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Pharmaceutical Prosthesis and White Racial Rescue in the Prescription Opioid "Epidemic"

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Introduction

A U.S. public discourse of addiction as a disabling psychiatric condition (as opposed to a moral flaw or social deviancy) was codified into Social Security policy in 1972, following its emergence in post-war clinical science and popular media (Conrad & Schneider, 1980; Duster, 1970). In recent years, this discourse has taken divergent forms in policy and media debates surrounding black and brown urban heroin users on one hand, and white suburban and rural prescription opioid users on the other. In both populations, efforts to decriminalize addiction led treatment advocates to rebrand it a disabling "chronic brain disease." Whites, however, are imagined as in need of rescue within the gentle discipline of private medical offices, while brown and black heroin users are seen as in need of public discipline within federally-regulated methadone programs and/or the criminal justice system. Whether white, black, or brown, the U.S. social imaginary associates urban heroin use with violence and welfare dependency, inspiring public fear.

To quell the potential public dangers associated with heroin users, U.S. policies support what I am calling "pharmaceutical containment," with adherence to multiple, sedating psychotropic medications a requirement to qualify for Social Security benefits. For white prescription opioid users, federal and state legislatures, pharmaceutical manufacturers, and community physicians have conjointly developed a new apparatus of private office opioid maintenance designed to rescue youth from "wasting their whiteness," in line with a trope of white drug use as a tragedy of wasted potential as documented by analyses of popular media (Daniels, 2012). This apparatus of private clinical care endows them with "pharmaceutical citizenship" through which they have access to psychotropics that "bring the patient back into (middle-class consumer) society" (Ecks, 2005). Opioid maintenance acts as a kind of pharmaceutical prosthesis which promises to return white "addicts" to regaining their status as full human persons and middle-class consumers. Meanwhile, black and brown users are not deemed as persons to be rescued, but rather dangerous subjects to be pharmaceutically *contained* within the public discipline of the state. These contrasts make visible the

convergence of biological and political vulnerabilities in the efforts of middle-class whites to reproduce their privilege; that is, to stay in mid- to upper-level service industry jobs and stave off public benefits. U.S. middle-class whites face a crisis of social reproduction in the face of a volatile, globalized service economy that is exporting jobs, as well as growing individual debt and credit financing with increasing rates of foreclosure and bankruptcy. In this setting, exclusive, patented pharmaceuticals serve as a commoditized racial rescue agent in the epoch of disaster capitalism. [i]

Below I describe the political context for racially-contrasting biomedical responses to opioid addiction, based on my interviews with policy makers, pharmaceutical executives, addictions researchers, maintenance opioid prescribers, and patients. I also trace the impact of these responses on two opioid maintenance patients I have followed over four years of participant observation in public clinics and private practices in New York City: Ruben, a Puerto Rican whose Social Security benefits require him to take multiple psychotropic medications, and Jonathan, a white college student whose opioid maintenance allows him to complete his degree and plan a career.

“Opiate Receptor Deficiency” Take One: The War on Poverty and on Drugs

State-sponsored opioid maintenance in the U.S. can be traced at least as far back as 1966, when Rockefeller University scientists published findings from their first clinical trial of methadone maintenance for heroin-addicted patients (Dole, Nyswander & Kreek, 1966). The paper was notable for its subject population, primarily African-American heroin injectors from Harlem, and its reported outcomes, which were not only clinical but also social: it reported not only optimal methadone doses and rates of relapse to heroin use, but also decreases in crime rates in the course of treatment. Dole, the lead author, was a metabolism researcher who conceived of heroin dependence as a metabolic disease—a chronic physiological condition that required pharmaceutical intervention. He compared heroin withdrawal to a diabetic’s need for insulin, concluding that heroin use permanently reduced opiate receptors in the brain, and therefore that heroin users required opioid medication maintenance to prevent withdrawal and cravings.

Politicians were searching for a response to a perceived heroin crisis in black center cities in the era of race riots that neither advocated social change nor relied on law enforcement. Methadone maintenance allowed figures such as New York City Mayor Lindsey to propose a clinical intervention for otherwise seemingly intractable social problems in racially-segregated zones of high unemployment and unrest (Hansen &

Roberts, 2012). By 1971, President Nixon, faced with public fears surrounding race riots as well as heroin-addicted returning Vietnam veterans, declared the nation's "War on Drugs" and appointed psychiatrist Jerome Jaffe his first Drug Czar. Jaffe, who had implemented among the first experimental methadone maintenance programs in New York and Chicago, made methadone the primary weapon in the War on Drugs, and established the network of Drug Enforcement Administration-regulated clinics that we know today (Musto, 1987).

In the decades that followed, the number of methadone clinics grew, concentrated in low-income black and Latino neighborhoods. Medicaid and public hospitals provide major funding for methadone. For instance, New York City subsidized methadone in the 1980s as a response to the HIV crisis, and in the 1990s under Mayor Rudolf Guiliani (Stopthedrugwar.com, 1999), reportedly because a major campaign contributor had a son who was on methadone. [ii]

In this very period of the ascendance of methadone maintenance for heroin addiction—from 1972 to 1996—federal law made disability caused by drug and alcohol addiction eligible for Social Security benefits. The 1970s had seen liberalization of public attitudes toward addiction, and toward public entitlement programs, which led Congress to allow Social Security payments for applicants with alcoholism or drug addiction as a primary disabling diagnosis (Hunt & Baumohl, 2003). By 1996, the Ronald Reagan and post-Reagan discourse of "personal accountability" led to a reversal of this law. In 1994, in the midst of mounting media coverage of welfare abuses and pressure on Congress to cut entitlement programs, *Dateline* and *60 Minutes* aired exposes of overdose deaths from drugs purchased with Social Security checks. Reporters claimed that "the Social Security Department is the largest supplier of drug and alcohol to addicts in America" and that the Social Security Administration's Drug Addiction and Alcoholism program is "a misguided enabler of addiction" (Hunt & Baumohl, 2003:39).

1996 was a watershed year for U.S. social policy: the federal government abruptly discontinued Social Security beneficiaries who had qualified with an alcoholism or drug dependence diagnosis, and the new Personal Responsibility and Work Opportunity Reconciliation Act imposed five-year lifetime limits on welfare eligibility across the board. This meant a sea change for low-income Americans whose families and neighborhoods had subsisted on SSI and welfare payments. Caseloads shifted as alcohol and drug dependent Social Security beneficiaries either got recertified under another psychiatric diagnosis or lost disability benefits, and as masses of people formerly on welfare applied for Social Security under a psychiatric diagnosis. As a result, Social Security rolls increased four fold between 1996-98 with young adults representing the fastest growing group (Jans,

Stoddard & Kraus, 2004; Wiseman & Wamhoff, 2005/2006; Lakdawalla, Bhattacharya & Goldman, 2004), with the largest single area of growth in mental and psychiatric disorders (Drake, Skinner, Bond & Goldman, 2009).

This growth created a virtual industry of Social Security qualification, replete with a new class of “neurocrats” who evaluate the veracity of psychiatric claims (Knight, 2015), including state-funded case managers trained to coach clients off of state welfare rolls onto the federally-funded SSI program to save the state funds, and private lawyers who demand as much as 25% of awarded monthly Social Security checks (Hansen, Bourgois & Drucker, 2014). Qualifying and recertifying for Social Security payments on the basis of psychiatric disability requires clinical assessments and medical records that demonstrate functional impairment from mental illness. Social Security applicants are advised to stay on high-dose antipsychotics and mood stabilizers as evidence of severe, disabling symptoms, despite their side effects, in order to strengthen their case for disability benefits.

As a result, maintenance medications, such as antipsychotics and mood stabilizers combined with methadone, and Social Security payments based on co-occurring psychiatric disorders, enable low-income, opioid addicted people to survive, but also marginalize them socially and economically. The multiple, sedating psychotropic regimens of SSI beneficiaries contrast with those of middle-class opioid dependent people, whose doctors limit medications with side effects that interfere with function at school and work.

Ruben’s story makes the landscape of Social Security disability payments and medical maintenance visible. Ruben is Puerto Rican, born in the Lower East Side projects of Manhattan and the oldest of twelve children. He is the son of a Korean War veteran who returned home with one arm, and with a morphine-cum-heroin habit that Ruben discovered in high school, when he accidentally walked in on his father’s war buddy injecting his father’s remaining arm.

Ruben’s father died of AIDS and his mother of alcohol-related organ failure a few years later. Ruben had moved out, determined to become a tax-paying, substance-free citizen. Eventually, however, while driving Access-a-Ride vans for seniors and disabled children, Ruben’s boss introduced him to heroin. He later discovered his boss was making a sizeable side income providing free heroin samples to his employees and later, as they needed larger quantities over time, charging them for heroin by docking their pay.

Ruben violently confronted his boss, left his job, became homeless, and

ended up at Bellevue's methadone program. There, his psychiatrist helped him qualify for Supplemental Security Income (SSI) based on his unpredictable angry explosions, for which he got a bipolar disorder diagnosis. SSI checks allowed him to pay his rent in an unofficial three-quarter house; he signed over $500 per month from his Social Security check for a closet-sized room and a shared bath with eighteen other men in a run down walkup on a notoriously dangerous strip in Brownsville, Brooklyn. Social Security also made him eligible for Medicaid coverage, which paid for his methadone and psychiatric treatment.

Ruben's substance abuse clinic introduced him to art therapy. Over the subsequent three years he spent hours every day in the clinic's studio. He eventually joined an "outsider art" movement in the city and began identifying himself as an artist. Emboldened by the fact that his art was being successfully displayed and sold in galleries, he called his estranged brother and sister and arranged to meet them at his sister's house. On arrival, his sister, who over the years had referred to Ruben as "crazy" and "the addict" (despite her own history of crack cocaine use), waved away Ruben's printed invitation to a gallery show of his work, saying, "You still on heroin?" Ruben left her house, thankful that he had not told her about his bipolar diagnosis and vowing never to return.

In Ruben's mind, working for pay and living independently would make him an adult, a citizen, someone who could answer to his sister. Ironically, it was Ruben's effort to enter the licit service economy, as an Access-a-Ride driver, that led Ruben to heroin. With a psychiatric disability, he became eligible for housing and art therapy. Without it, Ruben most likely would have ended up on the default route of addicted working class Puerto Ricans: prison.

"Opiate Receptor Deficiency" Take Two: The War Against Waste of Whiteness

Ironically, 1996, the year that the federal government excluded addiction as the basis for SSI eligibility, and the year that welfare reform instituted time limits on benefits, was the same year that Purdue Pharmaceuticals marketed Oxycontin as a "minimally addictive pain reliever" in suburban and rural America, sewing the seeds for a separate, white opioid epidemic driven by privatized, industry-led initiatives.

On the basis of new sustained release capsule technology, and a three-month clinical trial in terminal cancer patients, Purdue Pharmaceuticals gained FDA approval for Oxycontin as a synthetic opiate (opioid) suitable for management of moderate, chronic pain with only a "one percent risk" of addiction. In the first three years that Oxycontin was on the market, Purdue hosted 5,000 physicians, nurses, and pharmacists

at all-expenses-paid luxury resort trainings on pain management, and hired 671 drug representatives to visit community, generalist doctors who, based on the company's claims of safety and low risk of addiction, prescribed Oxycontin for a wide range of complaints not previously treated with opioids, such as chronic lower back pain (Van Zee, 2009). The number of prescriptions of opioids for non-cancer related pain increased ten fold in the first eight years that Oxycontin was on the market, and by 2010 prescription opioids generated over $11 billion in annual revenue in the U.S. alone (Eban, 2011). Many consumers learned to crack open the patented time release capsule and snort or inject its contents, which delivered an opioid rush that was twice as potent as that of heroin: states such as Maine and Kentucky reported 400-500% increases in the numbers of patients seeking treatment for opioid dependence, and Virginia reported an 860% increase in opioid overdose deaths, most of them Oxycontin related (Van Zee, 2009).

These suburban and rural white prescription opioid users appear to be transitioning to heroin as tamper-resistant opioid formulations and new prescription monitoring laws are making prescription opioids harder to get and harder to inject or snort; nationwide heroin use is on the rise (SAMHSA News Release, 2013), and heroin poisoning deaths in New York City increased in 2014 after a long negative trend, with the largest increase in largely white and suburban Staten Island. Of heroin users surveyed, 80% had used opioid analgesics first, compared to one percent who used heroin before opioid analgesics (NYC DOHMH, 2014). Media coverage of whites as the "new face of heroin" reported this trend (ABC News, 2010, Carroll, 2014) which was followed by calls for a "gentler war on drugs" (Seelye, 2015).

Few arrests occurred in response to the white opioid crisis, and, in fact, even more opioids were sold. Among them were tamper-resistant formulations of Oxycontin itself, FDA approved in 2010 (FDA, 2010), just as the patent on the original extended-release formulation of Oxycontin expired. Another was a new opioid for maintenance treatment of addiction: buprenorphine, commercially known as Suboxone®. Pharmacologically similar in action to methadone, federal law was changed to legalize the prescription of Suboxone in private, general physicians' offices, reversing the prohibition on generalist physician prescribing of narcotics to treat narcotic addiction that was established by the 1914 Harrison Act. The law, DATA 2000 (SAMHSA, 2015), provided an exception for buprenorphine, which the FDA approved in 2002 for office-based prescription. Congressional debates surrounding the law explicitly referenced the need for an alternative treatment for suburban opioid-dependent youth for whom methadone was "not appropriate" (Netherland, 2010).

The DEA collaborated with buprenorphine's manufacturer, Reckitt

Benckiser Pharmaceuticals, to develop an eight-hour training course for physicians to receive certification to prescribe buprenorphine. Overburdened, salary-based safety net clinic doctors had no incentive to get certified. Instead, private practice doctors sought certification and, in New York City, charge $1,000 or more for initial half-hour buprenorphine visits with patients who are privately insured or able to pay out of pocket.

The first and last nationally representative study of buprenorphine patients in the U.S. reported that 91% were white, and over half college educated and employed at baseline, in direct contrast to methadone patients, of whom less than half were white, and only 17% employed (Stanton, 2006), a pattern that has persisted (Hansen et al., 2013).

These market forces worked in tandem with media and community movements in support of white opioid exceptionalism that sheltered suburban and rural users from Drug War reasoning. Drawing on an emergent concept of addiction as “chronic relapsing brain disease” requiring pharmaceutical treatment, they cultivated a geographically distinct (suburban and rural) network of community physicians providing buprenorphine maintenance, designed to maintain their function and membership in the broader community by mainstreaming their treatment in primary care clinics.

To examine the logic of disability among middle-class whites, I offer the narrative of Jonathan, a white man in his twenties living with his parents in a suburban Queens neighborhood. Jonathan’s father is unable to work due to a severely debilitating chronic condition for which he was prescribed opioids, opioids that Jonathan stole and took with friends. Jonathan’s pill and heroin use led his parents to bring him to the same public clinic that Ruben attends, where he also participates in art therapy groups. Unlike Ruben, who accepts that he will probably be on Social Security Disability payments for the rest of his life, Jonathan’s preoccupation, and that of his psychiatrist, who prescribes him buprenorphine and antidepressants, is to help him to take a developmental step from his youthful heroin use and mood swings into adult responsibilities and independence. Group therapy, especially art therapy, has been a way to wrest Jonathan away from his high school friends, who get high in their parents’ basements. In art therapy, Jonathan discovered his love for the video camera, and on his therapist’s advice, he enrolled in City College to study film production. His doctor never suggested that he apply for Social Security: rather, he framed Jonathan’s “chronic relapsing brain disease” as one to be medically managed to allow him to finish college and find competitive work.

On good days, Jonathan attends college classes and works part time in a department store, imagining that a future film production internship will

land him artistically satisfying jobs. On bad days, Jonathan's depression and nihilistic thoughts about never earning enough to move out of his parents' apartment lead him to relapse. His vulnerability was recently brought home by the overdose death of a long-term friend who had been progressing in job training, but decided to become "drug free" and wean himself off of opioid maintenance treatment before he died. Tears welled in Jonathan's eyes when he learned of his friend's death: "He hadn't called me for a long time. I guess he didn't want me to know he wasn't doing well. When I did see him he looked skinny; he was probably already back to using."

The problem that Jonathan, his family, and the white middle class face is one of social reproduction in an economy that may no longer afford them the insulation of white privilege that it did in the post-war years of industrial growth. New York City, like much of the U.S., has experienced cycles of expansion and contraction in the face of illusory, venture capital investments, globalized labor pools, and mortgage bubbles that have displaced middle managers and small business owners, creating subjectivities of personal insecurity and questioning of self-worth even among middle-class whites (Newman, 1999).

In this sense, and in the face of such white precariousness, opioid manufacturers such as Purdue Pharmaceuticals and Reckitt Benckiser could be seen to practice a form of disaster capitalism in the sense described by Naomi Klein (2007). Non-medical (or supra-medical) opioids, and eventually opioid maintenance treatments once opioid use becomes dependence, are commodified as tools for the white middle class to face the uncertainties of economic implosion and political impotence.

What is new in this current white opioid crisis? Its confluence with a broader industry of maintenance medication for chronic disease. As Joe Dumit (2012) writes in *Drugs for Life*, the current strategy for growing consumer markets is to change the reference ranges for tests indicating normal, at risk, and diseased states, and to treat risk of disease rather than only diseased states themselves. In the case of white opioids, prior non-medical opioid use is now a lifetime risk factor for future opioid addiction; large numbers of suburban whites meet criteria for buprenorphine maintenance treatment. Following Purdue's posting of $3 billion annually in U.S. Oxycontin sales, Reckitt Benckiser posted $1.5 billion in U.S. annual sales of buprenorphine/suboxone in 2013 alone (Drugs.com, 2014).

Implicit in Dumit's argument that chronic disease is what is marketed and sold among middle-class Americans is the idea that maximizing health and the biological self will ward off risk and uncertain futures (Rabinow & Rose, 2006; Rose, 2007). Buprenorphine works as *pharmaceutical prosthesis*,

prescribed to keep the white middle class in their privileged position as managers and consumers in the service economy and to ward off the vagaries of physical and existential pain, as well as addiction. As prosthesis, however, this pharmaceutically bolstered social position carries uncanny reminders of what is missing: a "recognition that the world can be undone" (Cohen, 2012:18). Like a phantom limb, the former security of race and class dominance is not really there. And unlike the cholesterol, hypertension, and depression drugs of Dumit's marketers, white narcotics require ongoing distinction from regimes of black and brown narcotic control, a delicate balance with its costs. In the logic of the Greek *pharmakon*, opioids are both poison and cure in American racial politics; the symbolic and political apparatuses needed to sustain white narcotic privilege also create blind spots and prey on white vulnerabilities in the narrow therapeutic index of these psychoactive substances.

Notes

[i] This term refers to Naomi Klein's (2007) documentation of privatization in the wake of man-made and natural disasters. In this case, the socioeconomic pain and anxiety of displaced and vulnerable middle-class whites has been transformed into market opportunities by opioid manufacturers, as detailed below.

[ii] Dr. Robert Maslansky, former director of Bellevue Hospital's methadone clinic, personal communication, March 11, 2011.

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