not regard group membership as pivotal for understanding wrongful discrimination nor for understanding antidiscrimination law. *See, e.g.*, *id.* at 400, 408–09; Meital Pinto, *Arbitrariness as Discrimination*, 34 CAN. J.L. & JURIS. 391, 392 (2021) (arguing that arbitrary distinctions that are not based in group membership qualify as discrimination and should be protected against by antidiscrimination law). Dagan and Dorfman argue that discrimination violates the right not to have one's traits or constitutive choice turned into a transactional barrier, which derives from their underlying normative commitment to the maxim of reciprocal respect, and therefore is not limited to barriers based in membership to salient social groups. Dagan & Dorfman, *supra* note 262, at 400. Such approaches render redundant the categorization of people into social groups for the purpose of identifying and addressing wrongful discrimination, and accordingly call into question the legitimate aims of the categorization of people into groups to begin with. However, they offer a revised view of antidiscrimination law, which currently does not reflect legal text and related jurisprudence.

264. Kasper Lippert-Rasmussen, *The Badness of Discrimination*, 9 ETHICAL THEORY & MORAL PRAC. 167 (2006).

265. *Id.* at 169.

potential to cause serious harm to group members.[266] Similarly, according to Tarunab Khaitan, group disadvantage is key to antidiscrimination law because of the myriad ways in which relative group disadvantage affects the basic goods of people belonging to those groups.[267] In a slightly different vein, Sophia Moreau claims that group membership serves a heuristic function in identifying instances where wrongful discrimination is taking place, even if its wrongfulness is due to some other reasons.[268] Thus, for Moreau, membership to a particular social group plays a role in ascertaining whether one's treatment amounts to a failure to treat that person as an equal, which, according to her, is the core of wrongful discrimination.[269] For example, group membership allows us to evaluate whether a certain treatment reinforces the subordination of group members,[270] whether it requires individuals to have their group membership loom in front of their eyes when deliberating about their lives,[271] or whether a treatment would deny people from seeing themselves as equals or being seen as equals in a given society.[272]

In either view, the point of having social categories in the context of antidiscrimination law is to single out instances in which members of a certain social group are disadvantaged in a wide range of social contexts. Group membership is either constitutive to the wrongfulness of discrimination because, without it, a disadvantage is not disadvantaging enough, or because it serves to illuminate traits that are more likely to be used to disadvantage people.

An ameliorative account of social categories in the antidiscrimination context should serve the legitimate purpose of eliminating discrimination. It should therefore single out the features associated with a kind of disadvantage antidiscrimination law seeks to address. Depending on the view of wrongful discrimination one endorses, these are the features associated with subordinated social and political status, degrading and humiliating treatment, limited opportunities to exercise freedom and autonomy, and not being seen and treated as equals.

This understanding of the function of social categorization in the context of antidiscrimination law has far-reaching implications for the

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266. *Id.*; *see also* HELLMAN, *supra* note 260, at 21–22 (focusing on groups with a history of social disadvantage).

267. KHAITAN, *supra* note 259, at 91–92; *see also* HELLMAN, *supra* note 260, at 33 (asserting that drawing distinctions among groups demeans and can affect basic goods).

268. MOREAU, *supra* note 261, at 109–10.

269. *See id.*

270. *Id.* at 40–41.

271. *Id.* at 84–86.

272. *Id.* at 124–26.

conceptualization of disability. In what follows, I offer three key insights on the conceptualization of disability to ameliorative discrimination. However, these insights are not exhaustive, and so I leave the further theoretical development to a later stage.

Firstly, given that the legitimate function of dividing people into groups in the context of antidiscrimination law is to address some disadvantaging and unjust social treatment, disability does not need to involve a pathology. As Dana Howard and Sean Aas persuasively argue, it is plausible and consistent with the goals of the disability rights movement that *disability* includes bodily or psychological states that are perceived or "represented" as impairments, namely as dysfunctional bodily states that limit some major life activity, even if not pathological per se, and which explain people's subjection to continuous social disadvantage.[273] Their view of impairment is particularly fitting in the context of antidiscrimination law, whereby a *social perception* of one as impaired is the marker of social categorization that often leads to adverse treatment.

Secondly, the legitimate function of categorizing people into groups for the purpose of remedying discrimination does not lend support to the view that only people whose impairments substantially limit a major life activity should qualify as disabled in this context. As discussed earlier, requiring a causal link between people's impairments and their limitation in life activities rests on a medical model of disability, according to which disability is an impairment that limits functionality and social participation.[274] Such delineation serves no legitimate purpose if, as argued previously, the categorization of people into social groups in the context of antidiscrimination law is designed to track the manner in which society disadvantages certain people relative to others on the basis of certain traits. What matters for the purpose of antidiscrimination law is not whether impairments are pathological or cause functional limitations. What matters is whether people's features are perceived as limiting and thus lead to disadvantaging treatment and social exclusion in a wide range of social interactions.

Finally, given the purpose of antidiscrimination law, people who previously had impairments or are only regarded as having an impairment

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273. Dana Howard & Sean Aas, *On Valuing Impairment*, 175 PHIL. STUD. 1113 (2018). Another example of disability without pathology is found in a very different view according to which one is disabled if one is in a "harmed condition" that renders one worse off, even if that condition is not pathological. John Harris, *One Principle and Three Fallacies of Disability Studies*, 27 J. MED. ETHICS 383, 384 (2001).

274. *See supra* notes 60, 226 and accompanying text.

should qualify as disabled under antidiscrimination law. As Boorse observed, the three-prong definition is textually confusing and implies that some disabled people have no impairments at all.[275] But an ameliorative approach to disability can explain this conundrum. If the just aim of antidiscrimination law is to address the disadvantage people experience on the grounds of their perceived membership to some social group (e.g., by being made cognizant of others' views about perceived features associated with group membership when deliberating their options), actually having the feature attributed to a protected group is not a necessary condition for being part of one. What matters for social categorization in this domain is that people are subject to the same kind of social disadvantage, either because of who they are or because of how society perceives them to be.

Taken together, and given the ameliorative purpose of distinguishing between disabled and nondisabled people in the context of antidiscrimination law, disability should be understood broadly along the following lines. A person should be deemed disabled in this context if that person has a feature that society generally views as an impairment, that is, a feature of the body or mind that society views as a clinical pathology that limits that person's capacities, *and* that feature or perception thereof is associated with socially caused disadvantage in a wide range of domains.

D. Addiction as a Disability

Accepting my insights regarding the conceptualization of disability in the antidiscrimination law context opens up the path to recognizing that addiction is a disability within the meaning of the ADA, and in turn surmounting related challenges that plaintiffs are facing in qualifying as disabled. The first two insights—that impairment need not be pathological nor substantially limiting to qualify as a disability—are key in this regard. A person qualifies as disabled when their features are socially regarded as limiting impairments *and* give rise to disadvantaging social treatment in a wide range of domains. To conclude this Part, I now demonstrate that addiction is a disability along these lines, echoing my previous discussion of the nature of addiction and the ADA case law involving people with addiction.

Addiction meets the first condition of my proposed conception of disability because it is represented as a limiting impairment in our society. As evidenced by the strong entrenchment of the orthodox conception, addiction is widely seen as a brain disorder, a behavioral disorder, or a psychological

275. Boorse, *supra* note 32, at 71–73.

disorder. In particular, addiction is regarded as limiting people's capacities, primarily the capacity to make good and reliable choices, which in turn generates a significant disadvantage for addicts in a wide range of domains. Therefore, even if addiction is not a clinical condition or, indeed, a disease, the fact that it is socially represented as an impairment is enough to satisfy the first condition of qualifying as a disability.[276]

Crucially, accepting that addiction is *seen* as an impairment does not concede to the view that addiction is a compulsive use disorder, as the orthodox conception suggests. Instead, this view sidelines the debate concerning the designation of addiction as a clinical pathology, at least in the context of antidiscrimination law. In practice, keeping this debate at bay, would allow potential plaintiffs who use drugs or alcohol continuously to surmount challenges in qualifying as disabled due to insufficient medical evidence to prove their pathology. As long as a condition of continuous use despite negative consequences is seen in our society as an impairment, they would qualify as disabled for the purpose of antidiscrimination law.

Second, addiction qualifies as a disability because having an addiction is typically associated with social exclusion and disadvantage for addicts in a wide range of domains. As demonstrated in the case law, these disadvantages are prominent in employment practices, but they are also prominent in access to healthcare, in public spaces, and in the criminal justice system. On this proposed view, it makes little difference whether this disadvantage emanates from the social response to continuous use (past, present, or perceived) or to people's reduced capacity to function due to substance use. An impairment need not actually limit a major life activity to qualify as a disability on this view. This facilitates the extension of ADA coverage to "functioning" addicts.

IV. CONCLUSION

Against the backdrop of the growing opioid epidemic and attempts by legal scholars and practitioners to utilize the ADA to address this social crisis, this Article showed that the ADA is limited in its ability to protect people with addiction. This is due to specific provisions within the Act that limit ADA's protection to people with addiction and people using drugs.

This Article demonstrated that the conceptualization of addiction as a clinical condition characterized by compulsive use leads to a broad interpretation of the these provisions and thus excludes addicts from ADA

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276. *See infra* Section II.A.

protection. By contrast, a multifactorial view of addiction that recognizes addicts' ability to make choices vis-à-vis continuous usage is not only more realistic but could extend ADA coverage to addicts. If addicts retain the ability to choose, the social response to addiction should include various mechanisms to incentivize addicts to forgo use. The law has a key role to play in structuring such mechanisms where possible by extending ADA protection.

However, adopting the multifactorial conception of addiction brings back an old challenge facing people with addiction in qualifying as people with a disability. To address this tension, this Article took first steps in developing a novel conception of disability, which emanates from the legitimate purpose of categorizing people as disabled within the context of antidiscrimination law. Concretely, this view of disability allows for conditions that are not pathological to qualify as disabilities for the purpose of antidiscrimination law, as long as they are generally represented by society as impairments and when people having those features are associated with socially caused disadvantage in a wide range of contexts.

With regards to addiction, this Article argued that addiction qualifies as a disability in this new conception, even if it is not a clinical condition. This is because addiction is represented as an impairment in our society, and it is associated with a disadvantage in a wide range of social interactions due to entrenched views about limited capacities and risks that addicts pose to themselves and to those around them.

Looking forward, more work is needed to explore the implications beyond antidiscrimination law of endorsing the multifactorial view of addiction in lieu of the orthodox view. More broadly, it is my hope that the insights regarding the concept of disability developed herein will assist in other hard cases of discerning whether one qualifies as disabled.