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## At the Expense of a Life: Race, Class, and the Meaning of Buprenorphine in Pharmaceuticalized “Care”

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### Abstract

**Background/Objective**—Office-based buprenorphine maintenance has been legalized and promoted as a treatment approach that not only expands access to care, but also reduces the stigma of addiction treatment by placing it in a mainstream clinical setting. At the same time, there are differences in buprenorphine treatment utilization by race, ethnicity, and socioeconomic status.

**Methods**—This article draws on qualitative data from interviews with 77 diverse patients receiving buprenorphine in a primary care clinic and two outpatient substance dependence clinics to examine differences in patients’ experiences of stigma in relation their need for psychosocial supports and services.

**Results**—Management of stigma and perception of social needs varied significantly by ethnicity, race and SES, with white educated patients best able to capitalize on the medical focus and confidentiality of office-based buprenorphine, given that they have other sources of support outside of the clinic, and Black or Latino/a low income patients experiencing office-based buprenorphine treatment as isolating.

**Conclusion**—Drawing on Agamben’s theory of “bare life,” and on the theory of intersectionality, the article argues that without attention to the multiple oppressions and survival needs of addiction patients who are further stigmatized by race and class, buprenorphine treatment can become a form of clinical abandonment.

### Keywords

Medication assisted treatment; addiction; race; socioeconomic status; intersectionality; multiple oppressions; structural violence; stigma

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#### Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

## Introduction

The 2002 FDA approval of buprenorphine, commercially known as Suboxone<sup>®</sup>, for office-based treatment of opioid dependence, was a sea change in addiction medicine. It made buprenorphine the first opioid medication in the U.S. since the 1914 Harrison Act that could be used for maintenance treatment of opioid addiction in general doctors' offices. Buprenorphine has comparable effectiveness to methadone in treating opioid addiction (Mattick, Breen, Kimber, & Davoli, 2013), and buprenorphine maintenance treatment (BMT) in primary care and generalist physician office-based settings has characteristics that make it particularly effective in the U.S. public clinic sector. These characteristics include: (1) enhanced accessibility due to multiple venues for treatment, (2) flexible dosing schedules that require less institutional oversight than methadone, (3) demonstrated effectiveness among populations that heavily rely on public healthcare systems, such as the formerly incarcerated and the homeless (Lee et al., 2012), (4) the potential to treat co-morbid chronic conditions prevalent among opiate dependent people such as HIV, and (5) the potential to lessen the stigma of drug dependency among low income patients and ethnic minorities who already experience other forms of social stigmatization. Reducing stigma has been an oft cited rationale for moving BMT into the general medical office setting, a setting that enables patients to receive addiction treatment undetected, alongside patients treated for physical ailments (Duncan, Mendoza, & Hansen, 2015).

The benefits of BMT have been unevenly distributed, however. The most complete nationally representative study of buprenorphine patients found 91% were white, the majority had some college education, were employed at baseline, and sought treatment primarily for prescription opioid dependence (Stanton, McLeod, Luckey, Kissin, & Sonnefeld, 2006; Magura et al., 2007). Most buprenorphine patients are treated in private physician practices (Roman, Ducharme, & Knudsen, 2006; Fiellin, 2007; Barry et al., 2010; Stanton et al., 2006; Magura et al., 2007) and pay out-of-pocket (Kissin, McLeod, Sonnefeld, & Staton, 2006) or are privately insured (Andrews, D'Aunno, Pollack, & Friedmann, 2014). Studies mapping buprenorphine prescriptions in New York City, the U.S. city with the largest opiate dependent population, confirm higher prescription rates in high-income residential areas with low percentages of Black and Latino/a residents (Hansen et al., 2013; Hansen et al., 2016).

Treatment rate disparities have been fuelled by buprenorphine marketing that has focused on the private sector, regulations and certification requirements that impede its implementation in the public sector (Hansen & Netherland, 2016), and by clinicians' perception that office-based buprenorphine treatment is most appropriate for employed, "stable" patients, (Casadonte, Kolodner, Horton, & McMurphy, 2004; Larance et al., 2014). Like clinicians, upon passing legislation that legalized office-based buprenorphine, the DATA 2000 bill, Congressional lawmakers responded to testimony that office-based buprenorphine is more suitable for "suburban youth" (implicitly white patients) than methadone. They have also affirmed that the setting of general medicine clinics is more appropriate for private patients that presumably do not need the social services and mental health interventions provided in the public sector, nor the social control that is provided in highly regimented methadone programs (Hansen & Netherland, 2016).

These assumptions have scarcely been examined in comparisons of middle and low income, White, Black, or Latino/a buprenorphine patients, and little attention has been given to patients' experiences of stigma, secrecy, surveillance, and social control when maintained on buprenorphine. This raises questions about the differential experiences of patients from middle- as compared to low-income backgrounds that may be referred to BMT from different sources (such as colleagues and personal doctors, versus social services and the criminal justice system) while living under disparate social conditions. How do they experience agency in their buprenorphine treatment, and what are their institutional and social supports while in treatment? How does stigma operate in different populations, especially those who have multiple, mutually reinforcing stigmas related to race, income, and legal histories?

### State of exception, bare life, and structural intersectionality

Our research draws on the theoretical framework of philosopher Giorgio Agamben (Agamben, 1998). Agamben's work examines the impact of the State (government) on individual life and freedom, by introducing three key concepts: the state of exception, bare life, and qualified life. Agamben describes the state of exception as arising during a time of crisis, in which the State extends the law into spaces that were not traditionally political. For example, the rise of opioid deaths across the country created what the CDC reported as an epidemic, resulting in increased support for the instatement of BMT as an alternative to incarceration for drug offenders. Diversion from incarceration through BMT often times extends primarily to those who can access it, and creates a social stratification in treatment versus incarceration because of insurance barriers and implicit bias in drug courts. This can result in some getting treatment in the medical institution like primary care rather than the criminal justice system, and therefore creates treatment bias based on the mode of access to BMT. Agamben would argue that this intervention in treatment would occur during a state of exception whereby people fall into two categories, *bare life* and *qualified life*. To have a bare life is to reduce a person life down to their basic physiological existence, in which the state can choose to end or preserve a person's life with impunity. The other, qualified life, is an acknowledgement and recognition of individual rights and personhood even during the state of exception. Thus, the state of exception therefore disenfranchises some while honoring others.

Sociologist of stigma Erving Goffman's (1963) concept of *impression management* complements Agamben's view of differential citizenship. Impression management involves the process by which a person regulates information that they share about themselves in a given setting and situational context. In this article, we use impression management to examine the ways patients with multiple oppressions manage their stigma when their stigmatizing characteristic (of addiction) is rendered visible or invisible in some treatment settings.

Given the degree to which bare versus qualified life, and impression management among people in treatment for addiction relate to identity and identity politics, we interweave critical race theorist Kimberlé Crenshaw's structural intersectionality (Crenshaw, 1991) to conceptualize the role of marginalized identities and addiction stigma in the novel setting of

office-based buprenorphine. Structural intersectionality is the reproduction of subordination of those with marginalized identities within institutions/structures that, on the surface, appear designed to be helpful, where intersectionality refers to multiple oppressed identities, such as patients of color who face discrimination on the basis of, for example, race, gender, and class, in addition to the stigma of addiction.

As some point out, it is important to take into account the impact of BMT on patients who are the most socially displaced, as the insights gained stand to strengthen the treatment model as a whole. In the process, we ask, how is office-based BMT experienced differently by people in different social locations within social hierarchies, and of different racial, ethnic, and class identities? What is the relative importance of psychosocial services and of mechanisms of social control and discipline in these actors' management of addicted identities, and in their experience of themselves as citizens? Are they experiencing qualified lives, or bare lives? To address these questions, we interviewed patients with a range of statuses relative to race, ethnicity, gender, education, income and housing status, who received BMT in either primary care settings or intensive substance dependence clinics.

## Methods

Our data is derived from a larger study of the differences in patient's experiences of stigma and of social support based on their treatment settings (primary care versus outpatient substance dependence clinics), in two public hospitals in New York City. This study deliberately sampled from these two settings in order to compare participants' responses in terms of their race, ethnicity, and markers of socioeconomic status such as education, employment and housing status. The primary care clinic from which participants were recruited was known to have a higher percentage of white, college educated, employed, and housed patients than the two participating substance dependence clinics. Primary care based buprenorphine was a new treatment venue that more educated patients specifically requested when looking for treatment. Patients enrolled in primary care also had more information about what primary care BMT comprised of, usually citing news reports and internet sources. Substance dependence clinic patients were more likely to have been referred to treatment from the emergency room or by court mandates, and those who received BMT in the substance dependence clinics learned about buprenorphine only after entering treatment, from their providers. The larger study employed both open-ended qualitative interview questions about participants' perceptions of stigma and the social context of participants, and quantitative scales measuring dimensions of stigma including secrecy and shame.

Recruitment was done primarily at a teaching and research hospital where patients were solicited through flyers and clinician referrals. The researchers of this study had prior working relationships with the providers, communicated regularly with them about the study, and experienced a high degree of trust from the providers. The clinic providers cooperated in referring all patients meeting the study inclusion criteria. Given the setting of a research hospital, in which similar studies are often conducted, both patients and providers were aware of and comfortable with this research activity. Patients had to be at least 18 years old and on BMT. Once patients agreed to participate in the research, consent was obtained and participants were informed that their involvement was voluntary and that interviews

would be de-identified. Scheduled interviews and continuous recruitment were carried out between 2013 and 2016.

Trained post-graduate level interviewers conducted semi-structured interviews lasting 30 to 120 minutes with 77 patients. The questionnaire addressed views about and experiences of stigma and opioid dependence.

Interviewers transcribed responses onto electronic text documents using portable computers during the interview. Transcripts from responses to qualitative interview questions were analyzed with NVIVO 10, a qualitative coding software, using iterative thematic coding techniques well established in qualitative research, including continuous comparison and a pragmatic adaptation of grounded theory to develop relevant coding categories (Strauss and Corbin, 1997; Emerson, Fretz, & Shaw, 2011; Lingard, Albert, & Levinson, 2008; Reeves, Kuper, & Hodges, 2008). The team collectively separated the specific codes regarding enrollment, secrecy, isolation, difference, treatment and race into four larger categories. Multiple coders were used for all transcripts to check inter-coder reliability. Discrepancies between coders were resolved through team discussion and consensus.

### **Ethics, consent and permissions**

This research was conducted with oral informed consent procedures, data storage techniques designed to safeguard the confidentiality of participants' identities, and participant protection from court subpoena of the study's data as provided by a U.S. Health and Human Services Certificate of Confidentiality. These measures were approved by New York University's Human Subjects Institutional Review Board.

### **Findings**

Of the 77 patients, the average age was 46.5 years (SD = 9.4) (Table 1). Over half of the population was male (77.9%), most had a high school diploma as their highest degree of education (51.9%). About 22.2% of primary care patients had a bachelor's degree compared to 5.0% of the Opioid Treatment Program (OTP, an intensive substance dependence treatment program) population. More than half of the patients were housed (63.6%), 32.4% in transitional housing, and 3.8% were homeless. OTP patients had a higher rate of being in transitional housing compared to primary care patients (44.0% versus 19.4%). White patients made up the bulk of primary care (36.1%) followed by 30.6% Latino/a and 27.8% Black. In the OTP clinic 53.7% were Latino/a, 24.4% Black and 19.5% White. Finally, more primary care patients had no a history of substance dependence treatment (27.8%) compared to 12.2% of the OTP population.

Patients in this sample experienced and managed the stigma of addiction differently along lines of their social identities and resources. Housed patients reported that they were more likely to hide their addiction from others. Homeless patients and patients with a high school education or less, reportedly experienced more negative social and interpersonal interactions due to their addiction. Three significant differences arose that distinguished more enfranchised BMT patients from those who are multiply oppressed: how patients decided to enroll (self-referral to treatment versus drug court or clinician referral), their enmeshment

with multiple social systems (such as probation and welfare offices) that shape their experience of treatment, and their view of themselves as more than their addiction, which was related to the quality of their relationship with their clinical providers. The following contrasting vignettes highlight the dynamics of patients' experience of stigma and support relative to addiction treatment based on their situational positioning (e.g., race, gender, and class).

### **Primary care—state of exception, qualified life and passing: Frances**

Frances, a white middle aged, educated cinematographer, housed, with dense social and professional connections, speaks assertively about her experiences with buprenorphine while enrolled in the primary care clinic.

In 1999 Frances's partner connected her to a buprenorphine trial in Australia. At the time, she had just finished an assignment in Europe and had a significant amount of money left over from the production. Frances and her partner decided to travel to Australia to enter an addiction treatment program, where Frances had a positive experience with the medication and the providers. Although she faced barriers because of the cost of the treatment, upon approaching the end of the intensive part of her treatment, her healthcare provider continued her buprenorphine maintenance for 6 to 9 months after that.

Years later, when she returned to New York City, Frances relapsed. She was able to contact her former provider—with whom she maintained a good working relationship—and who referred her to the New York City public clinic, where she currently receives BMT. Her Australian provider believed in her recovery and promoted in her a sense of health and productivity, enabling Frances to take her care into her own hands, and to forge another close partnership with her doctor in NYC.

Frances described that she does not discuss her addiction treatment with peers. She stated, “professionally speaking I have to be careful, you can lose grants, respect; it's a stigma to be opiate dependent.” Frances stressed the importance of anonymity in treatment and argued that traditional treatment would expose her to the scrutiny of her addiction. Of addiction treatment clinics and alternatives to buprenorphine she went on to say, “I never wanted to go through the methadone program because of privacy issues and stigma associated with methadone.” The seeming anonymity of receiving BMT in a primary care setting enabled Frances to go about her life without fear of exposure.

Aside from the professional benefit, Frances distanced herself from the stigma of addiction by drawing lines between herself and those in traditional treatment. She notes the assembly line ethos of public treatment by groups, NA meetings, and routinized methadone clinics:

“[Taking] methadone every day, and going to treatment means seeing people who constantly remind patients of their addictions ... meetings, and methadone treatment are a belt like factory and in a group with people with very little in common”

Frances begins a larger conversation of the dataset that details the isolation and stigma of opioid maintenance treatment. Other patient interviewees support these claims by stating

that they feel stigmatized and uncomfortable—like Frances—in other treatment settings while on BMT.

“Some people stigmatize BMT, some people don’t see it as recovery. They see it as a substitute for heroin. In certain contexts, you are subject to prejudice if you’re open about it. Most of the time I don’t tell people because I feel the prejudice.”

Primary Care Patient, White Male, age 47

“And then you get your help somewhere else, counseling and NA meetings. I don’t mention Suboxone because more than half of the people there will give you a hard time ‘you’re not really clean!’ I just don’t mention it. I don’t bother or get into it or talk about it.”

Primary Care Patient, Latino Male, age 46

For Frances, her professional networks serve a different purpose than her personal networks. She manages information about her addiction differently with each network and discloses information accordingly. For example, Frances will confide in those in her friendship networks for support because she understands that it is not safe to disclose her addiction among those in her professional networks. Despite the security of these social networks she also understands that some things regarding her addiction are not worth sharing:

“All of my friends love me, they are there for me if I have a need for them— ... they know that if I need them to keep me busy or keep my mind off of things, I know I can count on friends.”

Frances elaborates that those same friends make her feel safe enough to share her information with because “they drink, they smoke marijuana, [they] have cocaine at parties, but they are not [opioid] users, which is why I keep them in my network of people that I reach out to.” Frances distinguishes this peer group apart from her professional network because of their open relationship to drugs. However she would never disclose her use to her professional network because there is no clear embracement of drug use, to Frances’ knowledge. She demonstrates the professional differences when she shares that with her camera man, “I have a professional relationship with him, I can speak to him about gear ... we share a professional relationship.” Frances repeats the *professional relationship* phrasing in the interview almost to stress that she cannot speak about her drug use and personal struggles with her colleague.

Frances’ case demonstrates a style of impression management that reflects her social position as a professional white woman. The primary care clinic enables her to receive treatment over the course of five years without punishment, surveillance and/or collateral consequences. For example her first dosing of treatment in Australia enabled her to access the “last 6 to 9 month’s worth ... for free,” from doctors after she ran out of money. In fact, she also had constant investment from peers and doctors. The flagship program referred her to the municipal hospital despite the long waiting list for treatment, and she was able to get in. Since Frances had a connection, she “was put on the top of the waiting list,” and feels that the clinic prioritized her because the doctor “saw her as a patient worth taking into the program.” She went on to say that she is “actually good friends” with her doctor. Frances’

ability to control and manage her stigma is situated on her racial identity and secure capital. She is able to pass as non-addicted, preserving her status of full citizenship with a qualified life. While hiding her history of addiction from her professional networks, she is able to share her needs with her social networks without fear of repercussions, highlighting how much less isolated she is than many others living with addiction, and allowing her a well-rounded sense of personhood in which addiction does not constitute her identity. Frances tightly controls and manages with whom she speaks and for what purpose, whether it be in her search for addiction treatment or for social support or professional contracts.

### **Opioid treatment program—exposure, surveillance and the state: Rupert**

“I’m not on welfare, I just came home from prison,” Rupert tells the interviewer. He is a 50-year-old Latino man with a grammar school education, no housing and no social network. Rupert describes his current living situation as a “MICA [Mentally Ill, Chemically Addicted] shelter for people who have problems.” Rupert’s problems go beyond addiction and involve housing, the criminal justice system, and limited social networks. When asked who he turns to for help, he went on to say:

“No one, I have a parole officer I speak to. I have a case manager in the shelter ... I have nobody, I feel lonely and alone, I feel empty and I feel like there is nobody there. I just did 16 years in prison. My mother died, and everything, what am I supposed to do? They just kicked me out in the street and that’s it! You’re on your own. I’ve been struggling. I’m starting to struggle again. If I start to struggle I have to come right in to inpatient and that is what I’m thinking about because you know I’m not trying to go upstate. I’m going to try to talk to them if I still keep failing, I can stay here in inpatient 6 months to a year as long as I get my life back.”

Prior to Rupert’s incarceration he indicated that he lived with his mother. His mother struggled with English as a second language, and as a result he went on to explain that his Aunt Claudia supplemented that help when necessary. However, by the time he was released from prison his “Aunt Claudia passed away—my mom had passed” too. The last of his relatives died from an AIDS-related illness and Rupert begins to provide some insight into his views on use and bare life.

“My brother died of AIDS because he was shooting up, I saw the way he suffered. I prefer to kill myself.”

Rupert expresses feelings of loneliness throughout his interview in terms of feelings of sadness and isolation. The services provided to him by the state are mandated, including the Probation Officer (PO) and social services (by a housing agency). They serve as gatekeepers and track Rupert’s patterns of drug use. Rupert talks at length about his fear that the state will rearrests him if he does relapse. He is constantly exposed to triggers within his environment that reproduce these fears:

“Maybe it’s the environment or people around me, I don’t know.... I went to the shelter and started to see people getting high and I said I wouldn’t do that, I stayed away. But then you start meeting people, they pulled out a bat [became involved in a physical confrontation], and there it is! Now my PO is on me...”



“I wasn’t getting high and I was doing good and then when I came out, I used again. I’m in the wrong place! I’m right here at Orange St and Broadview, at *Helping Hand* [treatment center], they are there every day, ambulance and police. There is not one day when the ambulance and the police aren’t here.”

Rupert was closely monitored by his PO because of his relapse, and he was admitted to the outpatient treatment program because of the shelter setting it offered. Three agents supervise Rupert: the outpatient treatment program, the PO, and his caseworker. In addition, every time Rupert enters his shelter setting, he runs the risks of being exposed to police violence. As in other metropolitan areas with large populations with poor and Latino/a people, police violence in homeless shelters is fairly common (*New York Times* 2016; *Hattem*, 2014). Although BMT helps Rupert tackle his cravings, it does not address his issues with housing, the criminal justice system, or lack of promising attachment figures.

Rupert exemplifies intersectionality of multiple oppressions. His addiction cannot be viewed as a singular issue, rather, his addiction is compounded by inequalities of race, class, law enforcement, housing, and education. Rupert is constantly facing structural violence because of the structural limitations of social services. Although BMT may help Rupert in some ways, the uni-dimensional nature of pharmacotherapy exacerbates underlying inequities in housing and social support, in addition to creating more surveillance from the state. Rupert’s extreme isolation due to familial loss and imprisonment leaves him struggling to create peer networks, because most of the people around him are using substances. In his case he is forced to isolate himself in an effort to protect his sobriety. He is under surveillance by agents of the state and is not able to control and manage information regarding his addiction. This exemplifies Crenshaw’s *structural intersectionality* because the same services that are supposed to enrich Rupert’s life are actually incriminating him, causing him trauma and leaving him bare and exposed. BMT is helping control his cravings, however, it does little to improve the overall quality of Rupert’s life or to address his psychosocial needs.

### **Outpatient treatment program—multiple oppressions and the stripping of life: Lucas**

Lucas is a 52 year old Latino man enrolled in OTP, with a grammar school education, no employment, and/or housing. Lucas does not have any social networks and lives in large shelter system of 900 men. Lucas does in fact have a family and children but over the course of his addiction, he lost contact with them:

“I have children that are not speaking to me, and two girlfriends who don’t want to be bothered by me.... My family doesn’t speak with me; it is a religious thing.”

Lucas relates instances of stigma based not on his addiction but on his appearance. As a man of color it is difficult for him to pass or to even be around others without feeling stereotyped. Lucas lacks social supports and stresses the impact of multiple oppressions—having more than one marginalized identity at time—on his livelihood:

“I’m stereotyped all the time, because of my race, the way I talk and the way I look. I look like an addict. Stereotypes and racism all over ... people treat me negatively based on racisms because of who I am. If they look at me as a fiend, they’ll turn me down for a job.... it eats away at the person’s health, life skills, quality of life,

everything. I can't engage in activities with people who are sober, because they look down on me. I heard that I have that 'dope fiend' look."

"They say 'time to go,' they think you'll steal something at the house. Fiends are looked down upon, you're a thief or a liar."

Race-based negative visibility—being seen as a “dope fiend”—hinders Lucas quality of life. He details not being able to find employment and the impacts on interpersonal relationships. He talks at length and describes how he does not like to integrate with others because that makes him susceptible to triggers him; he feels most at peace when alone. The intensive isolation and multiple oppressions weigh so heavily on Lucas that he describes what Agamben terms bare life, exceedingly painful and lonely:

"For the most part I am a loner, I can be around people, but, I rather be home. I can stay home all day. It is triggering to go out."

"Sometimes I feel like I can't get any lower. I just want to end my life."

Lucas is so discouraged that, at times, he sees little value in his own life. He has internalized the bare, exposed nature of his institutional and social position.

### **Primary care—at all cost, securing status: Elizabeth**

Elizabeth is a white woman in her middle thirties, has a bachelor's of fine arts, lives in an apartment, and receives BMT at a public primary care clinic to overcome her illicit methadone dependence.

Prior to being on BMT in primary care Elizabeth was on methadone treatment while securing welfare and public housing. She struggled to maintain her sobriety and employment, especially because of methadone's side-effects. About methadone, she stated: "[it is hard] to deal with [methadone treatment] if you want to get a job, [it] makes you dopy and sleepy." Another barrier to her treatment while on methadone was the public housing. The environment of her public housing made it difficult for her to maintain a sober space.

"Living in an apartment with people who use, they want you to be miserable with them. They seek you out—they would come and knock at my door. [They] want you to buy it, then it's a slippery slope to using methadone again."

"I'm collecting welfare but they make you do the Back to Work program, they don't want me to do outpatient anymore.... they won't help with this transition to buprenorphine primary care at the hospital either."

Elizabeth's relationship with her housing and welfare officers hindered her ability to receive methadone services. Changing to buprenorphine meant not only getting flexibility in her schedule, it also meant gaining status. It enabled her to secure a job and personal autonomy.

"This clinic is under the radar, it was just a fluke, and my WTC [World Trade Center] doctor helped me. I like this clinic, less red tape."

Her ability to mobilize to a better form of treatment even in the face of resistance is important, especially with the help of a doctor.

Elizabeth's enrollment into primary care based BMT through an outside professional made the difference in her outcome, because it gave her more autonomy and flexibility in treatment. It gave her the option of entering the labor market without the physiological affect of methadone, without the disruptive scheduling demands or surveillance of a methadone treatment program. Furthermore, Elizabeth names the oppressive, stigmatizing and isolative nature of methadone, and how that manifests on one's autonomy. When asked about the benefits of BMT compared to other treatment types, she stated the following:

“Not being treated like a criminal or separated from the general population. In methadone you feel like you're in prison, and it's embarrassing and you worry about who you see going in and out. The whole stigma of it, and its years before you get any freedom. You're treated like a child, it [BMT] reduces some of the stigma, it makes you feel less of a leper, so to speak. I've been blamed and made to feel like a bad child, irresponsible, selfish and no self-control and refusing to group up at the other program.”

Elizabeth, unlike Rupert and Lucas, is able to successfully advocate for herself. She was able to transition out of her outpatient treatment program, which many patients are unable to do even if they are on buprenorphine maintenance. As Elizabeth and many of the patients above demonstrate, new medication does not absolve addiction stigma. Yet, the absence of oppressive surveillance allows her to recover.

Elizabeth highlights the importance of identity and addiction. She reports advocating for her treatment and receiving support from doctors. Her high level of education and her white race emboldens her to demand services and receive them. Her racial identity is a protective factor, as she can more successfully pass as a non-addict. Her identity qualifies her life and makes her treatment and her employment a priority.

## Discussion

### Many faces of buprenorphine

Demonstrating structural barriers and structural violence in treatment, Rupert's and Lucas' vignettes enable us to think more broadly about patients' social context and what psychosocial needs they bring to the space. Although OTPs provide wrap-around services, we use Crenshaw's theory of multiple oppressions to demonstrate that these same services and providers can be another form of oppression for patients in the most need. Privacy in primary care can only be granted for those who are not dependent on social services. We hope by comparing the difference in treatment demonstrates how the setting of treatment, stigma of the referral process, and provider can weigh heavily in individual recovery and patients ability to thrive. For instance, Elizabeth moved from methadone maintenance treatment to BMT in a primary care clinic, which opened up a plethora of options for her. As we move forward we hope to help providers think more holistically about the treatment they provide all patients, especially those most impacted by structural violence and are dealing with racist reactions to social and emotional needs. Our analysis is not suggesting that only White, middleclass, educated, and housed patients should have access to buprenorphine treatment but rather points to the need for social and psychological interventions in

combination with Medically Assisted Treatment to address the range of interlocking needs that people have in pursuing recovery.

### **States of exception: qualified vs. bare life**

By funding and regulating services differentially so that some populations have access to primary care based BMT and others do not, cities, states and the Federal government codify who is deserving of qualified services and who deserves only the bare minimum. We see in our data the increased number of patients in a primary care setting that are less regulated than patients in outpatient settings; it so happens that the majority patients in the primary care sample are white, while the majority of patients in OTP in our sample are of ethnic or racial minority status. These patients are able to hide their addiction in this setting in a way that minimizes their exposure to stigmatizing responses from colleagues and family members. Yet, as Rupert clearly describes, less insulated people experiencing other forms of discrimination and exclusion such as race and class, in addition to addiction, cross a treacherous battlefield daily to access treatment. Rupert illustrates that a medicalized treatment developed on a biological model of addiction does not necessarily destigmatize addiction (Pescosolido et al., 2010; Phelan & Link, 2012; Link & Phelan, 2010), and that this is especially true among people experiencing multiple oppressions (by race, class and often gender) within structurally intersectional institutions.

### **Attachment**

Rupert, and many other study participants like him who came to treatment without the social networks and educational capital of the educated white patients in our sample, did not report the same sense of interpersonal connection with their buprenorphine prescriber; their clinical visits did not give them the encouragement of contact with a professional who was invested in their recovery. This is a crucial distinction.

As psychodynamic literature on the correlation of attachment and ego psychology highlights the importance of attachment figures and safety. Patient and provider interaction offer a setting for providers to lend their ego to patients, this is known as ego strength. Ego strength is described as the internal drive of a secure individual to another in a particular social environment (Goldstein, 1996). The extension of security enables the provider to act a pseudo attachment figure for the patient to confidently explore/progress in recovery while safely under a primary doctor for areas where they may struggle without punishments (Ainsworth, 1963). This independence in treatment enables patients that need long-term care— those on buprenorphine for opioid dependence—to persist and continue treatment over time in spite of setbacks.

Given that low income black and Latino/a patients are challenged by multiple, intersecting sources of marginalization, hindering their ability to advocate for themselves, the role of providers is increasingly important because they are the gatekeepers of institutional resources. For patients facing many sources of institutional discrimination, it may be necessary to meet their basic needs for shelter, financial support, and social support in order for them to experience BMT as promoting personal freedoms in the ways described by white, educated patients in primary care. Without attention to the basic needs of patients without race and

class privilege, BMT, as medication alone, rather than being liberatory, can turn into a form of institutional neglect and even structural violence to the extent that it is considered adequate for their recovery, and to the extent that patients' difficulty continuing pharmacotherapy in the face of competing demands for their survival is framed as their lack of personal commitment to treatment.

### Options for treatment

BMT as a treatment is effective in mitigating and managing addiction craving, but on its own it does not address identity formation around opioid maintenance. For example, the question all patients faced when told that BMT is long term, was what to do if they were without their BMT. For patients in primary care it was even more anxiety provoking because they had not had previous substance use treatment and did not have a language or coping skills to manage themselves as opioid maintained. These anxieties and demands for identity adjustment as chronically maintained call for some form of psychosocial support, which better resourced patients sought from their social networks and their interested clinical providers, but which less resourced patients described as a source of nihilism about their futures, to the point, as Lucas shows, of thoughts of suicide.

One of the few free and accessible psychosocial treatments to which buprenorphine patients had access outside of the clinic was 12-step programs in the community, such as Alcoholics Anonymous and Narcotics Anonymous. However, their groups are traditionally "drug free" meaning participants are discouraged from taking opioids as a maintenance treatment and they are told that they are not sober if they are taking opioids for their opiate addiction. As a result, our study participants reported feeling different from group members and alienated, with a need to separate themselves from twelve step groups. This represents a lost opportunity for patients on BMT to build community based support networks, further exacerbating the disparities between those patients who begin BMT with a social network in place compared with those who need to build one to support their recovery.

This places even more responsibility on the shoulders of providers to ensure a psychosocial wrap around for patients without social resources. Without these efforts, providers are consigning their disenfranchised BMT patients to bare life, to a life that is not societally valued, from which little is expected and into which nothing is invested. To be effective in promoting abstinence and recovery, addiction treatment providers must be agents of institutional change, promoting the investment of social service resources and interpersonal, therapeutic support that are necessary to counteract the many levels of institutional abandonment and disinvestment that the narratives of our most marginalized addiction patients reveal.

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**Table 1**

## Quantitative Data.

Characteristic by Clinic Type	Total (N = 77) (%)	Primary Care (N = 36) (%)	Outpatient Treatment (N = 41) (%)
<b>Age</b>	<b>46.5 (9.4)</b>	—	—
<b>Patient Type</b>			
Within first month of BMT	<b>32 (41.5%)</b>	13 (36.1%)	19 (46.3%)
More than one month	<b>42 (54.5%)</b>	23 (64.9%)	22 (53.7%)
<b>Race/Ethnicity</b>			
White	<b>21 (27.2%)</b>	13 (36.1%)	8 (19.5%)
Black/African American	<b>20 (25.9%)</b>	10 (27.8%)	10 (24.4%)
Hispanic	<b>33 (42.8%)</b>	11 (30.6%)	22 (53.7%)
Other-Mixed	<b>3 (3.8%)</b>	2 (5.6%)	1 (2.4%)
<b>Gender</b>			
Male	<b>60 (77.9%)</b>	28 (77.8%)	32 (78.0%)
Female	<b>17 (22.0%)</b>	8 (22.2%)	9 (22.0%)
<b>Education</b>			
Grade School–High School Diploma	<b>40 (51.9%)</b>	17 (47%)	23 (56.1%)
Vocational/Some College	<b>27 (35.0%)</b>	11 (30.6%)	16 (39.0%)
College	<b>10 (12.9%)</b>	8 (22.2%)	2 (5.0%)
<b>Living Arrangement</b>			
House or Apartment	<b>49 (63.6%)</b>	27 (75.0%)	22 (53.7%)
Transitional (Shelter, Half-Housing, Three-Quarter Housing)	<b>25 (32.4%)</b>	7 (19.4%)	18 (44.0%)
Homeless	<b>3 (3.8%)</b>	2 (5.6%)	1 (2.4%)
<b>Treatment History</b>			
Previously treated for SUD	<b>56 (72.7%)</b>	24 (66.7%)	32 (78.0%)
No previous SUD treatment	<b>15 (19.4%)</b>	10 (27.8%)	5 (12.2%)
No Answer	<b>6 (7.7%)</b>	—	—