THESIS

PICKING UP THE PIECES: PLACE BASED RACE DISCOURSE IN PITTSBURGH OPIOID EPIDEMIC RESPONSES

Submitted by

Ericann A. LaFehr

Department of Ethnic Studies

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Master's Committee:

Advisor: Roe Bubar
Co-Advisor: Eric Ishiwata

Caridad Souza
Michelle Glant

ABSTRACT

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Public Health's dominant focus on white opioid users coupled with a colorblind ideology has resulted in the reiteration of racially stratified public health discussions, strategies, initiatives, and treatment both nationally and in the Pittsburgh region. This case study uses discourse analysis guided by a critical place-based intersectional and decolonial framework to explore the ways in which whiteness and place are considered by Pittsburgh Public Health entities who have positioned themselves as experts in addressing the opioid epidemic. Findings show that within Pittsburgh Public Health discourse, whiteness is reduced to a descriptor, omitting the reality of a racialized category with a distinct historical racial formation comprised of white supremacist violence. Findings also show that place is reduced to the backdrop in which opioid use happens resulting in the omission of the material relationships between land and people that are a critical component of the sociohistorical formation of whiteness within the industrial and deindustrial history of Pittsburgh. This study argues that the simplification of place based white racialized identity to a mere descriptor is a critical component that maintains white supremacy within Pittsburgh Public Health discourse and strategies that aim to address the opioid crisis. This study argues that if Public Health approaches are to be truly effective, discussions of the opioid epidemic in relation to white people must include the sociohistorical legacy of violent participation in white racial formations, as the collective historical memory holds the key in addressing the deeply seated underlying causes of pain.

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DEDICATION

To Aunt Jenn, who carries on through the wake of the devastation and loss created by the impact of opioid addiction.

PROLOGUE

This project comes to fruition in a time of great upheaval, as the decrepit bandages that have been covering the festering wounds cultivated by white supremacy in the United States are once again falling off. The quick spread of the global CO-VID19 Pandemic has both further revealed and compounded the deep collective pain that stems from these unattended wounds. The current administration's blundered attempt of enacting a mass shutdown in the United States to prevent spread of infection has created unprecedented levels of unemployment, financial instability, and the just now beginning wave of mass evictions. In the midst of this global crisis, a spotlight once again illuminates the murder of unarmed Black people at the hands of state sanctioned police officers and white vigilantes with the unjust killings of Ahmaud Arbery, Breonna Taylor, George Floyd, Tony McDade, and Modesto Reyes. As a result, uprisings in cities across the country have created new spaces to magnify the ways in which white supremacy continues to manifest and kill at will, most notably in the movement for police abolition.

As the discourse surrounding police abolition in the current moment unfolds, moves have been made to transfer some first responder responsibilities, such as welfare checks, to social workers and Public/ Behavioral Health professionals. These moves understandably come from a sense of urgency to move away from the overt violence at the hands of police, and yet also seem to function from an assumption that these entities can address the societal ills of racism, as well as other forms of societal oppression, more skillfully. Therefore, this moment serves as an opportune time to raise important criticisms of Public Health institutions and practices, specifically those found under Harm reduction, and their relation to and perpetuation of capitalist heteropatriarchal white supremacist practices. At an intersection between race, policing,

pandemic response, economic collapse, and Public Health lies and ongoing opioid epidemic that continues to claim thousands of lives. The crisis, which has been constructed in the mainstream as a problem that predominantly impacts white people in the suburbs, is predicted to intensify given the nature of social distancing mandates along with compounded stress. Prior to COVID-19, the framing of the Opioid epidemic as a white middle-class problem resulted in solutions that neglected historically targeted and economically decaying communities, and the current recalculation of response is no different.

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Chapter One: Introduction

"Whiteness expects everyone to deal with whiteness except for white people."
Sonya Renee Taylor

Death is the final consequence of opioid addiction. According to the Centers for Disease Control and Prevention, overdose deaths from opiates in the United States increased by 500 percent since the early nineteen nineties resulting in 450,000 deaths from 1990-2018 (WONDER, 2020; CDC, 2020). Current reports suggest that opioids kill 72,000 people each year, which equates to 130 overdose deaths per day, with a projected increase over the next five years (O'Donnell, Gladden & Seth, 2017; Burke, 2019). Consequently, national Public Health entities declared the exponential increase in opiate overdose deaths, which is now known as the 'Opioid Epidemic', as the largest and most serious instance of addiction related deaths in the history of the United States (Center for Disease Control and Prevention, 2020; Olsen & Sharfstein, 2019). As death tolls began to rise, the dominant profile of the "unlikely" overdose victim emerged in the mainstream discourse as white, suburban middle class "soccer moms" and white men in rural areas (McLean and others). This resulted in a hyper fixation on white overdose victims while Public Health simultaneously declared opioid addiction is an affliction that "sees no color" (Olsen & Sharfstein, 2019; Center for Disease Control and Prevention, 2020; Netherland & Hansen, 2016).

With the focus on white middle class and rural decedents, Public Health rendered opioid addiction and overdose death the "American disease", calling for a departure from carceral and judicial mitigation strategies of past drug epidemics (Center for Disease Control and Prevention, 2020; Olsen & Sharfstein, 2019). In this pivotal moment, Public Health entities asserted that understanding the benefits and risks of opioids for pain, the chronic nature of addiction, and the value of treatment helps people regain control of their lives (Kolodny, Courtwright, & Hwang,

2015). Public health entities thus claimed that this approach ought to be the dominant response to the opioid epidemic (Olsen & Sharfstein, 2019).

As areas struggling with the most severe numbers of overdose fatalities began declaring states of emergency in response to the crisis, they also began new partnerships with Public health and harm reduction entities (Lutgen, 2018). One such state is Pennsylvania, which is at the center of the epidemic with the third highest rates of mortality in the nation (OverdoseFreePA; CDC, 2020). In attempts to address the opioid overdose epidemic, the state pushed counties within its jurisdiction to partner with the leading Public Health entities to devise strategies for addressing the crisis. In Allegheny county, one of the state's severe hot spots, the county and the city of Pittsburgh moved with the University of Pittsburgh and its medical campus to create solutions that focused on the city's predominantly white areas that appeared to be suffering from the highest rates of overdose deaths. Subsequently, research has shown that Public Health's dominant focus on white opioid users coupled with a colorblind ideology has resulted in the reiteration of racially stratified public health discussions, strategies, initiatives, and treatment both nationally and in the Pittsburgh region (Netherland & Hansen, 2016; James & Jordan, 2018). There have been many important studies calling attention to the racial inequalities faced by Indigenous, Black, and Brown populations within opioid addiction treatment, including the continuation of criminality and incarceration.

While these studies are imperative in calling out the ways the Public health focus on white opioid users marginalizes Black and brown opioid users, less attention has been paid to the ways in which the racial category of whiteness has been relegated as a mere descriptor of opioid overdose victims rather than a racialized identity. In, *The Possessive Investment in Whiteness: Racialized Social Democracy and the "White" Problem in American Studies*, George Lipsitz

contends, “White power secures its dominance by seeming not to be anything in particular. As the unnamed category against which difference is constructed, whiteness never has to speak its name, never has to acknowledge its role as an organizing principle, its social and cultural relations” (Lipsitz, 1995, p. 69). As an organizing category, whiteness functions through a lens of universality despite the reality that the race category designated ‘white’ and ‘whiteness’ are created and reiterated through various processes through different spaces, places, and points in time. In, *Black Skin, White Masks*, Frantz Fanon argues that this process of becoming white is also a process of alienation and mystification that has diagnosable psychosomatic manifestations. With this, it becomes imperative to interrogate the ways in which whiteness functions through the dominant Public Health framing of the opioid epidemic in the areas that appear to be the most impacted.

Therefore, this case study employs an intersectional and decolonial place-based framework to explore the ways in which whiteness is discussed by various Public Health entities who have positioned themselves as experts in addressing the opioid epidemic in the former industrial city of Pittsburgh, Pennsylvania. Pittsburgh’s history as one of the first colonial settlements followed by its over one-hundred-year industrial dominance presents questions about the relationships of racial formation to the material formation of place and how this impacts contemporary social issues. Thus, this study is guided by two questions:

RQ 1): How is whiteness talked about in Pittsburgh Public Health discussions and solutions directed at the opioid epidemic?

RQ 2): How are the histories of race and labor in Pittsburgh considered within local Public Health discussions around opioid addiction?

In reflecting on Fanon’s explication on the mystifying nature of whiteness, the goals of this study are to introduce new approaches that demystify the workings of whiteness within localized

public health discourse concerning the opioid epidemic. In taking up this effort to demystify whiteness, I aim to bring explicit conversations concerning place-based manifestations of white racial formation into the purview of mystified Public health experts. To do this, this study will take up discourse analysis through an intersectional framework comprised of Indigenous and decolonial theoretical contributions, which will be laid out in the next section.

Theoretical Framework

To understand the workings of whiteness within Public health discourse, this study employs three theoretical tools of analysis. Specifically, this case study utilizes Frantz Fanon's concept of sociogenics which has been re- rooted in an intersectional framework and Indigenous theorizations of place. Here I offer this framework, along with the ways it will allow for an interrogation of the co-constructive process of an industrial white racial formation. However, before turning to the framework of this study, an understanding of racial formation must first be established.

In the foundational text, *Racial Formation in the United States*, Michael Omi and Howard Winant challenge the notion of race as a biologically concrete and static category by deconstructing and accounting for the ways in which race functions as a fluid social construct (1986). To do this, Omi and Winant define the concept of race as the "representation of identity that refers to different types of human bodies to the perceived corporeal and phenotypic markers of difference" (p. 106). Omi and Winant assert "in the United States, race is a master category- a fundamental concept that has profoundly shaped and continues to shape the history, polity, economic structure, and culture of the U.S." (p. 106). While acknowledging the act of categorizing people as a basic social navigation skill, Omi and Winant contend that the

categories with which people use are subject to "enormous variation over historical time and space" (106).

They further state, "processes of classification including self-classification are reflective of specific social structures, cultural meanings and practices and broader power relations" (p. 106). Building on the point of power relations, Omi and Winant argue, "Race-making can also be understood as a process of "othering", in which perceived distinctions are used to justify structures of inequality, differential treatment, subordinate status, and in some cases, violent conflict and war" (p. 106). In this way, the definition of categories is framed and contested from 'above' and 'below', as members of both the dominant and subordinate categories participate in the meaning making processes through domination or resistance. They define these processes of race making and their subsequent societal reverberations as *racial formation*, which they argue are always historically situated and "fraught with confusion, contradiction, and unintended consequences" (p. 105). In addition to the consideration of historical context, racial formation takes place between the macro and micro levels of structure and signification that occur in policy making, state activity, collective action, and everyday experiences (p. 125).

To illustrate this point further, Omi and Winant contend that race is never "merely representation or signification alone", rather its formation is a "synthesis, a constant reiterated outcome of the interaction of racial projects at a societal level" (p. 106, p. 125). They further offer, "race cannot be noticed without reference to social structures" going on to say, "To identify an individual or group racially is to locate them within a socially and historically demarcated set of demographics and cultural boundaries, state activities, "life chances", and tropes of identity/difference/ inequality" (p. 125). In this way, Omi and Winant contend "Race is both a social structure and set of accumulated signifiers that suffuse individual and collective

identities, inform social practices, shape institutions and communities, demarcate social boundaries and organize the distribution of resources" (p. 125). Thus, race functions as a mechanism that enfranchises those who belong to the dominant category, while disenfranchising those who are "othered" through an established, perpetually maintained, and regulated hierarchy. Therefore, examining the historical specificities of racial formations offers a way to identify and name the unique processes and contexts by which racialized categories were hierarchically constructed.

In the United States, the racial hierarchy is constructed along what Frederick Douglass identified as the color line between white and racialized non-white "others" (Douglass, 1881). The concept of whiteness appeared prior to the first European settlements in North America. The concept of whiteness gained power as a superior identity and ideology through the processes of settler colonialization, chattel slavery, citizenship and immigration, imperial colonization, and labor (Roediger, 2007). Whiteness is defined as both a biological marker as well as a racial discourse and set of behaviors, that includes "concepts of labor, gender, class, and images of personal beauty" (Leonardo 2002; Painter, 2010, p. xi). Whiteness is thus the normative category in which non-white categories are organized. While much attention has been paid to the ways in which whiteness, white supremacy, and white privilege has enacted violence and marginalization for Black, Indigenous, and people of color, there is little work that examines how white racial formations impact white people. In this way, the following theoretical framework offers a way to look into white racial formation beyond the scope of white privileges.

Intersectional Feminist Foundations

In questioning the positivist model of rationality, Michael Polyani writes "It is not by looking at things, but by dwelling in them that we understand" (Polyani, 1966, p. 18). The construction of the theoretical framework of this project began in 2017, as I traveled to the eastern part of Colorado for an undergraduate internship, I was grateful to have been chosen for. The internship was created out of the community building work my advising professor had taken up in a small town that was experiencing rapid demographic changes in relation to fluctuations in immigration and refugee resettlement. While we traveled along country roads that traversed rolling hills of green and beige and vast expanses of blue sky dotted with prairie clouds, he shared the history of the places we passed through. As I absorbed the information about the migratory patterns of the Arapaho, Ute, Kiowa, and other tribes, the abandoned Black marooner community of Deerfield, and the immigration history of sugar beet production, I began to wonder if and how these histories carried specific energies that stayed living in the land and how they informed the current struggles of relationship building within the small town. Beyond the overt tensions informed by a reemerging white supremacist nationalist populism, I felt that the long standing, unspoken feelings of the violent removal of the Indigenous peoples, the anti-Black racism that more than likely impacted the marooners, and the historical hostility and exclusion of migrant workers from Mexico are invisibly interlaced in the land, the air, and the bodies of the longer term and newly arrived residents of the small plains town.

I then began to deeply consider the ways in which colonizing and industrial processes driven by the interlocking systems of race, class, gender, and sexuality that occurred in the Ohio river valley where I was born shaped me, my family, and everyone who has lived there for all their lives. There is a captivating, layered affect that sits in the city of Pittsburgh and it grows stronger

as one makes their way out into the surrounding Boroughs where castle-like Steel mills once breathed fire into the air all day, every day, non-stop for over 100 years. When crossing over the threshold of the Liberty tunnel, one is met with the feeling of astonishing grandeur, as the city nestled at the confluence of the Ohio, Allegheny and Monongahela rivers confronts the visual senses. To the left, looking down the Allegheny, is bridge after bridge, cradled by hills adorned with row homes. To the right, bridge after bridge, cradled by hills adorned with row homes, and in the distance the distinct marker of the University of Pittsburgh's Cathedral of Learning beckons to all who want to pursue knowledge. Below, spans of railroad tracks on the banks of the Mon, and barges moving tons of coal intermingle with personal boats, guided tours, and swimmers, despite the unseen toxicity of the waters. From this vantage point, Pittsburgh gleans with Pride.

Traveling south east, away from the city epicenter, homes and buildings come into a closer view and what seemed shiny at first begins to pale as the dilapidation, decay, and ever remaining soot becomes apparent. The magnanimous pride gives way to a deep depression and melancholy. The air feels stagnant and still, even if the wind is blowing through the hilly, temperate forests. The bustle of the gentrified and middle-class parts of the city lessens, the amount of people walking on the streets and sitting in parks declines. A glaring racial division emerges. Graffiti walls, broken windows, and used syringes on the sidewalk are an indication that one finds themselves in parts of the city where someone might have told them they do not want to be. These boroughs and the bodies within them hold violence and deep, long lasting pain in ways that give evidence of an affectual cage. For most, the way out of this is through substance, the full bar stools in the neighborhood bar around noon is not so much a joke as it is a cultural marker.

As I dwelled in how these processes inform who I am, I began to explore the deeper and nuanced causes of this pain that are not typically considered in acute analysis within harm

reduction practices. From this place, I constructed my theoretical framework. The framework base is built from Intersectional Feminism as articulated by Black Feminist scholars, along with critical contributions made by Indigenous Feminists. At this moment, there is a noticeable trend within higher education and social justice spaces in which Intersectionality has come to be understood solely as an analysis of social identities within the interlocking systems of race, gender, sexuality, and class oppression. However, this is a simplified, and thus warped, understanding and application of intersectional feminist theory as it does not acknowledge the constructed power differentials in social locations, simultaneity of oppression, and origins of politics (Crenshaw, 1989; Hill Collins, 1986; Combahee, 1979; hooks, 1984). Intersectional Theory arose from the work of Black Feminists, who along with other women of color feminists, sought to challenge the dominance of white Liberal feminism within the second wave women's movement (hooks, 1984; Smith, 2006; Moraga, Anzaldua & Bambera,1981). Given this current trend, which is seemingly just a reiteration of white feminist attempts at dominance, it is imperative to correctly map out the features of intersectionality to resist the ongoing co-optation and misuse that ultimately serves the white supremacist heteropatriarchy.

As often noted, the term intersectionality was coined in 1989 by Black Feminist and lawyer, Kimberlé Crenshaw, in *Demarginalizing the Intersection of Race and Class: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics.* In her paper, Crenshaw argues against using single axis frameworks of analysis that presume gender and race to be mutually exclusive of each other by centering the experiences of Black women within antidiscrimination law (Crenshaw, 1989, p. 383). In centering the multidimensional experiences of Black women, Crenshaw shows how single axis analysis limit the focus of analysis to the dominant and privileged members within group categories which "marginalizes those who are

multiply burdened, and obscures claims that cannot be understood as resulting from discrete sources of discrimination." (Crenshaw, 1989, p. 383). By focusing on the most privileged groups, specifically white women in gender, middle class women in class, and Black men in race, Crenshaw contends that this "creates a distorted analysis of racism and sexism because the operative conceptions of race and sex become grounded in experiences that represent only a subset of a much more complex phenomenon" (Crenshaw, 1989, p. 384). Because of the ways in which the dominant descriptors function through similarity rather than difference, this limitation then allows the "unique discriminatory power" that functions through both racism and sexism to go unchecked and unacknowledged within antidiscrimination claims, as well as other areas of racialized gendered discrimination (Crenshaw, 1989).

This point of difference is essential in understanding the deeper implications of Crenshaw's conceptualization of intersectionality. In her paper, *Learning from the Outsider Within: The Sociological Significance of Black Feminist Thought*, Patricia Hill Collins identifies a main feature of the interlocking nature of oppression as the categorization of people within an either/or binary, what she refers to as "the construct of dichotomous oppositional difference" (1986, p.310). In unpacking this construction, she highlights three characteristics. The first characteristic is the relational difference that forms the foundation of the binary. She contends, "One fundamental characteristic of this construct is the categorization of people, things, and ideas in terms of their difference from one another. For example, the terms in dichotomies such as black/white, male/female, reason/emotion, fact/opinion, and subject/object gain their meaning only in relation to their difference from their oppositional counterpart." (Hill Collins, 1986, p. 311).

From here, she notes that this relational construct of difference is not complementary, writing "the dichotomous halves are different and inherently opposed to one another" (Hill Collins,

1986, p. 311). The third feature she identifies is the instability of these oppositional relationships that is solved through subordination. Hill Collins offers, “Dichotomous oppositional differences invariably imply relationships of superiority and inferiority, hierarchical relationships that mesh with political economics of domination and subordination” (1986, p. 311). Thus, we begin to see the structure that enables and necessitates white to rule over black, male over female, and subject over object within interpersonal interactions and the larger political arena (Hill Collins, 1986, p. 311). Consequently, she contends “the oppression experienced by most Black women is shaped by their subordinate status in an array of either/or dualities”, in that Black women are socially located within multiple categories of devaluation, rather than just one or two (Hill Collins, 1986, p. 311). Therefore, acknowledging that the valuation of difference is at the core construction of the interlocking nature of oppression is central to an Intersectional analysis, as Audre Lorde suggests “Refusing to recognize difference makes it impossible to see the different problems and pitfalls facing us as women” (Lorde, year, p.1984). By extension, it is imperative to understand that refusing to recognize difference makes it impossible to see the different problems faced within and between dominant and subordinate social locations in the general structure.

Another critical aspect of Intersectional theory is the simultaneity of oppression experienced by Black women. In, *A Black Feminist Statement*, the Combahee River Collective emphatically states “We believe that sexual politics under patriarchy is as pervasive in Black women’s lives as are the politics of class and race. We also often find it difficult to separate race from class from sex oppression because in our lives they are most often experienced simultaneously” (Combahee, 1978, p. 234). In this way, the multiple social locations of subordination are not played out in a singular form, rather, Black women’s lived experiences within these domains happens at the same time, all the time. This combination of location and

simultaneity was first described by Frances Beale as 'double jeopardy', which was built on as 'triple jeopardy' and then finally amended by Deborah King as 'multiple jeopardy' (Beale, 1979; King, 1988). King argued, "most applications of the concepts of double and triple jeopardy have been overly simplistic in assuming that the relationships among the various discriminations are merely additive" (1988, p. 297). King then asserts that "the modifier "multiple" refers not only to several, simultaneous oppression but to the multiplicative relationships among them as well" (1988, p. 297).

The naming of simultaneous multiplicative relationships of oppressions is significant in that doing so illuminates how these relationships form what Hill Collins names the matrix of domination (Hill Collins, 1986). This structure of interconnected dominant and subordinate relationships based in differential categorical classifications then determines how one can interact, what social groups one is in, and the networks one establishes (Hill Collins, 1986; Crenshaw, 1991; Moraga & Anzaldua, 1981). In seeing this multidimensional structure, an Intersectional approach allows for an interactive analysis, in which a pivoting center focus remains connected to the relations of power in which to fully see the margins, rather than on one constructed identity (hooks, 1984). Additionally, King contends, "in the interactive model, the relative significance of race, sex, or class, in determining the conditions of black women's lives is neither fixed nor absolute but, rather, is dependent on the socio-historical context and the social phenomenon under consideration" (King, 1988, p. 298). This is important given the ways that single axis analysis not only focus on one aspect of identity, but also relegates social phenomenon to a fixed position in time.

For Black women, this cuts off a full picture analysis that accounts for the ways in which a legacy of racialized and gendered chattel slavery has transformed into different iterations long

after its de facto abolition. Therefore, an Intersectional approach is interactively fluid in ways that enable critical comparisons that do not recreate false separations regarding the changing nature of power. Additionally, the ability to analyze relationships of domination pushes back on the hyper fixation on oppressed people and groups that ultimately ends up re-subjectifying or further objectifying, as King states "for as long as Black women have known our numerous discriminations, we have also resisted those oppressions" (King, 1988, p. 299). Subsequently, it is within Black women's confrontations within the matrix of domination that an Intersectional approach also informs and empowers political mobilization beyond the monist approaches of dominant liberation ideologies (King, 1988; Albert et al., 1986). Intersectionality is thus tenaciously resistant, as the approach is based in every day struggles of Black women resisting subordination. In this way, the reality and lived experiences of Black women as articulated through Black feminist thought make liberation possible for all people.

While Intersectional theorizing originates from Black Feminism, it is not a framework that is exclusive to Black women. Indeed, many Indigenous and Women of Color have made significant contributions that enable a wider and deeper frame to see how multiplicative oppressions impact different people from different standpoints. A significant theoretical contribution in Indigenous feminisms is the consideration of settler colonial logics, as well as the logics of slavery and orientalism (Smith, 2006). In her article, *Heteropatriarchy and the Three Pillars of White Supremacy: Rethinking Women of Color Organizing*, Andrea Smith highlights the common assumption that communities of color are impacted similarly by white supremacy, which has an impact on the strategies and movement taken up by communities working against it (Smith, 2006). To interrupt these assumptions and practices, she offers a framework with which to see the simultaneous and overlapping nature of white supremacist structures. She contends, "this

framework does not assume that racism and white supremacy is enacted in a singular fashion; rather, white supremacy is constituted by separate and distinct, but still interrelated, logics" (Smith, 2006, p. 67).

To illustrate her framework, she uses the metaphor of pillars, identifying each: "one labeled Slavery/Capitalism, another labeled Genocide/Colonialism, and the last one labeled Orientalism/War, as well as arrows connecting each of the pillars together" (Smith, 2006, p. 68). The naming of these pillars allows for the identification of the underlying logics in which white supremacy moves to constrict different racialized groups, which results in different considerations for liberation. Specifically, the logic of slavery/capitalism functions through anti-Blackness to enslave Black people at the bottom of the racial hierarchy to exploit their labor, while the logic of genocide/colonialism "holds that Indigenous people must disappear" and "must always be disappearing" so that non-Indigenous settlers can access the land (Smith, 2006, p. 68). The third pillar of Orientalism/War enacts a logic that "marks certain peoples or nations as inferior and as posing a constant threat to the well-being of empire", in this way "they will always be imagined as permanent foreign threats to empire" (Smith, 2006, p. 68). Thus, identifying the differences in how white supremacy operates aids in understanding how racial dynamics cannot be reduced or simplified.

For this project, I am interested in analyzing differences between groups of people situated in a specific place, as "the emerging paradigm of intersectionality problematizes the entire process of group construction" (Hill Collins, 2003, p. 68). Hill Collins offers that an intersectional framework can be used to "think through social institutions, organizational structures, patterns of social interactions, and other social practices on all levels of social organization" (Hill Collins, 2003, p. 68). She contends that this is so because "groups are constructed within these social

practices, with each group encountering a distinctive constellation of experiences based on its placement in hierarchical power relations" (Hill Collins, 2003 p. 68). This is to say, that while intersectionality enables analysis on an individual level within systems of oppression, it also allows for an analysis that interrogates how individuals who comprise groups experience subordination or participate in domination. In this case study, I am interested in looking at how racialized groups are addressed differentially by Pittsburgh's public health messaging and subsequent treatment measures regarding the opioid overdose crisis. By establishing an intersectional framework as my base, I hope to illuminate the ways in which logics of white supremacy continue to inform subordination and domination of different groups within a field that claims to be the only field equipped to solve the problem.

Indigenous conceptions of place

Building on an Intersectional base, a theoretical concept that encapsulates place-based understanding is imperative as it is directly tied to racialized group formations. Returning to the genocide/colonial logic offered by Andrea Smith, (2006) it is necessary to acknowledge the United States as a settler-nation state and as such, this project must be situated within critical Indigenous and decolonial studies. In doing so, this allows for an accounting of the ways in which the on-going structure of settler colonialism and the logic of elimination and Indigenous land dispossession informs white supremacy and its geographically specific constructions of race (Wolfe, 2006; Dunbar-Ortiz, 2014). Over the last few decades, Indigenous scholars who found themselves in postcolonial, critical race, and ethnic and diaspora studies spaces, have pushed beyond the subject of legal civil rights, resulting in the proliferation of distinguished literature focused on Indigenous sovereignty, the operationalization of genocide, and dispossession of land.

To fully understand why Indigenous theorizations of place are relevant to the public health discourse surrounding the opioid epidemic based in the Pittsburgh region and the importance of the intervention, there must first be a discussion around *sense of place*, as put forth by Indigenous studies scholars. In *Wisdom Sits in Places*, Keith Basso, utilizing the works of Sartre, Heidegger, and the ethnography of Western Apache people in Arizona, delves into the dimensions of human experience that constitute a sense of place beyond physical space (1996). He writes, "As natural "reflectors" that return awareness to the source from which it springs, places also provide points from which to look out on life, to grasp one's position in the order of things to contemplate events from somewhere in particular" (Basso, 1996, p.107). In connecting a sense of place to identity, he contends that the context of place colors how people experience place, as individual's project themselves onto the landscape (Basso, 1996). Arguing against an isolated and individualized relationship to the land, he contends "Relationships to places are lived most often in the company of other people, and it is on these communal occasions- when places are sensed together- that Native views of the physical world become accessible to strangers" (Basso, 1996, p.108.). From this awareness of the Indigenous relational connection to land, Basso illuminates how cultural and material context shapes the mental landscape of the mind, which informs how a person experiences place because place is more of a reflection of ourselves than it is a physical object. This relationship is not just psychological, but is also deeply and structurally affective, as Indigenous epistemological considerations do not sever knowledge from feeling (Rifkin, 2011; Million, 2018).

This theorizing on space is important for considering how the impacts of a racialized extractive industry, such as the creation of settler forts in colonial times, coal mining and steel production, and the newer technologies of gas extraction in the current moment are connected not only to the physical health of populations, but also their mental wellbeing (Tarr, 2013; Baldwin,

1971; Buck, 1969). This dimensional shift positions land as a way of a living way of knowing and understanding, rather than merely a stagnant object, considered only as a flat geographical map on which people reside. In other words, land actively has a relationship with people as they live their lives, rather than existing as a neutral backdrop in which life and society just happens on, as land is also living and is relationally impacted by other living beings, both human and non-human (Basso, 1996).

Sociogeny

Frantz Fanon's *Black Skin, White Masks* is considered a foundational work in the field of Ethnic Studies for its insights on the effects of dehumanizing anti-Black colonization. Fanon's work is remarkable in the ways he combines philosophy, phenomenology, psychiatry, and psychoanalysis within his clinical study to explore the destructive social relations of colonization that wound the body, psyche, and culture of colonized Black people (Fanon, 1952, p. 64). In *Black Skin, White Masks* Fanon puts forth his conceptualization of sociogeny, which he offers as a form of sociodiagnostics that connect the self to society. Fanon sees this connection as a central part of his clinical analysis as he argues "Society, unlike biochemical processes, does not escape human influence. We believe the juxtaposition of the Black and white races has resulted in a massive psycho-existential complex. By analyzing it we aim to destroy it" (1952, p. xvi). Thus, Fanon employs sociogeny within his narrative and ethnographic case studies to expose ways in which this psycho-existential complex manifests within colonized Black people in relationship to colonizing white people. In interrogating these relationships, Fanon mounts a significant challenge to Eurocentric notions of pathologizing and individualized models of health and healing.

Specifically, Fanon traces the embodied and affective suffering of the inferiority complex that results from the racialized colonization of Black people through education and potential interracial marriage. In his observations on language and culture in colonized education, Fanon offers "the Black man who leaves his home to study in France, notes that on his return he is "genetically speaking, his phenotype undergoes an absolute, definitive mutation" (3). He further contends, "white civilization and European culture have imposed an existential deviation on the black man", further stating, "there is one destiny for the Black man. And it is white" (Fanon, 1952, p. xvii, p. xiv).

In this way, Fanon is deeply concerned with the cyclical relationship between Black and white people. Fanon finds that as Black people strive to be white and white people attempt to live according to the "superior" standards of whiteness, "the white man is locked in his whiteness, the black man in his Blackness" (1952, p. xiv). While seemingly an abstract analysis, Fanon places this differentiation of experience, asserting "the Black man suffers in his body quite differently than the white man" (1952, p. 117). He illustrates this at length throughout the book, most notably in Chapters four, five, and six. In Chapter Five, he offers three poignant ethnographical insights relating to the body within social interactions with white people:

> I was responsible not only for my body but also for my race and my ancestors. I cast an objective gaze over myself, discovered my blackness, my ethnic features; deafened by cannibalism, backwardness, fetishism, racial stigmas, slave traders, and above all, yes, above all, the grinning Y a bon Banania. (1952, p. 92)

> Disoriented, incapable of confronting the Other, the white man, who had no scruples about imprisoning me, I transported myself on that particular day, very far, from myself and gave

> myself up as an object. What did this mean to me? Peeling, stripping my skin, causing a hemorrhage that left congealed black blood all over my body. Yet this reconsideration of myself, this thematization, was not my idea. (1952, p. 92)
>
> The white man is all around me; up above the sky is tearing at its navel; the earth crunches under my feet and sings white, white. All this whiteness burns me to a cinder. (1952, p. 93)

In his recognition of the body, he contends that the internalization of colonization creates an 'enormous wound' that "remains unseen and unfelt by the colonial powers even though they are the very cause of it" (Fanon, 1952, p. 48; Urena, 2019, p.1645). Fanon argues that the creation of wounded Black subjects cast through a master narrative of normativity renders them, and him, "an object among objects" who become pathologized as dependent, rather than relationally interdependent (Fanon, 1952, p. 92; Urena, year). Therefore, Fanon's stated purpose of destruction underlying sociogeny is imperative, as he sees the dismantlement of these racialized master normative narratives a necessary and essential part of overcoming and healing from the colonial wound. In this way, sociogeny is not a static concept, it is revolutionary and transformational in its application.

While his work is heralded in the fields of Ethnic Studies and philosophy, Fanon's groundbreaking decolonial conceptualizations have yet to break through into mainstream Western clinical fields, including and especially public health. This is interesting given Fanon's practice as a clinician was vital to his theorizing on the interrelation of colonized subjects and colonizers. In fact, he attempted to submit *Black Skin, White Masks* as his medical dissertation but due to hegemonic classification systems that dictate the confines of clinical epistemology, it was rejected for the ways in which it exceeded perceived boundaries (Urena, 2019, p.1641). This point of

rejection prompted critical disability scholar, Carolyn Urena to assert the importance of boundary breaking knowledge on health and illness, stating:

> By purposefully transgressing disciplinary boundaries, Fanon affirms the significance of looking beyond the traditional markers of pathology, to effectively explore the underlying traumas and wounds occasioned by the lived experience of coloniality. These wounds extend past the temporal limits of colonialism, for as Fanon (2004, p. 181) himself presciently wrote, 'the war goes on. And for many years to come we shall be bandaging the countless and sometimes indelible wounds inflicted on our people by the colonialist onslaught'" (2019, p. 1641)

For this project, I join Urena's and other decolonial scholars in their use of sociogeny as an intervention into the dominant normative epistemologies of Western health fields. The entry point in which I would like to take is the pathway that Fanon created in looking not only at the colonial wounds of the colonized, but also impacts that participation in colonizing had on the colonizer. Fanon's interrelation theorizing on Blackness and the Black man's pursuit of whiteness created a mirror for which to trace the impacts of participation in colonization and whiteness on white people, as he wrote "I am speaking here on the one hand of alienated (mystified) Blacks, and on the other of no less alienated (mystifying and mystified) Whites" (1952, p. 12). This mystification is a process used by colonizing powers on a structural and interpersonal level. Therefore, sociogeny is an expansive analytical tool that actively engages with and diagnoses destructive power relations that create and maintain disparate wounds, manifesting as health outcomes.

Thus, this intersectional application of sociogeny and Indigenous theorizing of place creates a deeper, multidimensional framework for demystifying the ways in which whiteness works within Public health discourse concerning the opioid crisis in Pittsburgh, Pennsylvania. With this analytical framework established, chapter two will review the dominant Public Health literature pertaining to the opioid epidemic along with a specific focus on geographically relevant research conducted through harm reduction 'risk environment' frameworks. Chapter three will

then discuss the methodological approach of this case study, which is posited in a Feminist Standpoint epistemology. Chapter four will lay out the case study findings in two data sets. The first data set focuses on state and Pittsburgh Public health discourse and the second is a photographic history of Pittsburgh's development. In chapter 5, I discuss the implications of the case study findings, arguing for the consideration of whiteness as a racialized identity which must be interrogated within Public health discourse and initiatives focused on solving the opioid epidemic. I contend that in doing this, the possibilities of diving further into the unaddressed pain from white supremacy becomes possible because it is no longer invisible.

Chapter Two: Literature Review

This chapter examines the dominant Public Health literature pertaining to the origins of the opioid epidemic and the various proposed policies and treatments to address the crisis. Reviewing the dominant literature in Public Health allows for an understanding of the ways in which medicalized origin narratives and universalized responses are reiterated in localities without the consideration and incorporation of place based relational context. The chapter begins with the historical use of the opium poppy for healing external bodily pains, tracing its development into the current forms of opiate prescription and street drugs. It then examines the proposed origins and driving factors of the current opioid crisis followed by Public Health's subsequent standardized approaches through prevention policy and practices, treatment and recovery Politics, and harm reduction policy. Last, the chapter focuses in on a study conducted in McKeesport, the former production site of the largest steel tube works. This is reviewed for the ways it utilizes the harm reduction 'risk environment' approach, which considers environmental factors that lead to risk behaviors, such as opioid use.

Historical Uses of Medicinal Opium

To better understand the current medicalized discourse and approaches concerning the opioid epidemic put forth by Pennsylvania and Pittsburgh based public health entities, is useful to contextualize the historical use of opium-based medicine and the processes that led to their current forms. Current forms of opiates are derivatives of the Opium poppy, which is a very powerful flower. Documented evidence suggests the flower was used in Neolithic cultures, Ancient Egypt, and in the ancient kingdoms of China although it was thought to be a native plant of the Swiss alps (Halpern & Blistein, 2019). Recorded uses of Opium include seeds and oil for

stomach issues, death rituals, adornment of tombs and coffins and ritual practices involving fertility goddesses (Halpern & Blistein, 2019) Contrary to the long-standing opinion through invasive archaeological studies on the Mesopotamians, the cultivation of Opium poppy began in the Mediterranean and subsequently spread eastward, with the first instance of domestication recorded at 6,000 years ago (Courtwright, 2001). Throughout its documented use, the poppy's history has been characterized by a paradox: periods of fear and disdain countered by periods of reverence for its power as a healing drug (Potter, 2014). While the poppy has been used medicinally in traditional practices of medicine in China and India, the scope of this paper will focus on the Western origins of traditional use and its instances of manipulation that pervert these careful and more holistic uses.

Between 50-70 AD, a Greek born Roman named Pedanius Dioscorides recorded knowledge and recommendation uses of the different kinds of poppies and their effects on human physiology in *De Materia Medica* (Halpern & Blistein, 2019; Potter, 2014). Dioscorides delineates three kinds of poppy: 1) "one with white seeds, 'cultivated and set-in gardens' which were used to make bread or used with honey; 2) the wild corn poppy, whose heads can be boiled in wine to produce a sleeping draught or taken with honey and water to soften the bowels; and 3) the 'more wild, more medicinal and longer than these' (Halpern & Blistein, 2019). Mainly Dioscorides recommended Opium poppy for conditions that called for a "cooling" remedy, citing instructions for how to apply generally: boil in water and apply with hot cloths or to treat a streptococcal skin infection known as erysipelas: pound into small poultices with polenta to reduce inflammation (Potter, 2014; Halpern & Blistein 2019)

Dioscorides writings treat Opium Poppy's power with a sense of care and respect that the plant deserves, as he warned that if the elixirs made from the flower were drunk too often, the

result “hurts”, by making people lethargic and kills (Potter, 2014)[1] He also laid out careful instructions for harvesting from the plant, laying out two forms of potency: a lesser potency could be made by squeezing the pounded stems and leaves through a press, beating the resulting mash in a mortar while pure opium was extracted by cutting slits in the fruit of the flower which resulted in the secretion of latex that is left to dry into a resin and scraped off later (Potter, 2014; Halpern & Blistein, 2019). Botanists point out that the latex is only released when the plant is wounded (incisions) as a form of self-defense (Kapoor, 1995 p. 195). Centuries later, William Turner declared “the white bringeth a pleasant sleep, but the black is evil and maketh a dull or sluggish sleep” after accidentally ingesting opium he had mixed with just water to treat a toothache (Potter, 2019, p. 114). He wrote that had he not taken “a piece of the root of masterwurt with wine” he would have died, going on to write down instructions to treat poisoning: “induce vomiting by drinking pepper and the scrotum of a beaver in honeyed vinegar, wake the patient by thrusting stinking things up his nose, bathe him in warm water, then feed him fat meats and hot wine” (Potter, 2014, p. 115).

In addition to the Greeks and Romans, traditional cultural healing practices involving the Opium poppy also derive from what now forms the nation states of India and China that reflect similar approaches (Halpern & Blistein, 2019). Interestingly, these practices did not produce issues of widespread abuse and addiction that occurred as opium was taken by other means. The Dutch, for example, introduced the smoking of Opium in China and Christopher Columbus and his sailors mixed opium with their “newfound discovery” of tobacco, combining two extremely

[1] In the cases of coughs and abdominal issues, the poppy could be boiled first in water and then in honey to produce a capsule called “a licking medicine” (Potter, 2014; 106). In terms of ingestion, black poppy seeds drunk with wine could be used to reduce diarrhea and excessive discharges in women (Potter 2014; De Materia Medica). Other parts of the flower could be mixed with other ingredients and be used for earaches, inflammation of the eyes, gout, wounds, and a general pain killing suppository (Halpern and Blistein, 2019; Potter 2014).

addictive plant substances into one single blend (Halpern & Blistein, 2019; Booth, 1996). Smoking opium is highly addictive due to the increased potency regarding how quickly it passes into the lungs and gets absorbed into the blood stream. Prior to this, opium was taken through dilution by boiling it and in combination with other complementary herbs, foods, and wine. In contrast, smoking opium sends the drug directly into the lungs, and thus into the bloodstream and then directly to the brain (Halpern & Blistein, 2019). The smoked form of opium addiction is often attributed to the Chinese, however, it's important to note that Europeans first used this form of opium recreational consumption not recommended by healers and other knowledge keepers (Halpern & Blistein, 2019; Booth, 1996). These recreational uses of opium began to circulate through the colonizing project of the Spice Trades.

Medicinal uses of opium continued from the middle ages and into the 18th century which saw a proliferation of medicinal opium by-products, called "gentler" over-the counter remedies made from the white poppy seeds that found their way into household medicine chests through developing capitalist markets (Potter, 2014). By the 18th century, poppy-based preparations were freely available in a wide variety of liquids and solids, with different recommended doses for men and women as well as opiate tinctures for children such as Godfrey's Cordial, McMunn's Elixir and Mother Bailey's Quieting Syrup (Booth, 1996; Courtwright, 2001; White, 2014). In the developing medical industry, new forms of *opiates*, which are the alkaloid derivatives of the poppy such as morphine, were used to treat severe pain and wounds from battles during the Civil War (Booth, 1996; Courtwright, 2001). This ushered in a new wave of use that resulted in the first instances of opioid addiction in the United States, as physicians began to prescribe opioids more frequently to middle-class and upper-class white women for menstrual cramps and other "female complaints" (Booth, 1996; Courtwright, 2001; White, 2014). As prescriptions increased,

so did demands, and by the end of the 19th century several states began to take action by passing laws that prohibited the sale of over the counter sale of opioids, with an exception for opioids included in patent medicines (Courtwright, 2001).

The Modern Turn

At the turn of the 20th century, Bayer Pharmaceuticals began to chemically modify opiates to create new types of *opioids* (Courtwright, 2001; White, 2014). In 1898, Bayer announced its first derivative of morphine for cough suppression which they called 'heroin', which was shortly abandoned as the estimates of habitual use of opioids was around 250,000 (White, 2014). Concern over opioids and addiction led to tightening restrictions on manufacturers and prescribers, culminating into the passage of the Harrison Act in 1914, which served as the regulatory structure that included registration and taxation of opioids (Courtwright, 2001; White, 2014)

In the decades following the Harrison Act, physicians rarely prescribed opioid medications for chronic use as doing so invited prosecution from the ruthless enforcement of the medical system, which carried over into law enforcement efforts against heroin and other illicit opioids (White, 2014). Despite the crackdown, heroin overdose was the leading cause of death in New York City during the 1960s, usage that again increased tenfold during the Vietnam War (Musto, 1999; White, 2014). Historian David Musto estimates that the number of heroin users increased from 50,000 to 500,000 from 1960 to 1970 (Musto,1999). The response to this epidemic is what became known as the "War on Drugs" established by President Richard Nixon who set a national goal "to destroy the market for drugs. This national goal also meant efforts were developed to prevent new addicts, to rehabilitate those addicted" by implementing efforts to decrease supply, greater penalties on drug sellers and the expedited prosecution of narcotic trafficking cases (White, 2014). Later in 1986, Ronald Reagan passed the Anti-Drug Abuse Act,

which provided billions of dollars for policing and imposed federal mandatory minimum sentencing for minor drug offenses. This resulted in an explosive growth of jails and prisons that were filled disproportionately with poor whites, Black and African Americans, Latinos, and other persons of color (White, 2014). It is in this context and time period that the culture of medical care started to shift.

Starting in the 1980s as the culture of medicine began to focus on treating pain, the publication of a short piece in the New England Journal of Medicine entitled "Addiction Rare in Patients Treated with Narcotics" asserted that the use of opioids in patients with chronic illness did not result in addiction (White, 2014). Its publication has been identified as a beginning point for the current opioid crisis since it has been cited hundreds of times over as a part of a movement to dismantle the stigma around the use of opioids and to expand their use into the treatment of chronic pain (Porter & Jick, 1980, p. 123; Hawkins, 2017; White, 2014). The movement to prescribe more opioids for pain was enthusiastically supported by pharmaceutical companies that created and marketed a new generation of synthetic long-acting opioid derivatives. These synthetic opioids created in the lab differs in potency and thus has differing effects for how long they stay in the body, how fast they move into the brain, and how they stimulate and bind to different brain receptors. All these factors determine the severity of addiction.

The biggest corporate supporter synthetic opioids were Purdue Pharma, which introduced Oxycontin into the market in 1996 with the described advantage of convenience in that the pill could be dosed twice a day rather than four times a day via a generic version. The company spent millions of dollars selling Oxycontin to physicians, giving bonuses to sales representatives who helped increase sales revenue of prescriptions. Critical to their success, Purdue minimized the

concerns regarding addiction by extensively citing data out of context, such as safety information taken from short-term use to reassure physicians about the safety of long-term use (White, 2014). In addition, they convinced the U.S. Food and Drug Administration to state on the label that the long-acting nature of the drug made it less likely to cause addiction, which was not in fact true (White, 2014). The cultural change in prescribing Opioids impacted every aspect of medical practices and systems. In 1996, the American Pain Society identified the concept of 'pain' that was to be reported by the patient as a fifth vital sign, which was then adopted by the Veterans Health Commission in 1998 (Quinones, 2015, p. 94). Later in the year 2000, along with the support of federal agencies, the Joint Commission on Accreditation of Healthcare Organizations began to use pain control as a key element in the inspections of hospitals. Patient satisfaction was viewed as important and physicians feared the consequences from any drop-in patient satisfaction (White, 2014).

In 2011, the Institute of Medicine released a report declaring that pain is a public health crisis, affecting more than 100 million Americans, going on to suggest that opioids were still being underused and that addiction was the result of "the misdeeds or carelessness" of certain physicians and patients (Institute of Medicine, 2011). At the time of this publication, the United States was consuming 80 percent of the world's supply of prescription opioids (Lembke, 2016). Also, at this point in time, the opioid epidemic had been divided into three waves: Prescription Opioids, Heroin, and Fentanyl. It's important to note this remains the current focus as the re-emergence of Fentanyl in 2013 has only gotten stronger. In response, the field of public health and its corresponding entities are looking to be the leaders of holistic care in addressing and mitigating the rise of predicted deaths from opioids. This so-called new approach by the

behavioral health field articulates that this is a distinctly different approach than behavioral health measures taken in the past.

Social Determinants of Addiction: Public Health's Intervention

The AIDS epidemic in the 1980s helped catalyze a new public health movement that shifted focus on disease away from predominantly biomedical understandings toward the inclusion of the social and environmental impacts on health (Rhodes, 2002; Ashton & Seymour, 1988). In 1986, the World Health Organization codified five principles of the public health movement in the Ottawa Charter for Health Promotion: (1) developing individual personal and social skills (2) re-orientating health services toward improving access, availability, and use (3) facilitating and strengthening community participation and collective action (4) creating local environments that are conducive to individual and community health; and (5) creating public policies supportive of health (WHO, 1986). Commenting on the multi-dimensional nature of WHO's principles, prominent AIDS researcher, Tim Rhodes states "risk reduction is an inter-sectoral and multi-level activity encouraging individual, community, policy, and environmental change" (2002).

With this framework, Public Health initiatives focus on ways to promote well-being by preventing or intervening in mental illness, substance abuse, and other detriments to public health by advocating for "the need to balance individual and collective action as a means of facilitating changes in individual and population health" (Rhodes, 2002; WHO, 1986). In addition, a paradigm shift within Public Health and Epidemiology generally toward ecology has, coalesced more recently around the foundational concept known as *social determinants of health* (Rhodes, 2002; Islam, 2019). The World Health Organization defines the social determinants of

health as the conditions or circumstances in which people are born, grow, live, work, and age that are shaped by political, social, and economic forces (WHO, 2008). Through this concept, health outcomes are connected to the ways in which material and social resources, such as a healthy living environment, employment opportunities, education, food, and healthcare, are distributed through policy and governance (WHO, 2008). The aforementioned list was the initial set of social determinants of health, but over the last decade the list has grown longer and now includes housing, income distribution, stress, early life, social exclusion, work, unemployment, social support, transportation, and addiction. Even more recently, social determinant literature has expanded dimensionally into health systems, gender, sexuality, social safety nets, culture or social norms, media, discrimination, social capital, conflict, rule of law, racism, racialized legal status, immigration, family, religion, colonialism, and marginalization (Islam, 2019).

Public Health describes *addiction* as the pathological craving and compulsion that drives someone to keep using a substance even in the face of severe negative consequences to their life (NIH, 2018;). This craving is informed by the physiological tolerance that develops as the body adapts to opioids in a matter of days and brain receptors on the surface of the cells become desensitized (NIH 2018). The resulting physical dependence, which is noted as a function of biology alone regardless of behavior, suggests that "everyone who takes the equivalent of 60 mg of morphine a day will develop a physical dependence" (Nielsen et al 2016).

The Opioid Epidemic is described as a problem that "cuts across all categories of identity, and impacts people similarly regardless of race, class, and gender" with variations of addiction stemming from explanations of genetics (Olsen & Sharfstein, 13; Kapoor 1995; CDC June 2018). The origin of the Opioid Epidemic is thus seen as an issue of "misuse" of opioids, both in terms of overprescribing by doctors and the overtaking by patients (Saloner, 2018; Center

for Disease Control, 2018). As such, public health has delineated three areas of policy and care response focused on prevention, treatment and recovery, and harm reduction (Strand & Eukel, 2019; Kolodny et al., 2015; Manchikanti et al., 2012).

Prevention Policy and Practices

According to Olsen and Sharfstein, addiction involves the interaction between substances, individuals, and their environment. They outline three ways to prevent addiction: reducing exposure, assisting people when exposure occurs, and by promoting a healthy environment for all (2019, p. 159). Current measures that help reduce exposure to opioids include accessibility to opioid alternatives, training prescribers, limiting new prescriptions, promoting evidence-based guidelines, the implementation of drug monitoring programs and take back days. Researchers argue that many patients do not require use of opioids at all, suggesting alternative such as physical therapy, acupuncture, massage therapy, and counseling to address chronic pain without medication (Tick, Nielsen, Bonakdr, Simmons, Glick, Ratner, Lemmon, Wayne & Zadur, 2018). Research efforts also provide evidence to suggest that many physicians and nurse practitioners have received little or no formal education in basic aspects of opioid prescribing and suggest more training hours as a condition of license renewal (Olsen & Sharfstein, 2019). Additionally, research demonstrates that doctors tend to prescribe 20 to 30 times more pills than patients need, and therefore suggest that the implementation of 2 to7 days prescriptions reduces the chances of addiction (Strand & Eukel, 2019; Gottlieb, 2018; Mass. Medical Society, 2016). Public health officials suggested that both practices should be guided by evidence-based guidelines such as those put forth by the Centers for Disease Control or Optumlabs (Sanghavi, Atlan, Hane & Bleicher, 2017).[2]

[2] Optum labs is a private health research facility co-founded by Optum and Mayo Clinic in late 2012.

In addition, researchers find that prescription drug monitoring programs, which have databases with information about the prescriptions of controlled substances, can help prevent harm from opioids in three ways (Weiner, Bao, & Meisel, 2017). These programs monitor patient appointment times and prescription origin and monitor for multiple prescription origins which signal misuse. Public health officials claim that these programs can be used to monitor physicians who show signs of overprescribing opioids. Lastly, Public Health researchers suggest that policymakers can use the monitoring programs to assess whether prescribing overall is improving (Weiner, Bao, & Meisel, 2017). Another form of prevention comes from take-back days where the general public can return any unused opioids and other medications to prevent theft and misuse (Weiner, Bao, & Meisel, 2017). However, because the number of drugs returned on take-back days have been insignificant in proportion to the amount that are dispensed, other solutions are being put forth. Other options suggested including crushing up the pills and mixing them with coffee grounds to throw them out or flushing them down the toilet (FDA, 2018).

Public Health experts suggest the promotion of a healthy environment prevents opioid use. To do this, they suggest that the U.S. Food and Drug Administration should closely monitor prescription medications and the marketing of opioids, change the labels of opioid medications and packing of products, and restrict the use of certain medications. In addition, Public Health research shows a wide range of biomedical and public health scientists have invented new products to prevent the misuse of opioid medications, including new types of pill bottles, pills with sensors, time-release bottles, and chemicals that can be mixed with excess opioids and other controlled medications to turn them into useless gel before they are thrown out (National Academies of Science, Engineering, and Medicine, 2017).

Treatment and Recovery Policy

Broad access to effective treatment is crucially important as it does more than just help save overdosing people. Public health studies suggest that if treatment is well-organized into a system of care that is broadly accessible it can bend the curve of the epidemic (Olsen & Sharfstein, 2019). Effective treatment for opioid addiction addresses problems caused by both prescription and illicit opioids, resulting in fewer overdoses, less crime, smaller drug markets, and more employment, all changes lauded to facilitate economic development (Olsen & Sharfstein, 2019). Effective treatment works as prevention, as it is seen as a way to stop the spread of a disease that is contagious, as "more people in treatment means fewer opportunities for people "misuse" opioids (Baltimore Substance Abuse Systems, 2018; Institute of Medicine, 2011). A "successful treatment *program* is one that offers high quality services to a group of patients, whereas a treatment *system* offers a full range of effective services, based on evidence-based solutions, offered to a population" (Olsen & Sharfstein 2019, p. 172; Institute of Medicine, 2011). An effective treatment system is characterized by a sufficient scale, well-coordinated organization, and high-quality assessments (Institute of Medicine, 2011; National Institute on Drug Abuse, 2016). The measurement of sufficient scale means that there is enough readily accessible treatment for all people who need it. The measurement of organized coordination suggests that treatment settings be well connected to one another in order to build a network of care. Lastly, the measurement of quality assessment tracks the key metrics of quality and service for programs focused on public health outcomes, such as progress in treatment and reduction in overdoses (Olsen & Sharfstein, 2019; Institute of Medicine 2011).

Public health literature suggests three important elements of an effective treatment system include access to medications, counseling, and a variety of supportive health areas (Olsen

& Sharfstein, 2019; Institute of Medicine, 2011; National Institute on Drug Abuse, 2016). The Food and Drug Administration has approved three medications for opioid addiction: methadone, buprenorphine, and naltrexone. The Department of Health and Human services along with current research suggests that medication use increases retention in treatment, reduces the risk for overdose, and helps people to achieve remission and recovery. This approach is also backed by the National Institutes of Health, the Centers for Disease Control and Prevention, and the World Health Organization (SAHMSA, 2018; CDC, 2016; WHO, 2009; Schwartz et. al 1995-2000)

Research regarding the treatment and recovery policy and practice approach suggests that communities themselves should play a role in the creation of treatment and recovery plans, as community opposition to addiction treatment can act as a barrier to needed services (Padgett, Stanhope, Henwood & Stefancic, 2011, p. 227). This includes the call for expanding housing services, as many people with severe addiction experience homelessness, which compounds issues and complicates efforts for people to receive ongoing treatment (Padgett, Stanhope, Henwood & Stefancic, 2011, p. 229 Suggestions for effective models include Housing First models that do not require criteria to be met to obtain housing, as well as “supportive housing," which are residences for people where they can also receive the care that they need (Larimer and Garner et al., 2009). Additionally, the establishment of employment programs is also included under treatment and recovery, as many people face unemployment as a result of their addiction (Marshall, Goldberg, Braude et al., 2014). Stable employment is seen as a way for people to reconnect with their families and develop productive routines that do not include or revolve around drug use (Marshall, Goldberg, Braude et al., 2014).

Harm Reduction Policy

The Harm Reduction movement emerged both historically and conceptually alongside new forms of public health practices during the AIDs crisis (Rhodes, 2002). As both public health and harm reduction share the same principles, harm reduction is often held up as the ideal model of the public health practice due to the well-established and effective interventions in public health crises (Rhodes, 2002). These interventions are noted to be "rapid and pragmatic, community-based and community-level, and which develop user-friendly and low threshold services" (Rhodes, 2002; Stimson, 1995; Ball, 1998; Des Jarlais, Hagan & Friedman, 1995). Examples of these interventions include outreach programs, peer, social network, and group interventions, access to sterile injection equipment, low threshold drug treatment, community development advocacy and public policies that support community led initiatives (Rhodes, 2002).

Situated within the issue of substance use, harm reduction is described as "a set of practical strategies aimed at reducing negative consequences associated with drug use" and is predominantly focused on changing "risk behaviors" (Harm Reduction Coalition, 2018; Rhodes, 2002; Diclimente & Peterson, 1994). The focus on risk behaviors comes from a combination of 'rational decision making', 'reasoned action theories', and psychological concepts of health beliefs (Becker, 1974), and self-efficacy (Bandura, 1977) that construct 'risk' as an issue of cognitive health (Rhodes, 2002; Fishbein, Middlestadt & Hitchcock, 1994). Harm Reduction is also regarded as a "movement for social justice built on a belief in, and respect for, the rights of people who use drugs" (Harm Reduction Coalition, 2018). Harm reduction starts with the principle that the lives of people who use drugs are worth saving, and thus access to addiction treatment is a harm reduction strategy (Harm Reduction Coalition, 2018). Harm reduction

includes a variety of resources to help the many people who are not interested in treatment, which then helps to keep people alive, protected, caring for themselves and able to begin a process of recovery (Harm Reduction Coalition, 2018). Another key principle of harm reduction is listening to people who use drugs to hear directly their perspective about the dangers they face, which allows users to provide input in the design of services. Harm reduction also recognizes the social context of drug use, including the "realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities" (Harm Reduction Coalition, 2018).

Effective harm reduction approaches not only provide specific services but also aim to support users of drugs with the major challenges in their lives. Examples of harm reduction programs include distribution of naloxone, syringe services, drug checking, and overdose prevention sites. First, Naloxone distribution programs seek to make the medication accessible to people who are more likely to save lives from overdose, as well-designed studies show the medicine's effectiveness (Castillo, 2018). Naloxone is a medication that stops dangerous disruptions in heart rhythms, reversing overdoses and keeping people alive. Currently, naloxone is made available through a local health officer, who provides a standing order that allows anyone in a community to access a dose from a pharmacy. Behavioral health entities suggest that Naloxone should be available over the counter in order to increase greater availability (Mahoney, 2016; Naloxone overdose prevention laws, 2017). In addition to this, emergency responders such as the police and the fire department are being encouraged by states and communities to begin carrying Naloxone and today many first responders do carry it (Hawk, Vaca, & Onofrio, 2015).

Syringe services programs offer clean needles and other supplies, as well as training on safer drug use. Syringe services developed in response to the HIV/AIDS crisis in the 1980s to

mitigate the spreading of the disease through needle sharing (Hagan et. al., 2015). Beyond reducing the spread of disease, syringe services programs offer several important benefits, including reducing the number of syringes found in public places (Ksobiech, 2004; Tookes et. al., 2012). These programs can also be a first step in connecting people to social services such as housing, food assistance, and job training (Tookes et. al., 2012). Some of these programs have also made moves to incorporate the administration of buprenorphine (Freese, 2018). The most successful programs tend to encourage syringe return without requiring a one-to-one match and distribute the right number of syringes for short-term personal use, which creates opportunities for repeat visits and engagements (Bluthenthal et al., 2007).

Following this, drug checking is a service that provides information to people about what is in their street drugs in situations where people are unsure of what they bought. These programs were originally developed in Europe to test club drugs and is an emerging strategy to deal with the recent onset of the fentanyl epidemic (Sherman & Green, 2018). Drug check is advantageous for users and the community, as people can take steps to protect themselves and warn others. Lastly, overdose prevention sites are spaces where people can bring their drugs to use them. These sites have personnel who stand ready to revive those who overdose and can be co-located with other services (Sherman, Hunter, & Rouhani, 2017). Public health studies have found evidence that overdose prevention sites reduce overdose deaths and increase access point to effective treatment (Sherman & Green, 2018). In addition, there is evidence that shows the community benefits with the decline of syringes found in neighborhoods and reports of public drug use. Researchers disagree on the quality of evidence that supports supervised consumption facilities; however, this has not stopped testing and development.

Place Based Research on Drug Use

While most harm reduction policy and practices have been overwhelmingly focused on overdose mitigation risks, some harm reduction researchers have critiqued this approach for the ways in which it pathologizes individuals and ignores the intersections of micro and macro environments (Rhodes, 2002; McLean, 2016). This pathologizing sits in a contradiction to the supposed focus inherent to the social determinants of health that are connected to larger societal contexts (Rhodes, 1997a; 1997b). In challenging the focus on individuals as the only site of concern, there is a small body of work that has taken up Place-Based frameworks to examine drug use, with a current focus on opioid use. In the article, *"There's nothing here": Deindustrialization as risk environment for overdose,* Katherine McClean applies Rhodes (1997a;1997b; 2002) "risk environment" approach to a study conducted in McKeesport, which is a former steel producing borough in the Pittsburgh metro area that has experienced severe deindustrialization and decay as a result of steel mill closures in the 1980s. The "risk environment" approach put forth by Rhodes is significant in the ways it pushes back against harm reduction's focus on individuated, neoliberal and epidemiological approaches that often do not involve communities or take up a political position in advocacy (Rhodes 2002; 1997a; 1997b; Rhodes, Stimson, Crofts, Ball, Dehne, & Khodakevich, 1999). In his work on the intersection of AIDS patients who are also injection drug users, Rhodes contends,

> "A harm reduction praxis founded on a risk environment framework illuminates the parallels in how social contexts influence health and vulnerability in general as well as drug-related harms in particular. This inevitably leads to a consideration of non-drug and non-health specific factors in harm reduction, and in turn, points to the importance of

what might be described as ‘non health-oriented interventions’ in harm reduction” (2002).

From this, Rhodes defines a risk environment as “the space—whether social or physical—in which a variety of factors interact to increase the chances of drug-related harm” (2002, 1997). Rhodes, noting the broadness of this definition, offers a simple model based on two key dimensions: types of environment and level of environmental influence (2002). The two dimensions are then organized by the four ideal types of environment that are used within the field of harm reduction: physical, social, economic, and policy which are all situated within the two ideal levels of environmental influence: micro and macro (Rhodes, 2002; Latkin, Mandell & Vlahov, 1994).

Research in relation to micro-risk environment includes interrogating the relationship between risk perception and behavior and social norms, rules and values (Friedman, Neaigus, Jose, Curtis, Goldstein, & Ildefonso, 1997; Latkin, 1996); the structures of social networks, relationships, peer groups (Latkin, Mandell & Vlahov, 1994; Latkin, Mandell, Vlahov, Oziemkowska & Celentano, 1996 ; Friedman et al., 1997, Neaigus, 1998; Wiebel, Jimenez, Johnson, Ouellet, Jovanovic, Lampinen, Murray, & O'Brien, 1996; Broadhead, Heckathorn, Weakliem, Anthony, Madray, Mills, & Hughes, 1998); the immediate social settings, including locales and neighborhoods, where drugs are used and users live (Ouellet, Jimenez & Johnson, 1991; Wiebel et al., 1996; Koester, 1994; Bourgois, 1998). Research regarding the macro risk environment includes both the public and legal context of risk management (Doyle, 1979), the material and social inequalities related to economic, gender, and ethnicity (Bourgois, Lettiere, Quesada, 1997; Friedman, Jose, Stepherson, Neaigus, Goldstein, Mota, Curtis & Ildefonso, 1998; Singer, 1998, Carlson, 1996); macro public health, drug, welfare and economic policies, as

well as public discourse that "shape the micro social relations of risk and risk resistance as we all as individual drug user practices" (Rhodes, 2002; Grund, Stern, Kaplan, Adriaans & Drucker, 1992; Bourgois, 1998).

In taking up this framework, McLean notes that most research is done in areas where free sterile equipment, naloxone, and/or harm reduction services like drug consumption rooms seem readily available. Thus, McClean's intention in conducting research in McKeesport is to explore the connections of mutually re-enforced public health issues so as to "generate critical insights into the geographic distribution of accidental drug overdose in a place buffeted by indifferent forces of economic restructuring, namely the decline of manufacturing and concomitant loss of jobs in western Pennsylvania" (McLean, 2016). To do this, she conducted a survey of 50 participants who were described as 64 percent male, 60 percent identified as white, and 40 percent identified as African American (McLean, 2016). McLean reported that survey participants sat at mean age of 40, with 56 percent of individuals between ages 30 and 50; with Two-thirds of participants indicating unemployed or permanently disabled status; and 22 percent lived in dependent housing facilities (McLean, 2016).

Following the survey, McLean conducted interviews with 18 clients accessing the only treatment facility located in McKeesport. Through in-depth interview sessions in which questions relating to experiences of opioid overdose, as well as the roots and potential remedies of the crisis, participants described what McLean identified as a micro risk environment (2016). McLean then contextualized this micro risk environment in media portrayal, stating "the "new" heroin users of Allegheny County have been depicted in highly normalized terms, variously described as "soccer moms, business executives, high school kids with money to spend, and people from every walk of life" (2016; Purcell, 2015). She argues that this depiction is

disconnected from the mortality data provided by the Allegheny County Medical Examiner's database that shows "an obvious spatial association between deadly overdose and poverty, with the highest fatality rates clustered in the region's deindustrialized communities and Pittsburgh's inner-city neighborhoods' (McLean, 2016).

In this way, McKeesport and other multiply distressed boroughs in Pittsburgh are on the margins of the opioid crisis, as they are rarely mentioned within public health or media coverage except in the instances of police raids and drug busts. McLean argues that the omission of context, combined with successful attempts to destigmatize addiction as an illness creates inadvertent addicts" whose "inhabiting idealized places – conventionally successful suburban dwellers whose exposure to opiates seems hardly predictable" (McLean, 2016). She further contends, "This class of victim is denied any established risk factors, a condition that again displaces culpability for addiction and overdose to an inherently dangerous drug, while obscuring a persistent connection between drug-related harm and low socioeconomic status that has been well-established by decades of scholarly studies" (2016). The interviews gathered for the study illuminate the interplay of place and socioeconomic conditions that inform a risk environment at both the micro and the macro levels. For example, in terms of micro-risk environment, none of the interview participants had contact with Naloxone despite its stated availability through Allegheny County's clean needle exchange program (McLean, 2016). In terms of the macro risk environment, the interviews point to the desperate felt reality of living in a deindustrialized area, as McLean offers "participants' descriptions of McKeesport, and the wider Mon-Valley, were consistently framed negatively, alluding to the many things that the community lacked – not only jobs, but also residents, effective government, social events and

activities" (McLean 2016). Examples of such descriptions are highlighted in the following block quotes from interviews within the study:

> "It's just a depressing area, there's nothing…I mean people come to McKeesport to get drugs, from other areas…because that's what is here…McKeesport, I just think there's nothing…all the good people have kind of moved out and moved away because of all the drug addiction and all the mental health here and, I mean, I think it's just depressing, there's really no good jobs here, no good, you know, anything."

> "People are like…. I don't know, [heroin]'s so readily available, and [the area is] so…gloomy? Depressing looking…Shit, let's just go and get some bags, and just lay up and get high. So, if you're not doing too much and you pull enough, you go die."

> "There is no sense of community here. Not one, not one iota of community here. Not one. So, left to your own devices, somebody that's drinking and drugging is gonna continue drinking and drugging. Nothing else, cause there ain't shit else to do."

McLean notes, "when users themselves were asked to explain a regional epidemic of overdose, they talked about the need to work upon the region itself, not only the most vulnerable residents within". In this way, she concludes her study by suggesting the inclusion of individuals who live in this deindustrialized context within the "affluent pandemic" narrative is imperative in drug policy considerations (2016). Therefore, McLean's intervention and consideration of deindustrialized place-based harm reduction research within public health policy and solutions is where this project emerges. While the review of the dominant Public health literature concerning the scope of the opioid epidemic and the subsequent research and proposed solutions show attempts to mitigate death from opioids in the short term, these discussions and solutions are missing other important underlying considerations, specifically place based racial factors. Furthermore, the dominant literature and explanations promote a narrowly specific understanding that limits solutions to a westernized medical model that does not consider other

ways of understanding or addressing pain. Thus, this project intends to create more space by offering a deeper and more nuanced intervention beyond diminished economic factors by interrogating the socio-historical intersections of place, race, and pain that remains in physical and relational structures.

Chapter Three: Methodology

"I am not interested in pursuing a society that uses analysis, research, and experimentation to concretize their vision of cruel destinies for those bastards of the pilgrims; a society with arrogance rising, moon in oppression, and sun in destruction."
Barbera Cameron

This is a qualitative case study guided by an intersectional Feminist Standpoint epistemology. Feminist researchers often employ qualitative methodologies to engage issues of power and subjugated meaning, creating innovative approaches that challenge knowledge production and discourse about "differently situated people, things, and issues by and circulating especially among those situated in positions of greater power, legitimacy, and/or authority" (Hesse-Biber & Leckenby; Haraway 1991; Clarke, 2005). According to Hesse-Biber and Leckenby, "Feminist research is marked by an openness to the fluidity and flux of the research question, allowing the question to be informed by shifting power relationships within the research process, methodological choices, and situational changes" (2004; 210).

Since 2008, the Opioid Overdose crisis has ravaged the United States. While the national death toll is undoubtedly grim, there have been areas of the country that have been impacted more so than others. In particular, in 2017 the state of Pennsylvania saw 5,546 drug-related deaths, the majority of which were due to opioids (Ahmad, Rossen, Warner, & Sutton, 2018). This equates to 43 deaths for every 100,000, which is almost double the national average of 22 per 100,00 (Ahmad et al., 2018). As a result, the current governor, Tom Wolf, has stated "the misuse of illicit and prescription opioids is a crisis without geographic, demographic, or socioeconomic boundaries in Pennsylvania (DEA Philadelphia Division and University of Pittsburgh, 2018). However, there is a range of difference between specific Pennsylvania locales that is reflective of geographic, demographic, and socioeconomic differences. The governor's

universal view on overdose death data has thus been used by state and Public health officials to describe the epidemic as an "uncurable, naturally existing disease" that predominantly impacts white, middle class men (Meyer & Sholtis, 2018). However, there is research that suggests that synthetic opioid death rates among non-Hispanic Black and Native people are the highest compared to all racial categories (SAMSHA, 2020). Additionally, there is also research that shows women who are struggling with addiction and have children are less likely to seek treatment given the reality of legal custody issues, which points to serious considerations around gendered rates of overdose (SAMSHA, 2020). Seemingly then, there appear to be many disconnects between Pennsylvania's public health framing of the crisis, the approach in addressing the crisis, and the social locations that are not being publicly accounted for.

Therefore, this is a discourse analysis that seeks to explore this disconnect within Pennsylvania's Public Health's framing of the opioid overdose crisis through a place-based focus on the city of Pittsburgh located within Allegheny county, which is listed as the fourth most impacted county in the state (DEA Philadelphia Division and University of Pittsburgh, 2018). Discourse analysis is an approach that focuses on written or spoken language and its connection to social context. Discourse also analyzes narrative structures, identifying sequences of events and making meaning of the actions and corresponding results (Labov, 1982; Schiffron, Tannen & Hamilton, 2001). Discourse analysis often employs ethnographic analysis, which focuses on the culture and social regularities of everyday life (Merriam & Tisdale, 2015). Going further, Wolcott (1994) offers that ethnographic data "presents analysis as description" explaining that "analysis and description are often combined as descriptive data and used interchangeably" (p. 11).

As such, this qualitative case study uses descriptive coding of document data as method to investigate two research questions: RQ 1): How is whiteness talked about in Pittsburgh Public Health discussions and solutions directed at the opioid epidemic? And RQ 2): How is place considered within local Public Health discussions around opioid addiction? Descriptive coding is a first cycle coding method which leads primarily to a categorized inventory, tabular account, summary or index (Saldaña, 2009, p. 48, p. 72). Descriptive coding addresses questions concerned with events, while also identifying and analyzing the essential features of systemic descriptors and their interrelationships (Saldaña, 2009, p. 12). In this way, descriptive coding allows for interpretation that speaks to social meanings, as descriptive words can carry overt and/or covert moral judgments and often serve as the basis for mor abstract interpretations of data and theory development (Saldana, 2009, p. 12; Corbin & Strauss, 2008, p. 54).

Case study serves as methodology given the place-based nature of this research. Case study is described as "an intensive, holistic description and analysis of a single, bounded unit", in which a *bounded system* is defined by the single entity or unit placed within limited parameters that contain the focus of the study (Merriam & Tisdale, 2015). The focus of study derives from the desire to gain and provide an in-depth understanding of cases as they exist in their real-world context, "especially when the boundaries between phenomenon and context are not clearly evident" (Yin, 2014, p.18). Therefore, an integral aspect of case study research is the inclusion of context and other complex conditions, which allows for an analysis beyond isolated variables. This case study is bounded by both time and place, as it investigates the framing of race in public health discourse around the high rates of opioid deaths from 2008 into the current year of 2020 in the boroughs of Pittsburgh. It is typical of case studies to include interviews, field observations, and documents (Merriam & Tisdale, p. 232). For this study I include field observations,

reflective journaling and memos, analysis of photos, and document data. This is a single case study, and it is important to note that one of the challenges in case study is the organization of the data. Organization for this case study database is organized into folders and files on a computer database designated by the domains of data collected (Yin, 2014). That is, the case record contains and organizes the data used for access to particular types of data to provide a method for crafting the final case analysis and case study (Patton, 2015).

This analysis combines an exploration of the racial formation of whiteness situated in the historical and geographical context of Pittsburgh. This allows for a critical interrogation of the messaging surrounding opioid overdose death, the recommendations for addressing the crisis, and the corresponding treatments offered to people who continue to struggle with opioid use. Case study in this project is particularly appropriate since the location and history of place in this study is of central importance to examining opioid deaths and public health messaging around whiteness (Yin, 2014). As with other forms of qualitative research, the researcher serves as the "primary source of data collection and analysis, an inductive investigation strategy" (Merriam & Tisdell, 2015, p. 37).

A preliminary study of document data began in 2017 and was completed in the summer of 2020. The initial study of documents started with the examination of voting data coming out of the 2016 election in correlation with Pittsburgh's deindustrialization in the 1980s and white flight using internet data bases, including national and local news outlets, social media forums, and archived data from peer reviewed databases. From this data, it was discovered that specific boroughs are subject to austerity measures under the Distressed Municipalities Act that would have severe implications for these deindustrialized areas which were already impacted by serious pollution, the emergence of fracking, and extremely high rates of cancer. In the spring of 2018, a

member of my family from this area died of opioid overdose and it was revealed that other family members, as well as friends, had all entered treatment for their own issues with Opioid use. While my family has clearly been impacted by the opioid crisis it was the place-based location of the opioid crisis and socio-economic (history of labor practices) prevalence of related deaths in Pittsburgh that caught my attention and emerged as relevant and timely for this study. It appeared that descriptions of the opioid crisis by public health officials was devoid of particular analysis that illuminate how whiteness and labor may actually inform what appeared to be fueling the crisis locally and specifically in Pittsburg. This is particularly important given how whiteness as race is largely overlooked and ignored in such a serious and contemporary health epidemic. This is a particularly important study given the ways in which race has been attended to by public health officials that arguably can privilege whites to the detriment of people of color. At this point, a case study protocol was formed, and document collection became focused on the alarming rate of opioid use and deaths in Pittsburgh and the subsequent state and community responses.

Feminist Standpoint Epistemology and Researcher Positionality

In response to positivist epistemological concerns of pursuing universal objective truths, many Feminist researchers argue that "all knowledge is constructed from a specific position and that what a knower can see is shaped by the location from which the knower's inquiry begins" (Sprague, 2016; Hill Collins, 2014; Jagger, 2014; Hartsock, 1983). This alternative way of positioned knowing comprises Standpoint epistemology, which Nancy Hartsock offers is "achieved rather than obvious, a mediated rather than immediate understanding" (1983, p. 132). Standpoint theory argues that knowledge is grounded in specific social and historical contexts in

which the researcher is a part of and thus pivotal to knowledge production, rather than a separate and invisible knower (Hill Collins, 2014; Jagger, 2014). To clarify, a standpoint is not how people in a specific location think about individual experiences rather, as offered by Patricia Hill Collins, is based within "historically shared, group-based experiences" that produce knowledge through dialogue of every day social actors (1997, p. 375). In this way, Standpoint challenges the perspective that legitimate knowledge is only produced through a hierarchy that distributes and controls knowledge that is released to a populace. Instead, as Sprague offers, "knowledge is not a thing that individuals possess but rather a form of communication and connection, a search for harmony in a community. Rather than opposing rationality to emotionality, emotions such as empathy and attachment become useful guides in asking and answering thoughtful and important questions" (Sprague, 2016, p. 49).

In this research project, I am positioned within my immersion of intersectional and Decolonial research as a single white cis-gender mother and first generation (Bachelors and Masters) student. I am positioned within this work as both an insider and an outsider. My insider knowledge comes from the reality that I and my family are from one of the poor, white, settler colonial, working class former steel producing boroughs of Pittsburgh discussed in this project. I am positioned as an outsider as I did not fully grow up in Pittsburgh, and so my connection to the communities and the issues that exists through my participation in Facebook community groups and keeping in contact with friends and family. Therefore, I am not immediately impacted by some of the conditions I explored in this work and acknowledge the power that exists as a researcher in a privileged position. With this, I fully understand and embrace the notion that my social identities are organizing features of social relationships that mutually constitute, reinforce, and naturalize one another (Hill Collins,1986; Crenshaw, 1991). In this way, I am continuously

trying to locate myself in relation to the people around me who I have been taught to demarcate as “other”, so as to not reproduce the social hierarchy of white feminist supremacy.

I came to the field of Ethnic Studies, compelled by the “great emptiness, the hollowness within the psyche” to learn about the intersections of my whiteness, class, gender oppression and how these positions have kept me from meaningful relationships with both myself and other people, an issue that I feel is pivotal to understand when it comes to healing from colonial wounds (Anzaldua & Keating, 2009, p. 154). Therefore, I take Gloria Anzaldua’s call for the white woman to go out on a limb and fight for women of color in workplaces, schools, and universities as a serious responsibility that comes with the privilege of learning from the texts that women of color have given their lives to in the pursuit of collective liberation (Anzaldua & Keating, year, p. 154). In consideration of emptiness and hollowness, Standpoint point theory also offers that situated Knowers are embodied, regardless of denial strategies. Writing on the role of embodiment in knowledge production, Clarke offers “That embodiment is inscribed on the knowledge produced in the very act of its claiming objectivity. Embodiment, so long refused, is thus today ever more salient and must increasingly and reflexively be taken into greater account” (Clarke, 2005, p. 21). Taking this further, Donna Haraway contends, **“**we need to learn in our bodies, endowed with primate color and stereoscopic vision, how to attach the objective to our theoretical and political scanners in order to name where we are and are not, in dimensions of mental and physical space we hardly know how to name” (1989, p. 348). In this work, it became clear to me all the ways my body knows and understands addiction to substances and dysfunctional relationships, whether through my own or through my family. My mother and my father met over a drug deal. My grandmother made a living selling speed and marijuana. My other grandmother encouraged communal drug use with her children. More than half of my

family have dependency issues with alcohol and currently, there are five family members in treatment for opioids. There is so much pain and it seems like we are all trying to feel or not feel something, a reality that has offered a deep well of embodied knowledge.

Specifically, considering the matter of embodied knowing, I am tied together in the history of the land in which Pittsburgh's steel empire lags in decay. My body, forged from the banks of the Monongahela, toughened by the jagged dolomite and sandstone rocks of the Appalachians, my spirit that is lifted by the fog that rests and rises between the maples and dogwoods, is connected through a shared historical legacy of violence. This violence began with the violent dispossession of the Lenape, Susquehannock, Iroquois Confederacy Tribes, Erie, Shawnee and others. In knowing and feeling this, it is important that I contend with my settler position in a serious way. In Rachel Flowers', *Refusal to Forgive: Indigenous Women's Love and Rage*, she argues, "often, the term settler is used without a critical understanding of its meaning and the relationships embedded within it, rendering it an empty signifier" (2015, p. 33). This results in the reduction of the privileges and practices to fit within a binary of Indigenous and non-Indigenous identities rather than examining the term 'settler' as a set of responsibilities and action. She contends that 'settler' is a position of privilege and enjoyment of standing in relation to the settler's relationship to colonialism (Flowers, 2015). Thus, the category of settler is both a structural location and a product of social relations that produce privilege. Flowers argues, "The process of colonization is intimately linked to patriarchy and capital; these are the primary obstacles to even beginning to imagine the co-existence of settlers with Indigenous peoples" and asserts that the labor of settlers should be to imagine alternative ways to be in relation with Indigenous peoples (Flowers, 2015, p.35).

Therefore, as a settler colonist who is actively trying to dismantle the colonial power within myself, I offer this work as a means of co-resistance rather than continue in the Western tradition of denying and co-opting Indigenous Feminist and women of color theories. I seek to join hands with the ones who have taught me, to build bridges as a means of guiding our actions to address our differing yet collective oppression. To do this, it is critical to center Intersectional and Indigenous Feminist theoretical interventions within critical theories. It is also imperative for me to practice reflexivity in order to produce research that is a break from the historical trends within academia that appropriate and perpetuate epistemic harm. I am brought to this project because of my reflections on how participation in whiteness produces a specific kind of trauma, one in which I want to argue informs opioid use. I am brought to this project because of the loss of my cousin from overdose, the number of family members I have in recovery, and the number who remain at risk for use to take over their lives. The privileges afforded through the participation in whiteness allows people to evade the responsibility of dismantling the structures of white supremacy and ignore their part in perpetuating it and settler colonialism. To dismantle whiteness, I center the voices of Black, Indigenous, and women of color to look at how whiteness stays invisible in the messaging and discourse around the opioid crisis in Pittsburgh.

Data Collection

The research setting was the internet, which has become a common site for obtaining research data and is no longer considered a "new" setting for research (Merriam & Tisdell, 2015). The extant document data were gathered through records searches and archival research. Data were obtained from six domains: State, county and city websites, The School of Public Health at the University of Pittsburgh, local news reports, population and demographic websites, photographic environmental history, and historical archives of steel labor and communities. Each

document within the domains represents the claims of an individual. Data range in length from three words to two single-spaced pages. Data were produced between September of 2008 and August 2020. In the case of mortality mapping, the researcher generated new documents to match the borough zip codes to corresponding population demographic information in order to investigate death rates rather than explore mere totals.

To guide the research sampling for this case study, a case study protocol was established through a set of inquiries based on the familiarity with Pittsburgh's place-based social history. The inquiries for this protocol included: How does place inform how pain and trauma are experienced? How does pain and trauma inform place? How do people participate in creating place-based pain/trauma? How does place-based trauma and pain inform social relations? How does place-based trauma/pain interact with identity formation? Specifically, white racial formations? How does the participation in white identity (racial) formation create pain/trauma for the participant as well as collectively? How do white people cope with the pain that comes from the participation in racial formation? How is this pain addressed?

These questions were employed through multiple levels of theoretical sampling, which is a method of data collection concerned with the concepts that are derived from and are responsive to the data being gathered (Corbin and Strauss, 2008, pg. 144). This differs from conventional sampling in that the aim of theoretical sampling is to discover the properties and dimensions of relevant concepts as they arise, rather than pre-established criteria that verify or test a hypothesis (Corbin and Strauss, 2008, pg. 144). Further, Charmaz (2014) suggests, "The main purpose of theoretical sampling is to elaborate and refine the categories constituting theory" (Charmaz, 2014, p. 193). This constitution of theory comes from the cycle of analysis with theoretical sampling. Unlike conventional sampling, analysis in not contingent on the completion of data

collection. Instead, theoretical sampling requires analysis after the first points of data are gathered, as this analysis is what leads to the identification of concepts, which then informs the next round of data collection, and so on until saturation has been reached (Corbin & Strauss, 2008, p. 144). The methods of data analysis utilized for this study were data comparison and an engaged ethnographical and memo writing process through which the initial theoretical framework was constructed and subsequently built upon.

In this study, the first level of theoretical sampling began with an in-depth exploration of place-based socio-historical data which led to four related conceptual lines of inquiry: Environmental degradation, economic devastation from deindustrialization, physiological degradation/disease, and mental/ spiritual health degradation, which is my theorization of what might have significant connections to opiate use and overdose. Following these initial emerging concepts and themes, a unique purposive sampling was used to comparatively explore opioid epidemic focused messaging from national Public Health, Pennsylvania State Public Health, and Allegheny County/City of Pittsburgh Public Health. Two-tiered sampling was generated for this study (Merriam & Tisdale, p. 99). Initially the first level of sampling was gathered from data with a general focus on the opioid epidemic in Pennsylvania. The selection criteria for unique purposive sampling was (1) documents/videos generated by federal, state, and/or county Public Health or Medical entities, (2) documents/videos that discuss Opioid Overdose Crisis, (3) documents that discuss opioid overdose mortality statistics, (4) documents/videos that discuss federal, state, county responses and solutions to Opioid overdose crisis, (5) documents/videos generated by news/media outlet covering government and Public Health discussions of Opioid Overdose Crisis, overdose mortality, and responses/solutions, and (6) documents/video generated by news/media outlets covering any story that is opioid related, including person narratives of

dealing with opioid addiction, death, or recovery, arrests and criminal prosecution, impacts to the community (positive and negative).

This sampling brought forth the organization of the data into the following emergent categories: social determinants of health, Whiteness, race, gender, class, pain, pain relief, addiction as a naturally occurring illness that is incurable, and lack of resources and opportunity. Following these concepts, the line of inquiry shifted to Allegheny County/ Pittsburgh specific data. The second level of sampling came from within the case study on Opioid addiction I Pittsburgh. The selection criteria specific to the Pittsburgh area included: (1) documents/videos/podcasts are generated by Public Health entities located within the county, city, or specific boroughs of interest, (2) documents/videos/podcasts are generated by Allegheny county/ Pittsburgh specific media, (3) discuss the mortality statistics of opioid overdose within Allegheny county, Pittsburgh proper, or surrounding boroughs, (4) discuss racial demographics relating to the opioid crisis within Allegheny county, Pittsburgh proper, or surround boroughs (5) related to environmental erosion within Allegheny county, Pittsburgh proper, or surrounding boroughs (6), related to rates of illness, cancer, and disease within Allegheny county, (7) related to steel manufacturing and deindustrialization and (8) are expressive of or relating to the impacts felt by communities and community members. After identifying recurring themes that emerged from all the data, a saturation point was reached.

Pittsburgh Sample Breakdown

62 documents were examined with over 1000 pages of material were analyzed. The domains of document data are organized into Table 1 below.

Table 1: Source of data *Number of Documents*

Deaths from opioid addiction in Pittsburgh from 2008-2020	5
Public Health discourse on opioid addiction in Pittsburgh	25
Breakdown of boroughs in Pittsburgh by race	12
Historic archival data on Industrial Development in Pittsburgh	20
Audit trail of labor	10

Limitations

There are four limitations to this study. First, it is important to note this study was conducted during COVID-19 which limited my access to certain materials and the researcher's ability to travel to Pittsburgh. Second, semi-structured interviews with Pittsburgh residents and public health officials impacted by or working with opioid addictions could have contributed significantly to the findings in this study. Third, borough specific drug treatment was influenced significantly by the criminalization of opioid use such that it was difficult to ascertain what treatment options were available outside of court ordered treatment modalities. This is striking considering how significant opioid additions are in this area of the country. Lastly, the breadth of the research questions I posed in this study generated an enormous amount of data and a more aerial view of the industrial formation of the Pittsburgh boroughs and subsequent opioid use. With a narrower inquiry this study might have yielded a more focused inquiry into whiteness and the environmental connection to opioid addictions. Baldwin is one of the boroughs which has a history of coal mine production and still has on-going steel production. These industries remain highly pollutive and I could have for example considered the cancer, illness, and racial

disparities in this borough to understand the history and race formation and how this relates to opioid addictions.

Internal Validity or Credibility

In a qualitative study, the issues of trustworthiness and rigor are critical. The framework that guides this study is positioned within a critical epistemological perspective, with elements of interpretivist and postmodern approaches. In using a critical epistemological framework, it is assumed that "all thought is mediated by power relations that are historically and socially constructed" (Kincheloe, McLaren, & Steinburg, 2011, p. 164). In this way critical research "must be connected to an attempt to confront the injustice of a particular society" as questions are concerned with the terms of power negotiations, structures, distribution, and reiterations/reinforcements (Kincheloe, McLaren, & Steinburg, 2011, p. 164; Merriam & Tisdale 2016, p. 10).

Further, interpretive epistemology contends that reality is comprised of multiple realities, which allows for multiple interpretations of one event (Merriam & Tisdale, 2016, p. 9). Postmodern epistemology contends that the social world is comprised through grand narratives, challenging the notion of objective truth in favor of multiple subject truths and ways of knowing (Merriam & Tisdale, 2016, p. 11). Postmodern epistemological approaches also "favor descriptive and individual interpreted mini-narratives which provide explanations for small-scale situations located within particular contexts with no pretentions of abstract theory, universality, or generalizability involved" (Grbich, 2013, p. 8). Thus, a multi-perspective research paradigm posited in critical epistemology with interpretivist and postmodern elements has different considerations for validity and credibility than general qualitative study protocols.

To account for validity, credibility, and trustworthiness, critical research paradigms focus on the historical situatedness of the research, the importance of the research in increasing consciousness about issues of power and oppression, and the potential of the research to create change (Guba & Lincoln, 1994). For this research project, the researcher in this study engaged in "persistent observation of extensive document data" and took care over a period of time to review and update each category of extant document data. Second, this two-year study was initiated in 2017 and continued into 2020. Third, the researcher considered the phenomena under study over a significant time and intentionally including a large number of documents. Triangulation of data included federal, state, and boroughs data sources and triangulation of researchers in which students, graduate peers, and professor's assisted in conversations around data analysis helped to achieve satisfying this criterion of credibility.

Another way of establishing credibility and trustworthiness was through praxis, which is the integration of theory and practice, within the research (Patton, 2002). Praxis within this project is employed through Feminist research ethics that are posited within an understanding that research is never value neutral. Therefore, researcher reflexivity, which provides an opportunity for the researcher to understand how their own experiences, understandings, and power affect the research process was satisfied through memo writing and reflexive journaling which leads to crystallization of the data. In this study, transferability is satisfied with extensive reflexive journaling, data mapping on white boards and notes on theoretical understandings of the data that occurred throughout the study (Patton, 2002). Dependability was achieved in this study by the organization of the case record that includes an audit trail of the data and reflexive journaling (Lynham, 2011). The last strategy for establishing credibility and validity was dialogue among various perspectives (Patton, 2002). This project is an Ethnic Studies critique of

Public Health. Ethnic Studies is interdisciplinary by nature, however, this researcher had to learn the field of Public Health while conducting this study. To provide a greater understanding and self-reflexive moments, this researcher engaged in dialogue with graduate students in the school of Public Health about the topics being researched. This allowed the researcher to gain clarity on concepts and approaches rather than assume an understanding.

In terms of generalizability, the application to the general population is a standard limitation (Merriam & Tisdale, 2016). This research concerns a specific place with a specific history within the larger scope of a national epidemic. This means that despite its particularity, the critical epistemological base of the questions and findings concerning the workings of power within the structure of the discourse within Public Health could be applied within other smaller contexts or different aspects of the larger scope.

Conclusion

This project, guided by a critical epistemological framework with elements of interpretivism and postmodernism, is a qualitative case study of discourse pertaining to the opioid epidemic in Pittsburgh, Pennsylvania. In this chapter, the methodological design and corresponding methods were discussed. This includes feminist standpoint praxis through positional accountability and strategies that account for ethical practices to ensure research credibility, validity, trustworthiness, and generalizability. The following chapter presents the findings compiled through this methodological framework and methods.

Chapter Four: Findings

"Before turning our eyes "forward" let's cast a look at the roads that led us here. The paths we've traveled on have been rocky and thorny, and no doubt they will continue to be so."
Gloria Anzaldua

The purpose of this project is to explore the ways in which Public Health entities located in Allegheny county contend with place based and race discourse in their framing of the opioid overdose crisis. In terms of overdose mortality, Allegheny county is the fourth most impacted county in the state of Pennsylvania (DEA Philadelphia Division and University of Pittsburgh, 2018). Because social determinants of health include the notion that geographical environment plays a role in health outcomes this study employs the basic schema of harm reduction's "risk environment" framework through the decolonial intersectional framework offered in the first chapter. This chapter presents the findings for data gathered from multiple websites that explore Public Health messaging related to the Opioid overdose crisis in Pittsburgh and its environs.

The first data set is comprised of photographic evidence of historical and current day extractivism in Pittsburgh, PA which renders the area an extractive zone. The second data set shows the current pollution concerns alongside the current cancer, disease, and mental health illness rates. The third data set presents different facets of Public Health messaging around the Opioid crisis, beginning with Pennsylvania state responses, followed by messaging put forth by Allegheny county, the city of Pittsburgh, the University of Pittsburgh School of Public Health and specific treatment facilities. The last data set looks at the ways in which opioid overdose mortality data is presented, which includes a comparison of borough demographics. The intent for this mixed set of data is to show the relationships between the history of the industrial and deindustrial environment, cancerous illnesses, mental health, and the ways in which Public

health entities are discussing and framing the causes of opioid use, which inform the strategies and initiatives being taken to address Opioid overdose cases.

Data Set One: Public Health Messaging on Opioid Epidemic

This section contains local news reports regarding the Opioid Crisis in Pittsburgh, with a specific focus on state, county, Pitt/UPMC public health entity responses and initiatives in relation to the framing and mentions or lack of mentions in regard to race/class/gender or social determinants of health. The selected materials span from 2008, when the Opioid crisis gained notable attention due to the exponential increase in overdose deaths in Allegheny county, to 2020, as the increase of fentanyl use and the impacts of COVID-19 are predicted to have severe implications for the 40 percent decrease in opioid overdose related deaths in 2018. Also contained here are headlines that show differences in reporting around the Opioid epidemic between localities. During this research process, general search results for opioid related articles for the areas of McKeesport brought up news and articles related to opioid related crimes and drug busts rather than articles focused on the crisis and needs or successes around treatment.

State Responses to Opioid Crisis

Governor Tom Wolf declares the opioid addiction a public health emergency, ten years after the problem first appears. The idea to treat a drug crisis like a natural disaster is notable. This command center was established online on the overdose free dashboard which was looked at for multiple data points during data collection phase of the study.

Wednesday, Jan. 10, 2018 at 4:35 p.m. ***Democratic Gov. Tom Wolf has declared Pennsylvania's opioid addiction epidemic a public health emergency and ordered a command center set up to treat the crisis like it would a natural disaster.***
Reported by Pittsburgh's NPR affiliate: https://www.wesa.fm/post/wolf-signs-disaster-emergency-over-opioid-crisis.

Prior to this declaration, the Drug Enforcement Agency of Pennsylvania compiled findings on the crisis in a 2016 report. The key findings are summarized below, with racial demographic statistics highlighted:

- The percent increase in drug-related overdose deaths between 2015 and 2016 was larger in rural counties (42 percent) compared to urban counties (34 percent).
- In 2016, 70 percent of drug-related overdose decedents were male, consistent with 2015, but not consistent with the population distribution across Pennsylvania.
- Males were more likely to die from a fentanyl and/or heroin overdose compared to females. Females were more likely to have alprazolam, clonazepam, and/or oxycodone present in overdose deaths, while males were more likely to have fentanyl, heroin, cocaine, and/or ethanol present in overdose deaths.
- In 2016, **77 percent of decedent were White, 12 percent were Black, 4 percent were Hispanic, and 7 percent were identified as Other**, consistent with 2015 and the population distribution across Pennsylvania.

https://www.overdosefreepa.pitt.edu/wp-content/uploads/2017/07/DEA-Analysis-of-Overdose-Deaths-in-Pennsylvania-2016.pd_-1.pdf

The racial demographics outlined here are repeated throughout the rest of the findings presented.

Following Wolf's state of emergency declaration, the state of Pennsylvania received federal funding in 2019 from the acting Trump administration.

Wolf Administration Receives More Than $75 Million To Further Address Substance Use Crisis in Pennsylvania
09/06/2019
https://www.media.pa.gov/Pages/Health-Details.aspx?newsid=646

Area where the funding will help with prevention include:

- Increased collaboration with county and municipal health departments.
- Additional naloxone training for first responders.
- Staffing the program's Patient Advocacy Unit.
- Provide individualized, one-on-one education to opioid prescribers; and
- Offering continuing medical education to providers on evidence-based approaches to opioid prescribing and addressing substance use disorder.

Work to address the opioid crisis focuses on three areas: prevention, rescue, and treatment. Efforts over the past four years, working with state agencies, local, regional, and federal officials, have resulted in significant action to address the opioid crisis. Recent efforts include:

- The Prescription Drug Monitoring Program has reduced opioid prescriptions by 27 percent and has virtually eliminated doctor shopping.
- The Opioid Data Dashboard and Data Dashboard 2.0 is providing public-facing data regarding prevention, rescue and treatment.
- The waiver of birth certificate fees for those with opioid use disorder has helped close to 2,700 people, enabling easier entry into recovery programs.
- A standing order signed by Dr. Rachel Levine in 2018 allowed EMS to leave behind nearly 1,100 doses of naloxone.
- More than 6,000 health care professionals have been visited and provided training on how to prescribe opioids cautiously and judiciously.
- 813 drug take-back boxes help Pennsylvanians properly dispose of unwanted drugs, including 482,000 pounds of unwanted drugs in 2018.
- The Get Help Now Hotline received more than 26,000 calls, with nearly half of all callers connected directly to a treatment provider.
- The state prison system has expanded their Medication-Assisted Treatment (MAT) program, which is viewed as a model program for other states.
- More than 100 licensed physicians or prescribers have been disciplined for wrongful practice over the past two years.
- Several agencies have worked together to collaborate on the seizure and destruction of illicit opioids across Pennsylvania.
- The coordination with seven major commercial providers has expanded access to naloxone and mental health care, while also working to make it more affordable.
- 3,055 cases of neonatal abstinence syndrome have been reported to the Opioid Command Center.
- Naloxone has been made available to first responders through the Commission on Crime and Delinquency, with more than 25,000 doses made available and more than 4,500 saves

through that program. In addition, EMS have administered more than 25,000 doses of naloxone and more than 7,000 doses were made available to members of the public during the state's naloxone distribution last year.

Allegheny County Responses to the Opioid Overdose Crisis

State data shows that from 2008-2017, the most highly impacted areas in the Opioid crisis included Allegheny county. The responding entities in Allegheny county include the Allegheny Health Network, the Allegheny Department of Human Services, and Public Health Department. The county also relied on partnerships with the University of Pittsburgh for data collection and recommendations.

Opiate-Related Overdose Deaths in Allegheny County Risks and Opportunities for Intervention, July 2016

Highlighted points of interest in this study:

- "Race: Each year, **a greater number of white than black residents died from an opiate-related overdose; white residents accounted for 91 percent of opiate-related overdose fatalities in 2014.** While fatal overdose rates are higher for whites each year, the increase in rates of overdose during this period were comparable. No statistical differences were observed in the overdose rates between white and black residents during this period.

- "Mental health services: An analysis was performed to identify how many individuals who died of an overdose had received a publicly-funded mental health service. Forty-four percent (616) had received such treatment service at any time in the past, and 36 percent (510) had received the treatment in the year prior to death.33 A separate analysis was conducted to assess the number of days between the most recent mental health service and the fatal overdose. Figure 21 describes the results, **which suggest that opiate-related fatalities occurred most frequently (45%, or 231 of 510) within 30 days of a recent mental health service. Forty-seven percent of those (109 of 231) actually died within one week of the most recent service, suggesting they may have been actively engaged in treatment**. FIGURE 21: Time between Last Mental Health Service and Death, in 30-Day Periods, N = 510"

- "Practice guidelines: As a result of the current epidemic, the Pennsylvania Physician General and the Department of Health, with support from DDAP, developed prescribing

guidelines for emergency departments, pharmacists, dentists and physicians specializing in chronic non-cancer pain, geriatrics and OB/GYN. **These guidelines provide guidance for safer, more effective pain relief practices, with greater emphasis on non-opioid therapies and greater caution to prevent addiction and diversion**. The Physician General has identified plans to develop prescribing guidelines for sports medicine, pediatrics and benzodiazepines in the near future. In addition, Community Care Behavioral Health Organization has developed best practice guidelines for MMT, Vivitrol® and Suboxone®, and managing benzodiazepines in MA

Allegheny Health Network Takes New, More Holistic Approach to Addiction Treatment
By Sarah Boden, April 16, 2019.
https://www.wesa.fm/post/allegheny-health-network-takes-new-more-holistic-approach-addiction-treatment

Article excerpts of interest:

"If patients have opioid dependency issues, in addition to medicated assisted treatment, they might also be referred to AHN's holistic pain management program, which the health care network is expanding. **A person can develop opioid dependency after receiving a prescription to manage pain from an injury or surgery, so their addiction might be entangled with chronic pain issues. AHN wants to replace powerful medications with more holistic treatments.** "These interventions include massage, acupuncture, behavioral health and physical therapy," said pain medicine specialist Dr. Jack Kabazie."

"Allegheny County Health Department Director Karen Hacker said she's pleased by these AHN initiatives, "**From my perspective [the opioid crisis] is not all that different from the HIV [epidemic,**]" said Hacker. "We have to address this issue from multiple angles."

The *Epidemiological Profile of Overdose Data, prepared for Allegheny County by Cynthia Holland, MPH, School of Pharmacology, University of Pittsburgh* contained the tables (presented below as Figures 1, 2, and 3 for the present study) on the nature of the racial demographics in opioid overdose deaths. Holland notes the changes in population demographics in terms of increase, decrease, and unavailable numbers for Latino/Hispanic population. Additionally, there is no demographic information for Asian Americans or Native Americans, despite Allegheny county having both demographics present in the overall population. Holland notes that death rates are highest for white males, followed by white females and then African Americans. Not included is a table that discusses the increased rate of use for African Americans

over the years. Also included is a table that shows where the most overdose deaths occurred from 2000-2006. However, the area demographics are not broken down in terms of race and there is no discussion of the specific environmental factors for these areas in the rest of the report.

6. Drug Overdoses By Race in Allegheny County 2000-2006

The table below depicts the breakdown of race for the population of Allegheny County for both 2000 and 2006 time periods. The number of white residents decreased slightly as did the number of African American residents while the number of Asian residents increased. The U.S. Census Bureau did not have figures for the number of Hispanic/Latino residents in the area.

	2000	2006
Total Population	**1,281,666**	**1,223,411**
White	**1,091,899**	**1,012,469**
African American	**166,731**	**156,335**
Hispanic/Latino	**Unknown**	**Unknown**
Asian	**24,722**	**28,452**

The following table shows the number and percent of overdoses across various races for Allegheny County. While rates for African Americans are increasing, there is not an increase in the number of African American residents, conversely the number of African Americans in the County decreased slightly over the six year time period. Additionally, the number of white residents decreased while the overdose rate for this population still remained the highest for across the race categories. (Note that the totals do not reflect the totals for each year as data for sex and race are missing for some cases).

Figure 1: Screenshot of overdose related deaths by demographics in the epidemiological report.

Year	White Male	White Female	Afr. Amer. Male	Afr. Amer. Female	Hispan-ic Male	Asian Male	Total
2000	75 (56.8%)	26 (19.7%)	24 (18.2%)	7 (5.3%)	0 (0.0%)	0 (0.0%)	132
2001	112 (60.9%)	43 (23.4%)	23 (12.5%)	6 (3.3%)	0 (0.0%)	0 (0.0%)	184
2002	139 (63.2%)	44 (20.0%)	24 (10.9%)	11 (5.0%)	1 (0.5%)	1 (0.5%)	220
2003	117 (54.2%)	59 (27.3%)	32 (14.8%)	7 (3.2%)	1 (0.5%)	0 (0.0%)	216
2004	118 (58.7%)	52 (25.9%)	23 (11.4%)	8 (4.0%)	0 (0.0%)	0 (0.0%)	201
2005	123 (58.3%)	51 (24.2%)	26 (12.3%)	10 (4.7%)	0 (0.0%)	1 (0.5%)	211
2006	72 (53.3%)	42 (31.1%)	21 (15.6%)	11 (8.1%)	0 (0.0%)	0 (0.0%)	135
Totals	**756 (58.2%)**	**306 (23.6%)**	**173 (13.3%)**	**60 (4.6%)**	**2 (0.2%)**	**2 (0.2%)**	**1299**

- Trends/Observations
  - Rate is highest for white males for every year from 2000 to 2006.
  - Second highest rate for same time period is for white females, followed by African American males and African American females having the lowest rates.
  - Rates for African American females and white females have fluctuated, but ultimately have increased over time (2.8% and 11.4% respectively). The rates for white and African American male populations have also experienced fluctuations, but decreased slightly over time (3.5% and 2.6%).
  - Magnitude – white males predominant. Female rates on the rise.

Figure 2: Screenshot of overdose trends by race in the epidemiological report

14. Deaths By Area – In or Outside City of Pittsburgh

Year	% of deaths in City/% outside of City	Areas w/ highest rate (In CITY)	Areas w/ highest rate (Outside of CITY)
2000	49% -- **51%**	-	-
2001	48.3% -- **51.7%**	**North Side, Hill District**	-
2002	46.6% -- **53.4%**	**North Side, Hill District, Lawrenceville**	-
2003	**50.2%** -- 49.8%	**North Side**, Brookline, **Hill District, Lawrenceville**	**Penn Hills**, Baldwin, Ross, **Clairton**, Monroeville
2004	**59.0%** -- 41.0%	**North Side, Hill District**, Mt. Washington, Hazlewood	Bethel Park, **McKeesport**, **Penn Hills**, **Clairton**
2005	43.9% -- **56.1%**	**Northside, Lawrenceville**, **E. Liberty, Hill District**	**Penn Hills**, **McKeesport**, Coraopolis, Bethel Park, **McKees Rocks**, Monroeville, **Clairton**
2006	40.5% -- **59.5%**	**North Side, E. Liberty, Hill District**	**McKeesport, McKees Rocks,** Plum, Baldwin, Sharpsburgh

- Trends
  - Within the City, the Northside and Hill District have been identified as having higher rates since 2001. East Liberty and Lawrenceville have also had higher rates of overdose in more than one year.
  - Outside of the City, Penn Hills, McKeesport, and McKees Rocks had higher rates of overdoses. Clairton and Bethel Park also had higher rates for several years.
  - For most years (5 out of 7), areas outside of the City, but still within Allegheny County, had slightly higher rates of overdoses.

Figure 3: Death rates by location in Pittsburgh

Next, there were a series of public health presentations that took place in the summer of 2017 to educate invested community 'stakeholders' on the strategies and initiatives the county was implementing to address opioid overdose deaths. Here, two examples of presentations are offered. In the presentation, "Addressing the Opioid Overdose Epidemic through Critical Partnerships: Public Health, Human Services, and Health Care" prepared by Karen Hacker, MD MPH, these slides of interest were pulled:

https://www.alleghenycounty.us/uploadedFiles/Allegheny_Home/Health_Department/Programs/Special_Initiatives/Overdose_Prevention/NA17-Hacker-overview-ppt.pdf

What Caused The Epidemic?

- Drastic increases in the number of prescriptions written and dispensed
- Greater social acceptability for using medications for different purposes
- Aggressive marketing by pharmaceutical companies of new long acting pain killers
- High addictive potential of pain killers
- Cheap cost of Heroin
- Entry of Fentanyl and its derivatives

Figure 4: Screenshot of Presentation discussing the origins of the opioid epidemic.

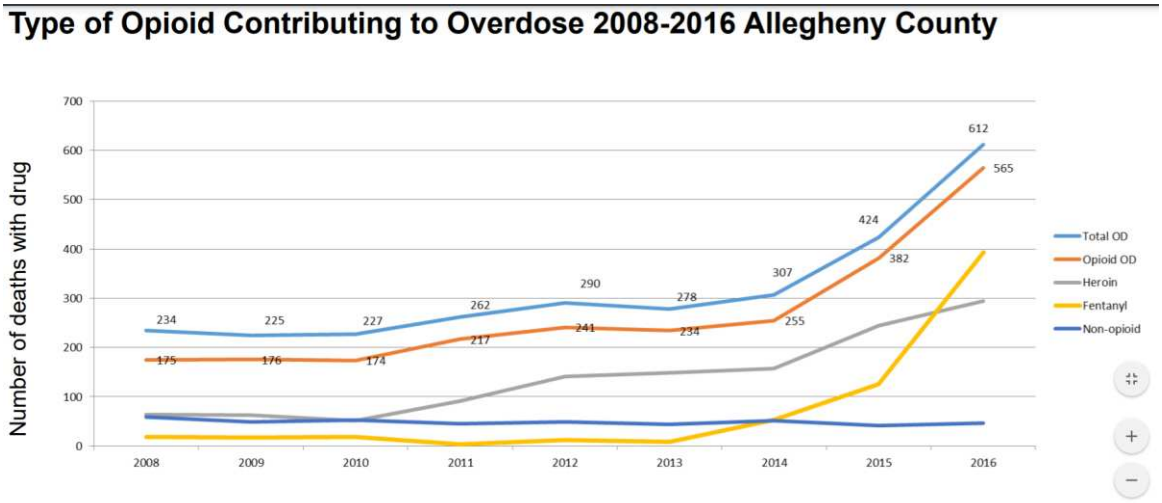


Figure 5: Screenshot of Presentation discussing types of opioids contributing to overdose.

The first slide was pulled because it is representative of the ways in which Public Health talks about the cause of the opioid crisis. Despite being concerned with Allegheny residents, there is no mention of contributing social determinants, cancer rates, or environmental causations in terms of economics or pollution. The second slide was pulled because it shows death rates according to opiate use in terms of the total population. There are no slides that break down death rates according to race or gender.

Next, in the *ACDHS, Seven Actions Presentation (2017)*, the Allegheny County Department of Health Services, whose goal is to "bridge clinical medicine and population health", lists seven initiatives it plans on taking to combat new opioid use. The Seven steps include:

(1) Identifying when substance use and risk of overdose is an issue for our clients—and where to turn; (2) Helping to stop the initial addiction through prevention programs with schools and community groups; (3) Creating an easy point of entry into substance use treatment; (4) Getting people into treatment and offering recovery supports as quickly as possible; (5) Making sure people with opioid use issues can get effective treatment, which includes medications (i.e., methadone, Suboxone, and Vivitrol); (6) Reversing opioid overdose by distributing Narcan (7) Preventing overdoses through community outreach teams and making prevention education part of every human service.

These steps followed slides containing contextualizing statistics which indicated: 119 overdose deaths were of caregivers involved with Children Youth and Families (CYF), 53 overdose deaths involved people who had received aging services, 100 deaths were of people who had received DHS homeless services, 54 deaths were of adults who had recently left the county jail, 510 deaths were of adults who had received behavioral health services within the past year (231 deaths were within the month before their deaths). There was no mention of race or gendered demographics, geographical distribution of death or addiction. The steps also did not connect to any of the social issues named in the contexts, rather focused on Narcan distribution and training and making sure people get services. There seemed to be no consideration of how the barriers homelessness or lack of childcare present in accessing services.

In *A Rapid Cycle Assessment Strategy for Understanding Opioid Epidemic in Local Communities (2016)*, the Allegheny County Health Department in conjunction with the Magee Women's Research Institute, and the Hillman Foundation conducted interviews in hotspot communities in efforts to include community members in the public health solutions that aim to address the opioid crisis. These hotspots were not named, and the demographics of people

were not broken down. This paper did however connect issues of family and barriers of resource access in ways that other papers, presentations, the dashboard, and news articles have not. Of interest for this study were the excerpts speaking on the nature of 'communities' in terms of location and resources:

- "**Overall participants perceived their communities as changing for the worse, which was illustrated by references to infrastructure, poverty, crime, drugs, violence and transient populations**. Participants generally felt that the opioid epidemic was not unique to their community"

- **"The opioid crisis cannot be viewed as separate from other socioeconomic and cultural contexts in these communities**. There are major differences between communities in terms of their awareness of, attention to, and ownership of the problem of opioids, as well as in infrastructure and geography."

- "**For many of these people that are in the thick of this generational poverty** this was never a choice and they're surrounded by other people who are in the same trenches of despair…Almost everyone knows someone who's died. And that's not scary in a way to them.

- "Several of our study communities are facing severe budget problems, violence and/or political changes that have drawn the attention and energies of community members and leaders, thus taking the focus from opioid overdoses."

- Community does not 'fit' media accounts of where and to whom the overdose crisis is happening. **Overdose crisis is perceived by some as a "white river town" problem, and their communities do not fit that description.**

- Perception that this is not a new problem. **Drug use and misuse in the community become 'normalized' over decades, such the opioid overdose crisis is just a different drug that happens to be deadlier with the addition of Fentanyl.**

- Differences in resources and relationships that make a difference in how to intervene: Goods and services Where are resources such as county offices, primary care, OUD treatment, stores located?

- **Geographic features that affect movement between neighboring communities.** 'People don't like to cross bridges.'

- Lack of public transportation between communities. "This little island…"

Report accessed from:
https://www.alleghenycounty.us/uploadedFiles/Allegheny_Home/Health_Department/Programs/Special_Initiatives/Overdose_Prevention/Hillman-Opioid-Project-Short-Report.pdf

The article, *"Will Lessons from The Opioid Crisis Be Retained for the Next Drug Epidemic*?" explores the parallels of the current opioid crisis to past drug crisis:

"While this current drug crisis is certainly the deadliest in American history, responses to previous epidemics ruined lives in other ways. For example, in the 1980s and '90s, **the crack cocaine epidemic was especially devastating to black communities, in large part because aggressive laws that targeted drug users led to the fracturing of many families through incarceration.**

"The response to crack cocaine was calamitous," said David Herzberg, a historian at the University of Buffalo, State University of New York. "I mean it was a catastrophe. The idea being that while these are just a bunch of criminal animals and we need to lock them up. We're still paying for it today."

In contrast, policy makers today are more likely to view a person with opioid use disorder as having a serious illness, rather than as a criminal or junkie. Public health experts agree this change is rooted in the demographic makeup of the communities most impacted by opioids.

"It was really when the news increasingly was carrying reports of whites succumbing to overdose, that as a nation … we engaged in a sympathetic response, and began responding constructively," said Caroline Acker, co-founder of Prevention Point Pittsburgh and Professor Emerita of History at Carnegie Mellon University.

One of the most significant changes was a robust push towards **harm reduction initiatives**.

Sterile needle exchanges are less taboo. Communities have been flooded with naloxone, the medication that can revive someone from an opioid overdose. And today, addiction treatment specialists are more likely to prescribe medicated-assisted treatment, as opposed to abstinence-only programs. People prescribed medicated-assisted treatment are given opioids so that cravings for the drug are reduced, but at the same patients experience little to no euphoric affects."

The experts interviewed in the article do not describe or explain why there are differences of treatment between the Black population through the Crack epidemic and the white population in the current opioid crisis beyond mentioning that "lessons were learned". There is no mention of what current carceral statistics look like in terms of opioid arrests in the area, and a discussion of

the area in general is completely absent. Despite the county's efforts in addressing the opioid overdose crisis through the above outlined solutions and steps, current data projections show the rates of opiate deaths are expected to increase. In, "Allegheny County hoped the tide had turned on the opioid epidemic. Early data suggests it may be surging again" published on July 2nd, 2020, Oliver Morrison reports on the current trajectory of the crisis. The article offers that is "unclear what is driving the resurgence of overdose cases". While COVID-19 will impact opioid users and access to treatment facilities, the reason for increase is depicted as an unreachable unknown. Of interest was the following passage concerning Allegheny counties default status as a model for overdose prevention:

"In June 2019, County Executive Rich Fitzgerald touted the county's success at reversing what was considered at the time the county's largest health crisis. "While we have a lot more work to do, the 41% reduction in deaths reflects that we are moving in the right direction," Fitzgerald said in a press statement.

Last year cities like Philadelphia were looking to Allegheny County as a model for how to address their own opioid epidemics but now Allegheny County's fatalities are growing five times faster than Philadelphia's, which grew by 3% in 2019"

The sentiment that Allegheny county is a model for addressing the opioid overdose crisis and is now facing growing fatalities once again is similar to how Pittsburgh itself is held up as a rustbelt comeback model despite the reality that many of its boroughs have been left in decay because the underlying causes of environmental and economic devastation, and thus causes of pain were never fully addressed except only cosmetically.

The University of Pittsburgh Public Health Program and UPMC

On the website for the University of Pittsburgh School of Public Health, under the key issues for research and practice tab, the opioid crisis is listed as a main issue in which graduate students

pursuing a graduate degree in Public Health are engaging. The front page describes the overdose prevention pilot research in the following way:

OPIOID ADDICTION EPIDEMIC

OPIOID OVERDOSE PREVENTION PILOT RESEARCH

The Pittsburgh region is at the center of an epidemic, but it isn't an infectious disease. It's an insidious illness that has been quietly spreading in communities, killing more people each year than car crashes – opioid drug overdoses. The number of people dying in the region has more than tripled in the past decade, and the University of Pittsburgh Graduate School of Public Health is piloting research projects to address the knowledge gaps of the opioid epidemic in a year-long initiative expected to lead to much larger life-saving efforts.

Figure 6: Screenshot of Pitt Public Health's home page on Opioid Overdose research, which includes a still of a Youtube interview with the dean summarizing research projects. Accessed from: https://publichealth.pitt.edu/opioid

Underneath the video of Donald S. Burke, there is a list of six faculty led projects with links to corresponding YouTube videos in which each faculty briefly explains the nature of their research: Jeanine Buchanich on profiling PA mortality 1999-2015; Zan Dodson on social media & mapping opioid-use clusters; Julie Donohue on prescribing; Mary Hawk on community-engaged research into optimizing health and survival; Christina Mair on mapping the problem with public data; Tom Songer on unintentional poisoning. In viewing each of the available

videos, there is no mention of the contextual environment except for the project that uses geospatial technology for mapping out user populations. There is no mention of racial, gender, or class demographic or otherwise named 'social determinants of health'.

In the article, "*Pitt attacking opioid crisis from all angles"* published on Tuesday February 18th, 2020, University Times reports on all the ways the University of Pittsburgh is contending with the Opioid crisis. This includes looking at the overprescribing of opioids in dental practices as well as physical therapy and there is finally a mention of cancers and surgeries. Interestingly, gender is mentioned is the context of the age study:

"The overprescribing of the most recent kinds of opioids, such as oxycodone, began about 1995, Burke said. "**The first peak was largely middle-aged, older, more female than traditional drug overdoses. And then about a decade ago, there was a transition to a younger population that was mostly male, much younger and initially started as the prescription drugs but rapidly transitioned to heroin and injection drugs.**" This second peak is larger than the first but is mostly caused by diverted drugs from overprescribing. **When a push started to cut back on overprescribing, those who were already addicted needed to find a replacement for the diverted prescription drugs. "And the cartels were happy to (provide) it," Burke said**. "It was a wonderful business opportunity because the market had already been created."
"We've got now this other … existing problem, which is essentially untethered to overprescribing," he said. "You can make a good case that the national response hasn't quite caught up to dealing with this second wave, which is a much harder problem."

There is no mention of racial demographics in relationship to the age and gender demographics. The use of the phrase "older, more female than traditional drug overdoses" is interesting and causes one to question: what counts as a traditional age for drug overdose? Is there a normative standard age for drug overdose that can be considered 'traditional'? The pivot of blame from overprescribing to drug cartels is noteworthy for how it fits in to the larger political rhetoric being used by the current presidential administration to justify building a wall at the border. Burke's quote concerning the transition of the problem from overprescribing to a problem that is

now detached treats the issue as something that is now isolated from systematic causes. Also, of note in this article were some of the listed projects and funding grants which include:

- Pitt Pharmacy's Program Evaluation and Research Unit (PERU), in the last year, has **trained 1,023 health care professionals and 936 health care professional students on substance use disorder and opioid use disorder prevention, intervention and treatment processes, according to Chancellor Patrick Gallagher's budget presentation to the state**.

- In November, **researchers from Pitt and UPMC were awarded nine grants totaling more than $32 million from the National Institutes of Health to improve prevention and treatment strategies for opioid misuse and addiction and to <u>enhance pain management.</u>**

- The Pitt Division of General Internal Medicine received a $5.8 million grant from the National Institutes of Health in June to facilitate opioid research in Appalachia. Jane Liebschutz, chief of the Division of General Internal Medicine, in partnership with Judith Feinberg, of West Virginia University, and Sarah Kawasaki, of the Penn State, will establish the Appalachian Node of the National Institute on Drug Abuse Clinical Trials Network to conduct opioid-related research in the region over the next five years. The emphasis will be placed on reaching rural and other underserved populations."

Several Departments and schools at the University of Pittsburgh and its corresponding Medical Campus have been given thousands of dollars to train people on strategies that have been devised to mitigate opioid death and enhance pain management. I am curious as to how a presentation on budgets carries the necessary information on dealing with a public health crisis, and I am also interested in the perceived expertise on the matter given the state of unknowns articulated by the dean of the school of public health. In 2019, the University of Pittsburgh Division of General

Internal Medicine received $5.8 Million for Opioid Research in Appalachia. Of interest is where the money for research will be applied:

"**Historical and cultural factors have caused Appalachia to experience the negative consequences of the opioid epidemic at a disproportionally high rate, including overdoses, neonatal abstinence syndrome and death,"** said Liebschutz. "Oftentimes, research does not include data from rural populations, meaning that the findings don't always apply in the same way they would to an urban population. This grant will help to ensure that we are addressing the opioid epidemic in a way that truly helps those who are most impacted."

These rural spaces are not named or defined and leaves me questioning where boroughs such as McKeesport lie, because they are not considered the suburbs and they are not considered the city. The gesture to historical and cultural factors is not illuminated further. Following this research project, the article "Pitt Study Finds Birth Year Helps Predict Drug Overdose Risk" by Sarah Boden, published on May 11, 2020, explores one of the piloted research projects from the Pitt School of Public Health. Below are excerpts of note:

"Researchers looked at data from 661,565 drug overdose death reports from the Centers for Disease Control and Prevention from 1979 to 2017. They found that since World War II, the more recent a person's birth year, the more likely they are to die from drug use.

"If you are born after 1945, then your risk of overdose death increases exponentially from one birth year to the next," said lead author Hawre Jalal, whose research expertise includes mathematical modeling on the opioid epidemic.

Also, the more recent the birth year, the younger someone is likely to be if they die. For example, a 25-year-old is more likely to fatally overdose today, than his or her parents were at the same age.

"Those patterns are too regular to be random. There is some driving force, there's some reason why drug overdoses are transmitting from one birth year to the next," said Jalal.

Jalal, an assistant professor at Pitt, said that while drug overdoses are increasing, it does not explain why younger people are so dramatically affected. He noted while age is often examined in epidemiological research, birth years are an understudied topic.

"We have to unravel those causes. And we have to understand why this pattern is happening to be able to curb the overdose epidemic," he said."

Rather than focus on race, gender, or class relationships to opioid addiction, this study focuses on age as a determinant. The identification of a pattern that stems from some "driving force" and the isolation of birth years is concerning as time and genetic legacies cannot be decontextualized.

While searching for borough specific information in relation to the opioid overdose crisis, the search yielded articles that were all related to crimes rather than treatment centers or addressing the opioid crisis. I sought information that was specific to McKeesport as the city was the focus of Katherine McLean's 'risk environment' study took place and where a significant number of opioid deaths have been reported. I also sought information about Duquesne and Braddock because these boroughs are adjacent to McKeesport and have similar reputations in terms of economic deprivation and high rates of crime. *Borough specific headline search yields:*

McKeesport:

Police arrest 2, confiscate 111 bricks of heroin, fentanyl in McKeesport, NOV 1, 2019
https://www.post-gazette.com/news/crime-courts/2019/11/01/McKeesport-drug-arrests-Crawford-Village-111-bricks-of-heroin-fentanyl/stories/201911010152

Former McKeesport Resident Indicted for Illegally Possessing Heroin and a Handgun
https://www.justice.gov/usao-wdpa/pr/former-mckeesport-resident-indicted-illegally-possessing-heroin-and-handgun

Two Men Arrested in Overdose Death Of 30-Year-Old Woman
https://pittsburgh.cbslocal.com/2020/03/05/overdose-death-arrests-mckeesport/

Harm Reduction Entities and Corresponding Practices

Scaling down from state and county responses, this section looks at three different websites for Harm reduction entities providing services for people who are contending with opioid addiction. There are more than three organizations that provide these services within Allegheny county, however for the sake of scope and space within this case study three were chosen: Prevention

Point Pittsburgh, Institute for Research, Education and Training in Addictions, and Sojourner House.

First, Prevention Point Pittsburgh was chosen because of the major role the organization has played in public health discussions and efforts in the opioid overdose crisis. It is mentioned in several articles due to its partnerships with city and county entities to mitigate opioid overdose deaths. For this study, the about section, a part of their response to the state public health declaration, and the list of services offered were of notable interest:

"Prevention Point Pittsburgh (PPP) is a nonprofit organization dedicated to providing health empowerment services to people who use drugs. **PPP is deeply rooted in a concern for the well-being of the individuals we provide services to and for the general health of the entire community**. Prevention Point Pittsburgh was founded in 1995 when James Crow and Caroline Acker, along with a handful of other dedicated volunteers, began providing needle exchange services once a week on a street corner in the Uptown neighborhood of Pittsburgh to prevent injection-related health problems. In April 2002, PPP established a county-authorized needle exchange site in Oakland. Since that time, over 5,000 injection drug users have enrolled into our program for critical prevention services. **PPP now has three outreach sites located in East Liberty, Perry Hilltop, and the Hill District.** In addition to needle exchange services, PPP has grown to include comprehensive case management services, assistance to drug treatment, **individualized risk-reduction counseling,** health education, condom and bleach distribution, overdose prevention with naloxone distribution, and free HIV, Hepatitis C, and STD screening in collaboration with Allies for Health + Wellbeing, formerly the Pittsburgh AIDS Task Force.

In PPP's response to state Public Health Declaration made by Governor Tom Wolf, the organization states:

"A declaration of a public health emergency is designed to allow Pennsylvania officials to "temporarily override any rules or regulations they perceive as hampering the state's ability to address the epidemic." This is an extraordinary step to meet an extraordinary public health crisis. It would be a shame for this historic opportunity to be squandered. **In 2018, we know what an effective public health strategy looks like. To address this epidemic we must take immediate steps to remove impediments and provide adequate resources to expand access to evidence based treatment, expand syringe access programs, expand programs providing naloxone to those most likely to be on the scene of an overdose, and removing obstacles to establishment of safe consumption sites."**
https://drive.google.com/file/d/1lEDVAHuQTaIMedEIPUyYTowHYtnqnsy5/view

Again, despite their locations being in predominantly Black neighborhoods, PPP's response had no mention of the intersectional implications of access to treatment, made no mention to race, gender, or place factors. Focused only on immediate treatment and need for more safe needle exchanges. The organization is very adamant in communicating its harm reduction framework in its approach:

"**Prevention Point Pittsburgh is a harm reduction organization**. We are the only county-approved syringe exchange program in Southwestern Pennsylvania. PPP considers syringe access as a foundation for addressing a broader set of drug users' needs from a harm reduction perspective. **We strive to meet needs that are not met through other existing services.** In addition to safer injection supplies, PPP provides comprehensive case management services, education on HIV and Hep C prevention, overdose prevention and response trainings, naloxone distribution, safer smoking supplies to help prevent transmission of COVID-19, wound care consultation and free onsite HIV, Hepatitis C, and other STD testing provided in collaboration with Allies for Health + Wellbeing, formerly the Pittsburgh AIDS Task Force. **PPP is also an advocacy organization, working to improve the health and lives or people who use drugs through harm reduction."**
https://drive.google.com/file/d/1lEDVAHuQTaIMedEIPUyYTowHYtnqnsy5/view

Prevention Point Pittsburgh services include:

- Legal syringe distribution services to prevent HIV and Hepatitis C transmission
- Free, confidential HIV, Hepatitis C, and other STD testing and counseling
- Health prevention and risk-reduction education
- Case management services
- Crisis intervention and counseling
- Overdose prevention and response education, with naloxone prescription
- Wound and vein care consultation
- Safer Smoking Supplies to prevent the spread of COVID-19 and other respiratory-borne illnesses
- Assistance to drug treatment, health care, housing, food pantries

While Prevention Point Pittsburgh is the only organization that offers a free syringe exchange program amongst other important and necessary services for users, the scope of harm reduction is narrowly focused on acute needs. Again, there are no services that extend beyond the in the moment need and individualized counseling is questionable given the systemic implications of opioid addiction.

Institute for Research, Education and Training in Addictions

The Institute for Research, Education and Training in Addictions (IRETA) is an independent 501(c)3 nonprofit located in Pittsburgh, PA. Their stated mission is to help people respond effectively to substance use and related problems. The Institute for Research, Education, and Training in Addictions was chosen because of their role in many initiatives designed to address the opioid overdose crisis, including providing training for a statewide opioid prescribing curriculum, training thousands of medical students on substance use disorder, training nurses in the use of SBIRT, mental health program evaluations in prisons and courts, and a statewide Public Health campaign about opioids. Noted in their information:

"What We Do: IRETA is a **nonprofit geared toward improving individual and system-level responses to addiction**. We take a boots-on-the-ground approach to problem solving and we don't mind if they get muddy.

'Broadly, IRETA offers three types of services: we educate, we evaluate, and we guide. Our services are modular (that is, they can be used independently or together), but the nexus of all three is where the most powerful changes occur."

Website here: https://ireta.org/

Sojourner House, Rehab for Mothers

Sojourner House provides in-patient residential treatment to addicted mothers and their children. Located in East Liberty, Sojourner House provides 24-hour residential rehabilitation services for 14 families at any given time. Mothers can bring three children with them and stay up to six months while receiving intensive treatment for their addiction. Sojourner House was chosen because it was the only public health service entity that focused on specifically helping women and their children by offering clients with material support beyond acute addiction resources. Sojourner House is proud to be the only program in Allegheny County that provides each family with their own apartment while the mother receives treatment. Mothers and children "can begin to experience the joys and challenges of living as an independent, drug-free family while

securely surrounded by round-the-clock support". The Sojourner House is named for Sojourner Truth, which appears to have more of an outward religious relationship to the mission of the house rather than a racial justice angle. The board and staff are comprised mostly of Black and Women of Color, however there are is no mention of race and implications for opioid use, the main focus is women and children. Of note in the history section:

"During this gathering, it was discovered that many women do not seek help for their addictions for fear they will lose their children and that there were far fewer rehabilitation programs for women than men. The consensus of the meeting was that drug and alcohol addicted mothers with their children were the group in greatest need and should be the prime target for significant aid."
https://www.sojournerhousepa.org/

Sojourner House also publishes yearly reports on their service successes in which they keep track of the demographics of the women they help. Notably, the majority of women they serve are white women who are struggling with opioid addiction; however, they offer services for women struggling with other substance use addictions. Additionally, Sojourner House's program appears to be more effective than some of the other treatment options available in Pittsburgh.

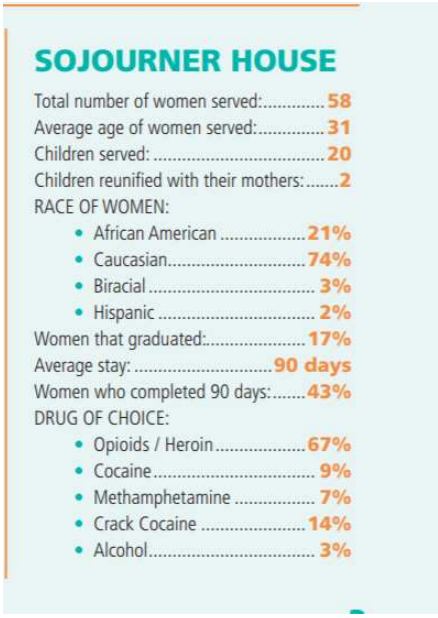


Figure 7: A screen shot that shows Sojourner House's demographics of women who are served in house in 2019.

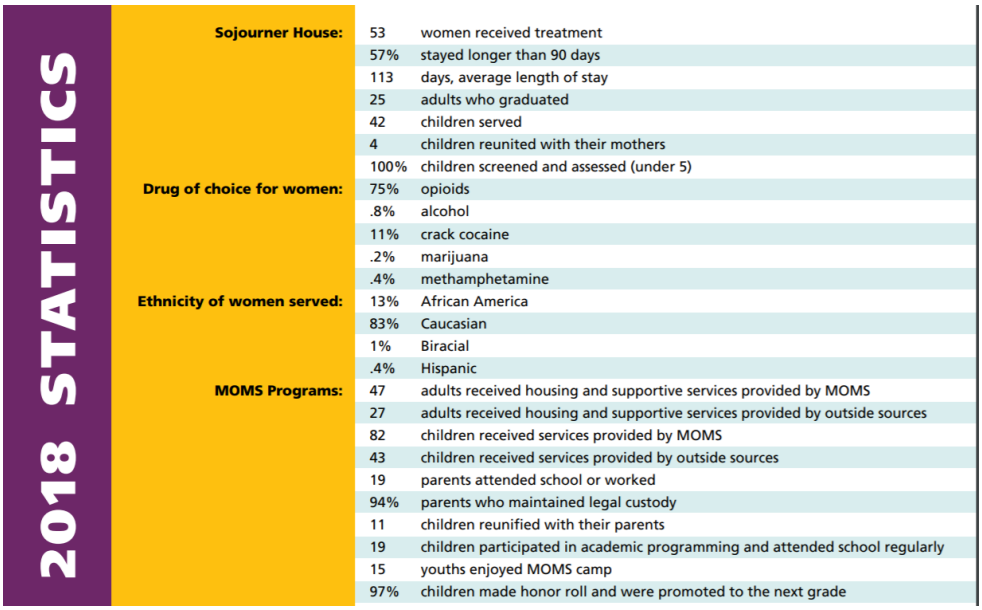


Figure 8: A screen that shows Sojourner House's demographics of women served in 2018.

Other Public health entities that exist but were not examined due to scope and space of case study include: Bridges to Hope, Pyramid Healthcare, Community Care Behavioral Health, Gateway Rehabilitation Center, Western Psychiatric Institute, and Clinic Narcotic Addiction Treatment Program.

Death Demographics and Mappings

Data from Overdose Free PA, a partnership between the University of Pittsburgh, Pennsylvania Psychiatric Society, Pennsylvania Dental Association, DEA 360 Strategy, Pennsylvania District Attorney's Association, The Hospital and Healthsystem Association of Pennsylvania, Pennsylvania Pharmacists Association, and Pennsylvania Medical Society: https://www.overdosefreepa.pitt.edu/ . The Overdose Free dashboard allows for an exploration of death data by county in Pennsylvania. The county information regarding race, gender, and age demographics are presented in line and bar graphs, as seen in Figure 8:

The more expansive feature is an interactive map that allows for exploring the county death rates by zip codes and years. However, in order to know which towns are encapsulated in the zip codes, a separate google search has to be done. I did this for each of the zip codes and provided them below.

Fatal Overdoses by Incident Zip Code, 2019

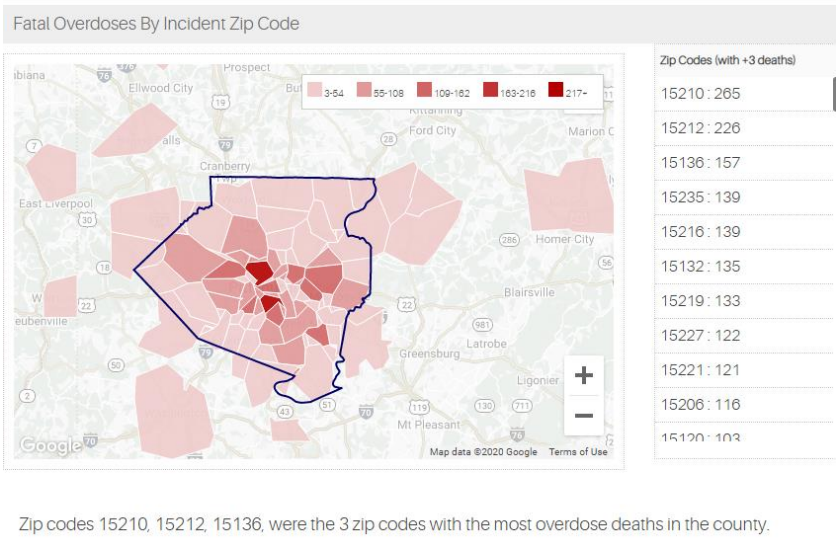
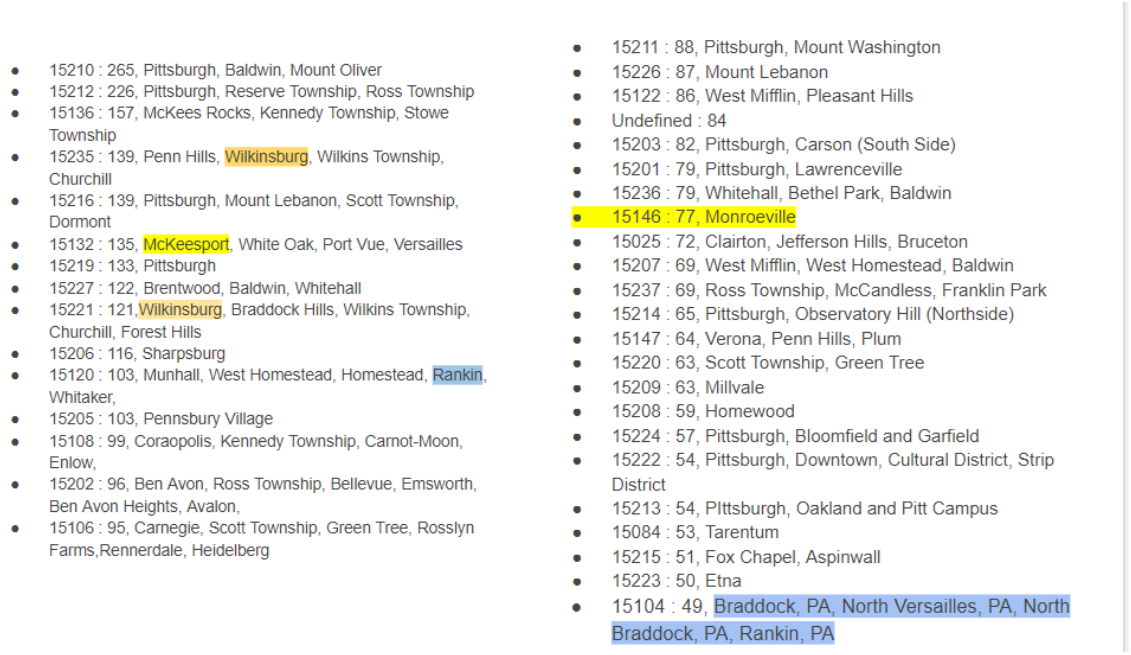
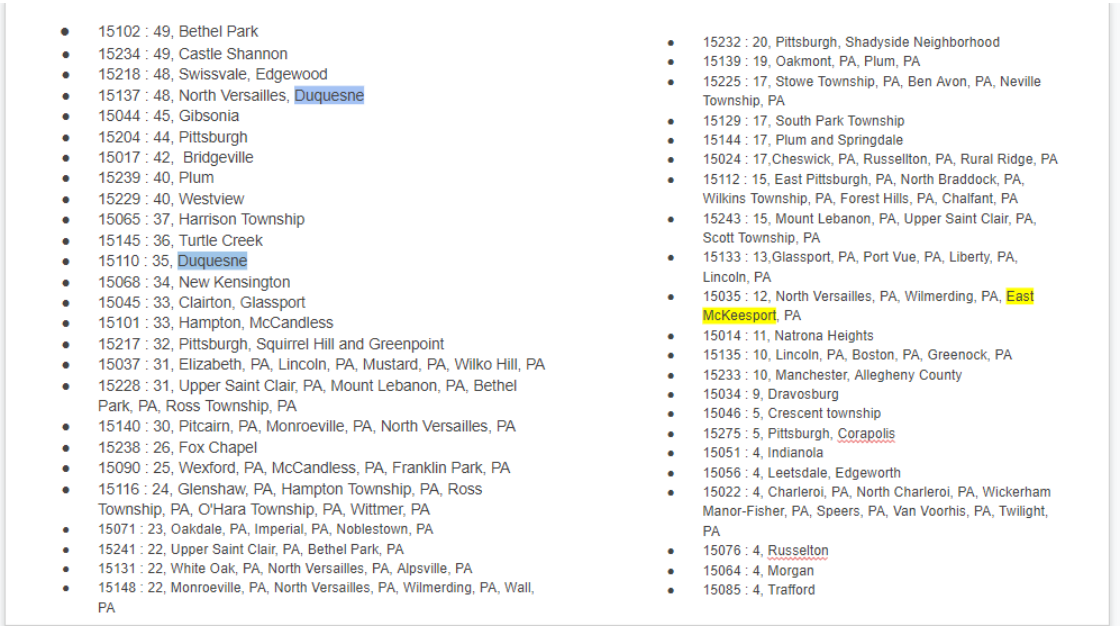


Figure 9: A screenshot of the fatal overdose by incident zip code interactive map housed on the Overdose Free PA dashboard.



- 15210 : 265, Pittsburgh, Baldwin, Mount Oliver
- 15212 : 226, Pittsburgh, Reserve Township, Ross Township
- 15136 : 157, McKees Rocks, Kennedy Township, Stowe Township
- 15235 : 139, Penn Hills, Wilkinsburg, Wilkins Township, Churchill
- 15216 : 139, Pittsburgh, Mount Lebanon, Scott Township, Dormont
- 15132 : 135, McKeesport, White Oak, Port Vue, Versailles
- 15219 : 133, Pittsburgh
- 15227 : 122, Brentwood, Baldwin, Whitehall
- 15221 : 121,Wilkinsburg, Braddock Hills, Wilkins Township, Churchill, Forest Hills
- 15206 : 116, Sharpsburg
- 15120 : 103, Munhall, West Homestead, Homestead, Rankin, Whitaker,
- 15205 : 103, Pennsbury Village
- 15108 : 99, Coraopolis, Kennedy Township, Carnot-Moon, Enlow,
- 15202 : 96, Ben Avon, Ross Township, Bellevue, Emsworth, Ben Avon Heights, Avalon,
- 15106 : 95, Carnegie, Scott Township, Green Tree, Rosslyn Farms,Rennerdale, Heidelberg
- 15211 : 88, Pittsburgh, Mount Washington
- 15226 : 87, Mount Lebanon
- 15122 : 86, West Mifflin, Pleasant Hills
- Undefined : 84
- 15203 : 82, Pittsburgh, Carson (South Side)
- 15201 : 79, Pittsburgh, Lawrenceville
- 15236 : 79, Whitehall, Bethel Park, Baldwin
- 15146 : 77, Monroeville
- 15025 : 72, Clairton, Jefferson Hills, Bruceton
- 15207 : 69, West Mifflin, West Homestead, Baldwin
- 15237 : 69, Ross Township, McCandless, Franklin Park
- 15214 : 65, Pittsburgh, Observatory Hill (Northside)
- 15147 : 64, Verona, Penn Hills, Plum
- 15220 : 63, Scott Township, Green Tree
- 15209 : 63, Millvale
- 15208 : 59, Homewood
- 15224 : 57, Pittsburgh, Bloomfield and Garfield
- 15222 : 54, Pittsburgh, Downtown, Cultural District, Strip District
- 15213 : 54, PIttsburgh, Oakland and Pitt Campus
- 15084 : 53, Tarentum
- 15215 : 51, Fox Chapel, Aspinwall
- 15223 : 50, Etna
- 15104 : 49, Braddock, PA, North Versailles, PA, North Braddock, PA, Rankin, PA

Figure 10 (above) and Figure 11 (below): The incidental zip code map did not offer detailed information about which boroughs or townships were included. In order to get a more in depth look at the areas being impacted, I looked up each incidental zip code and recorded the boroughs and townships the coding was including. In doing this, it showed that there were buroughs and townships being placed together, which erases important contextual differences that exist between different places in terms of racial, socioeconomic, and resource distribution.



- 15102 : 49, Bethel Park
- 15234 : 49, Castle Shannon
- 15218 : 48, Swissvale, Edgewood
- 15137 : 48, North Versailles, Duquesne
- 15044 : 45, Gibsonia
- 15204 : 44, Pittsburgh
- 15017 : 42, Bridgeville
- 15239 : 40, Plum
- 15229 : 40, Westview
- 15065 : 37, Harrison Township
- 15145 : 36, Turtle Creek
- 15110 : 35, Duquesne
- 15068 : 34, New Kensington
- 15045 : 33, Clairton, Glassport
- 15101 : 33, Hampton, McCandless
- 15217 : 32, Pittsburgh, Squirrel Hill and Greenpoint
- 15037 : 31, Elizabeth, PA, Lincoln, PA, Mustard, PA, Wilko Hill, PA
- 15228 : 31, Upper Saint Clair, PA, Mount Lebanon, PA, Bethel Park, PA, Ross Township, PA
- 15140 : 30, Pitcairn, PA, Monroeville, PA, North Versailles, PA
- 15238 : 26, Fox Chapel
- 15090 : 25, Wexford, PA, McCandless, PA, Franklin Park, PA
- 15116 : 24, Glenshaw, PA, Hampton Township, PA, Ross Township, PA, O'Hara Township, PA, Wittmer, PA
- 15071 : 23, Oakdale, PA, Imperial, PA, Noblestown, PA
- 15241 : 22, Upper Saint Clair, PA, Bethel Park, PA
- 15131 : 22, White Oak, PA, North Versailles, PA, Alpsville, PA
- 15148 : 22, Monroeville, PA, North Versailles, PA, Wilmerding, PA, Wall, PA
- 15232 : 20, Pittsburgh, Shadyside Neighborhood
- 15139 : 19, Oakmont, PA, Plum, PA
- 15225 : 17, Stowe Township, PA, Ben Avon, PA, Neville Township, PA
- 15129 : 17, South Park Township
- 15144 : 17, Plum and Springdale
- 15024 : 17,Cheswick, PA, Russellton, PA, Rural Ridge, PA
- 15112 : 15, East Pittsburgh, PA, North Braddock, PA, Wilkins Township, PA, Forest Hills, PA, Chalfant, PA
- 15243 : 15, Mount Lebanon, PA, Upper Saint Clair, PA, Scott Township, PA
- 15133 : 13,Glassport, PA, Port Vue, PA, Liberty, PA, Lincoln, PA
- 15035 : 12, North Versailles, PA, Wilmerding, PA, East McKeesport, PA
- 15014 : 11, Natrona Heights
- 15135 : 10, Lincoln, PA, Boston, PA, Greenock, PA
- 15233 : 10, Manchester, Allegheny County
- 15034 : 9, Dravosburg
- 15046 : 5, Crescent township
- 15275 : 5, Pittsburgh, Corapolis
- 15051 : 4, Indianola
- 15056 : 4, Leetsdale, Edgeworth
- 15022 : 4, Charleroi, PA, North Charleroi, PA, Wickerham Manor-Fisher, PA, Speers, PA, Van Voorhis, PA, Twilight, PA
- 15076 : 4, Russelton
- 15064 : 4, Morgan
- 15085 : 4, Trafford

There are multiple maps that try to encapsulate the scope of fatalities due to Opioid overdose. This map attempts to capture data by **incidental zip code**. The issue with this method is that while it helps to get a sense of where high rates of overdose related deaths are occurring, it leaves a lot out due to the ways in which the sprawl of the boroughs do not conform to the clean lines of zip codes. In the U.S. commonwealth of Pennsylvania, a borough (sometimes spelled boro) is a self-governing municipal entity, best thought of as a town that is usually smaller than a city, but with a similar population density in its residential areas. Sometimes thought of as "junior cities", boroughs generally have fewer powers and responsibilities than full-fledged cities. Additionally, a township is one class (with two forms) of the three types of municipalities codified. Townships are smaller municipal class legal entities that provide local self-government functions in most land areas in the more rural regions. Townships act as the lowest level municipal corporations of governance of the Commonwealth of Pennsylvania. The geospatial method of mapping overdose related deaths results in the severing of townships and boroughs, which leaves a lot of important details out. These matters because there are stark markers of racial segregation between boroughs/townships amidst population differences, as well as differences in class/socioeconomic standings that have implications for obtaining treatment, issues around policing (which equates to fear of calling for help in the instance of overdose), as well as environmental living conditions, job opportunities, public transportation, etc. For example, the incidental zip code with the highest total of Opioid related deaths this year includes Baldwin and Mount Oliver. Baldwin is a large borough in the Metro area of Pittsburgh with a total population 19,610 while Mount Oliver is a small borough with a population of 3315. Both areas are predominantly white. To see the social differences, below are compiled borough/township demographics offered by citydata.com with highlighted notes.

Mount Oliver
Population in 2017: 3,315 (100% urban, 0% rural).

Population changes since 2000: -16.5%

Males: 1,536 (46.3%) Females: 1,779 (53.7%)

White alone, 56.8 percent, 1,898 total

Black alone, 31.9 percent, 1066 total

Two or more races, 5.9 percent, 197 total

Hispanic, 2.6 percent, 86 total

Asian Alone, 2.5 percent, 85 total

American Indian Alone, 0.09 percent, 3 total

Notably:

- Black race population percentage above state average.
- Hispanic race population percentage significantly below state average.
- Ancestries: African (9.1%), German (7.9%), English (6.9%), Italian (6.6%), Polish (4.6%), Irish (3.0%)
- The population density for Mount Oliver is higher than the national average

Baldwin
Population in 2017: 19,610 (100% urban, 0% rural).

Population change since 2000: -1.9%

Males: 9,446 (48.2%) Females: 10,164 (51.8%)

White alone, 87.5 percent, 17,220 total

Black alone, 6.4 percent, 1,259 total

Asian alone, 2.7 percent, 536 total

Hispanic Alone, 1.5 percent, 298 total

Two or More races, 1.0 percent, 188 total

“Other race” alone, 0.3 percent, 50 total

Native Hawaiian and other Pacific Islander alone, 0.09 percent, 17 total

American Indian alone, 0.02 percent, 4 total

Notably:

- Ancestries: German (20.0%), Italian (12.2%), Irish (11.4%), Polish (10.2%), American (5.6%), Slovak (3.1%).
- Hispanic race population percentage significantly below state average.

Additionally, there are differences in the socioeconomic landscape:

In Mount Oliver the estimated median household income in 2017 was $42,811, which is an increase from $27,990 in 2000. Comparatively the median household income for the state of Pennsylvania is $59,195. The estimated per capita income in 2017 was $24,930, up $15,104 in 2000. The percentage of residents living in poverty in 2017 was 36.6%:

- 24.5% for White Non-Hispanic residents
- 56.6% for Black residents
- 78.2% for Hispanic or Latino residents
- 100.0% for other race residents
- 45.2% for two or more races residents

In Baldwin, the estimated median household income in 2017: $62,331, up from $40,752 in 2000. Comparatively, the median household income of $62,331 is above the state average of $59,195. The estimated per capita income in 2017 was $32,876, up from $19,918 in 2000. The percentage of residents living in poverty in 2017 is 6.5%:

- 5.1% for White Non-Hispanic residents,
- 21.4% for Black residents,
- 14.4% for Hispanic or Latino residents
- 12.1% for two or more races residents

Compared to McKeesport and the financially distressed municipalities of Braddock:*

McKeesport
Population in 2017: 19,245 (100% urban, 0% rural). Population change since 2000: -19.9%

Males: 8,889 (46.2%) Females: 10,356 (53.8%).

White alone, 58.1 percent, 11,270 total

Black alone, 31.9 percent, 6,188 total

Two or more race, 5.6 percent, 1095 total

Hispanic, 3.3 percent, 649 total

Asian alone, 0.4 percent, 87 total

“Other” race alone, 0.4 percent, 71 total

American Indian alone, 0.06 percent, 11 total

Notably:

- Ancestries: Polish (7.5%), German (6.5%), Italian (6.4%), American (5.0%), Irish (4.7%), English (2.9%).
- Black race population percentage above state average.
- Hispanic race population percentage below state average.
- Foreign-born population percentage significantly below state average.

The estimated median household income in 2017 was $36,273, an increase from $23,715 in 2000. The median household income in McKeesport is below the PA state average of $59,195.
The estimated per capita income in 2017 was $21,857, an increase from $13,242 in 2000.
The percentage of residents living in poverty in 2017: 33.3%

- 22.3% for White Non-Hispanic residents
- 50.6% for Black residents
- 30.1% for Hispanic or Latino residents
- 48.0% for American Indian residents
- 51.6% for other race residents
- 44.2% for two or more races residents

Other important notes:

- The median house value is significantly below the state average.
- Renting percentage above state average.
- Number of college students below state average.
- Percentage of population with a bachelor's degree or higher below state average.

Braddock
Males: 988 (46.7%) Females: 1,128 (53.3%)
Population in 2017: 2,116 (100% urban, 0% rural). Population changes since 2000: -27.3%

Black alone, 72.0 percent, 1,555 total
White alone, 22.6 percent, 489 total
Two or more races, 2.3 percent, 49 total
Hispanic, 1.9 percent, 40 total
American Indian alone, 0.6 percent, 14 total
Native Hawaiian and Other Pacific Islander alone, 0.2 percent, 4 total
“Other” race alone, 0.2 percent, 5 total
Asian alone, 0.1 percent, 3 total

Notable:

- Ancestries: African (19.6%), Italian (4.3%), American (3.9%), Polish (3.9%), Pennsylvania German (1.9%), German (1.3%).
- Black race population percentage significantly above state average.
- Hispanic race population percentage significantly below state average.

The estimated median household income in 2017 was $28,255, an increase from $18,473 in 2000. Braddock's median household income is below the PA state average of $59,195. The estimated per capita income in 2017 was $21,680, an increase from $13,135 in 2000.
The percentage of residents living in poverty in 2017 was 30.3%:

- 23.4% for White Non-Hispanic residents,
- 27.3% for Black residents,
- 23.1% for Hispanic or Latino residents,
- 76.2% for two or more races residents

The median house value is significantly below state average.

Notable:

- 107 people in correctional residential facilities
- 49 people in emergency and transitional shelters (with sleeping facilities) for people experiencing homelessness.
- 11 people in group homes intended for adults
- 11 people in residential treatment centers for adults 3 people in other noninstitutional facilities
- Institutionalized population percentage above state average.
- Number of college students significantly below state average.
- Percentage of population with a bachelor's degree or higher significantly below state average.
- Foreign-born population percentage significantly below state average.
- Renting percentage above state average

The dashboard also has the option to explore death demographic data by residential zip by year. In doing this, the story changes slightly and shows the top four areas of death are: Baldwin, Pittsburgh (Reserve Township), McKees Rocks, and McKeesport followed by Wilkinsburg in fifth. However, even with this slight change, the dashboard presents total death numbers without any in depth nuance or relationship to the area that is outlined. When looking at the demographic data for different boroughs, differences in racial composition and socioeconomic statuses can be considered in the picture of opioid overdose deaths. For example, Mt. Oliver and Baldwin are listed together in the as the number overdose incidental area for 2019. However, looking at Mt. Oliver and Baldwin separately shows very important distinctions. Specifically, Mt. Oliver is a borough with a population just above 3,000 whereas Baldwin is a borough that has over 19,000

people. Additionally, despite Mt. Oliver being predominantly white, there are more Black people who live there than is reflected in the state average, as well as Native peoples who have been left out of demographic information in relation to opioid use completely.

Looking comparatively at the socioeconomics of each area, on average people who live in Baldwin make almost $20,000 more than people who live in Mt. Oliver. In 2017, the percentage of people living in poverty in Mt. Oliver was 36.6% compared to 6.5% in Baldwin. Of that 36.6 percent, 56 percent of those people were Black, and 76 percent were Latino. In comparison, McKeesport is close to Baldwin in terms of population size but is comprised of 58 percent white people, 31 percent Black people, 5.6 percent Bi/multiracial, 3.3 Latino, 0.4 percent Asian, and 0.05 Native American. The estimated median household income in 2017 was $36,273, and 33 percent of people living there are living in poverty. In Braddock, which is a designated a financially distressed municipality, the population is just over two thousand and is predominantly Black. The estimated median household income in 2017 was $28,255 and 30.3 percent people live in poverty. Through matching up the incidental zip codes with the appropriate boroughs and townships it was discovered that most of the treatment centers were in Monroeville and Penn Hills, which are predominantly white and middle-class areas. The differences and distinctions between boroughs are significant in terms of thinking about the environment in which people live, which people live where, the opportunities they have access to, and their ability to access treatment. Monroeville is a far walk for people who live in Braddock who do not have cars. It is also a far bus ride if people have the bus fare to spare. These are some of the realities that are omitted from the dashboard when death totals are collapsed into zip codes that are not even named, turning complicated places into decontextualized spaces on a map.

Data Set Two: The Industrial History of Pittsburgh, Pennsylvania

The city of Pittsburgh and surrounding boroughs are known for their production of a significant portion of United States steel that began in the 1800s and lasted into the mid-1980s. Many entities including the city of Pittsburgh, Carnegie Mellon Library, the University of Pittsburgh, and the Heinz Historical Society have preserved the historical processes of the built environment, as they are a key aspect of Pittsburgh's history as the "workshop of the world" (Pennsylvania Department of Transportation, 2016). Here, data of the built environment is offered in snapshots of five historical time periods: Settler colonial contact/colonization, Early Industrial Period, Peak Industrial Period, Post-Industrial period, deindustrialization.

Setting Up the Settler Colonial Structure, 1747-1799

The location of what now constitutes the city of Pittsburgh was seen by European settler colonists as a strategic military and trade route post, named "the Gateway to the west" (Pennsylvania Department of Transportation, 2016). European settlement began as a series of forts which commenced with the clearing of dense forest life and excavation of land along the banks of the Monongahela and Allegheny rivers. The first fort, called Fort Duquesne, was built by the French, which they abandoned to avoid defeat by the British. The British then seized the

area from the French and built Fort Pitt.

Figure 12: Painting depicting George Washington's surveying of the land sitting at the confluence of the Monongahela and Allegheny for a British fort. The land is shown to have small river tributaries flowing towards the Monongahela and is populated by trees and grasses. Washington was impressed with the nature of the terrain and the commanding position it presented. On November 24, 1753, he wrote in his diary:

"As I got down before the canoe, I spent some time viewing the rivers, and the land in the fork, which I think extremely well situated for a fort, as it has the ***absolute command of both rivers****. The land at the point is twenty-five feet above the common surface of the water; and a considerable bottom of flat* ***well-timbered land all around it very convenient for building****. The rivers are each a quarter of a mile across and run here very nearly at right angles; Allegheny, bearing north-east; and Monongahela, south-east. The former of these two is a very rapid and swift running water, the other deep and still, without any perceptible fall." (The Diaries of George Washington, The Library of Congress)*

Figures 13 (top) and 14 (bottom): Model renderings of Fort Duquesne showing land and trees cleared for building of settlement, earth excavated to form the foundation of Fort Duquesne. Accessed from Brooklineconnection.com

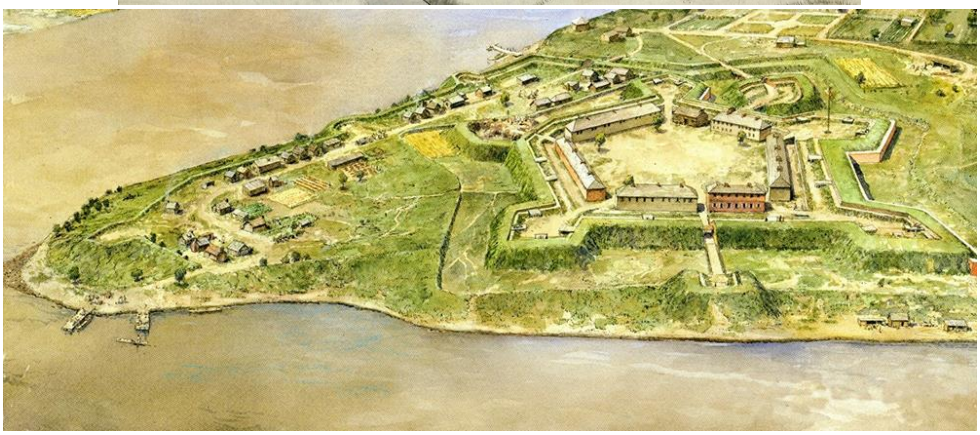


Figure 15 (top): A schematic of Fort Pitt plans show the leftover footprint of Fort Duquesne and the increase of size for Fort Pitt which includes the excavation of more land for the larger fort's construction, the creation of a water canal for irrigation, and the clearing of land for farming.
Figure 16 (bottom): An illustration of Fort Pitt after construction. Accessed from https://www.heinzhistorycenter.org/fort-pitt/

Early Industrial Period: Coal Mining and Iron Production, 1800-1859

Following the American Revolution, Fort Pitt was deemed no longer necessary. Residential settlement and industry became the focus of the strategic location along the three rivers. Settlers in the Pittsburgh area began to turn the raw materials around them into iron, glass, and woodworking industries. A big factor in this development was the increased use of coal, which resulted in the increase of coal mining. Pittsburgh is located on a major coal seam within the Appalachian basin and is noted to be the thickest and most extensive coal bed (Tewalt, Ruppert, Bragg, Carlton, Brezinski, Wallack, and Butler, 2000). In addition to the forming center of

Pittsburgh, smaller adjacent settlements began to prop up around coal mining operations. These settlements would later become the ‘industrial suburban’ Burroughs and townships of the Pittsburgh metro area.

Figure 17: Updated plans show the ruins of Fort Pitt along with the development of residential settlement, several canals. A predominant hill is marked as a stone quarry, and the waterways leading to it are most likely used for extractive practices. Accessed from *https://www.heinzhistorycenter.org/fort-pitt/*

Figure 18: Pittsburgh, Pennsylvania (vicinity). Montour no. 4 mine of the Pittsburgh Coal Company. Above the coal seam, dairy and farmlands lay undisturbed. Only occasionally there will be "sinks" and large "potholes" caused by the collapsing of "mined out" areas of the seam. Image: Library of Congress

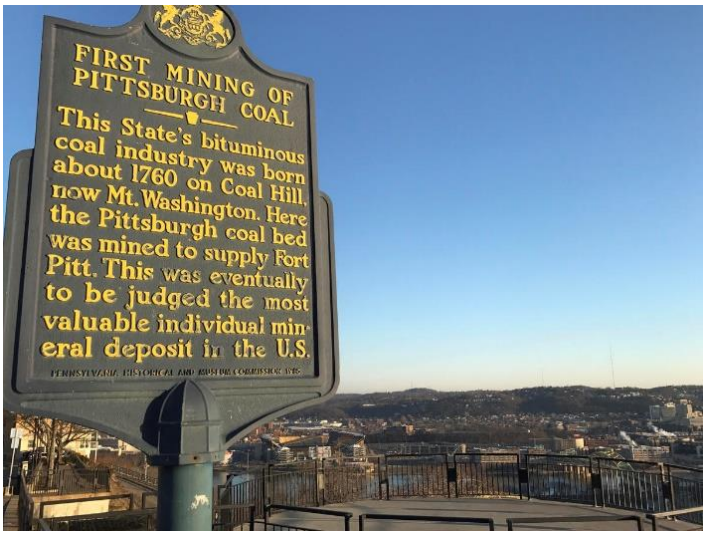


Figure 19: Historical Marker on Mount Washington denoting the first coal mine. Image source: Pittsburgh Post-Gazette

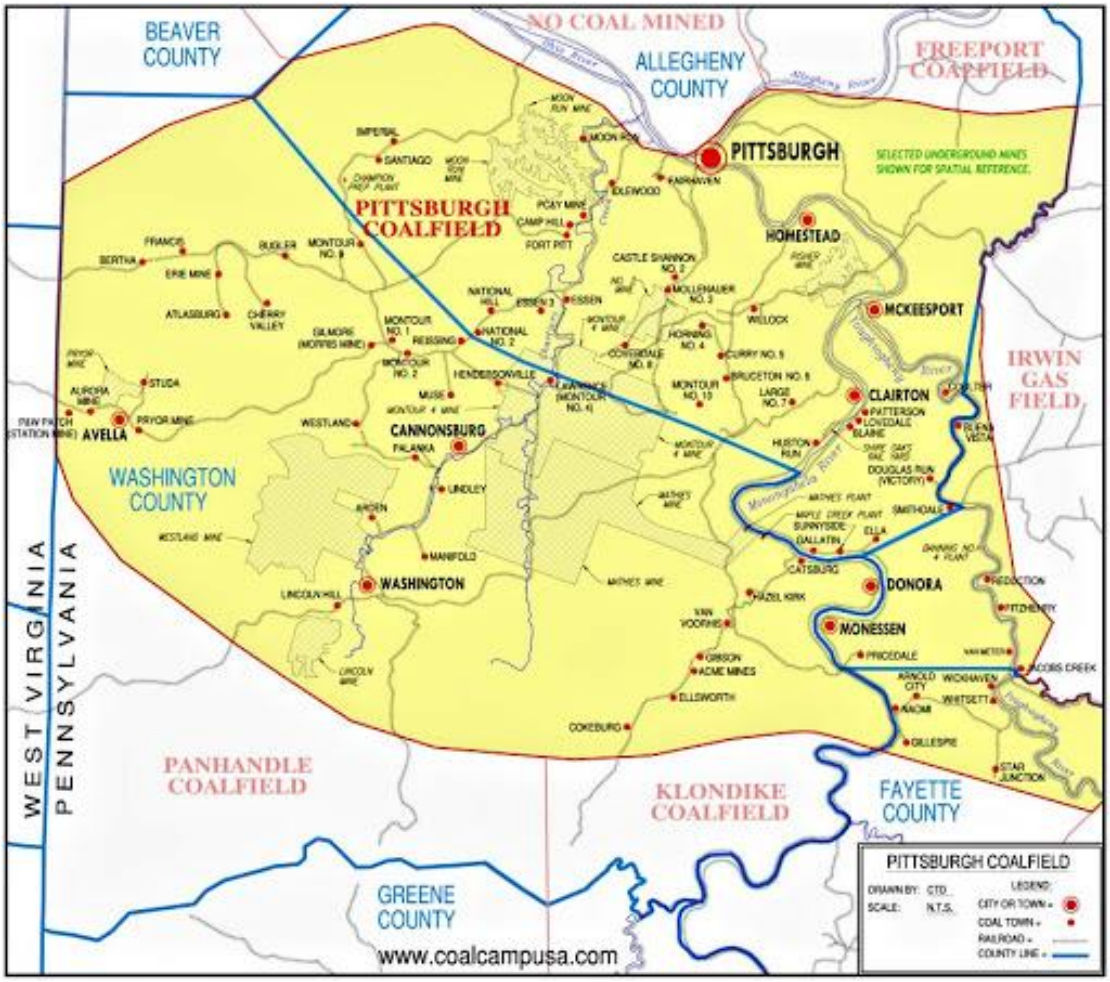


Figure 20: Map of the Pittsburgh coalfield. Image source: Coalcampusa.com

Steel City: Mass Coal Extraction, Coke and Steel Production, 1849-1946

From the mid-1800s into 1946, with the introduction of Coke and the Bessemer process, the Pittsburgh area transformed into an industrial production powerhouse. Logging operations resulted in quick deforestation along the banks and hills of the Mon river valley, clearing the way for railroads and inclines set to carry tons of raw materials from extraction sites to their intended production at coke works or steel mills.

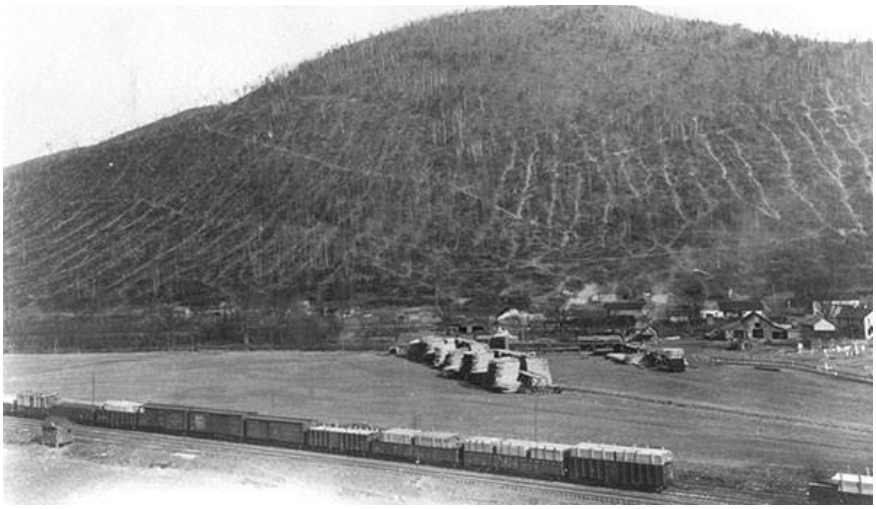


Figure 21: logging operations clear a hill of trees. Accessed from Pghcitypaper.com

Figure 22: Beehive coke ovens in the Connellsville coke district, circa 1890, Courtesy of the Pennsylvania State Archives

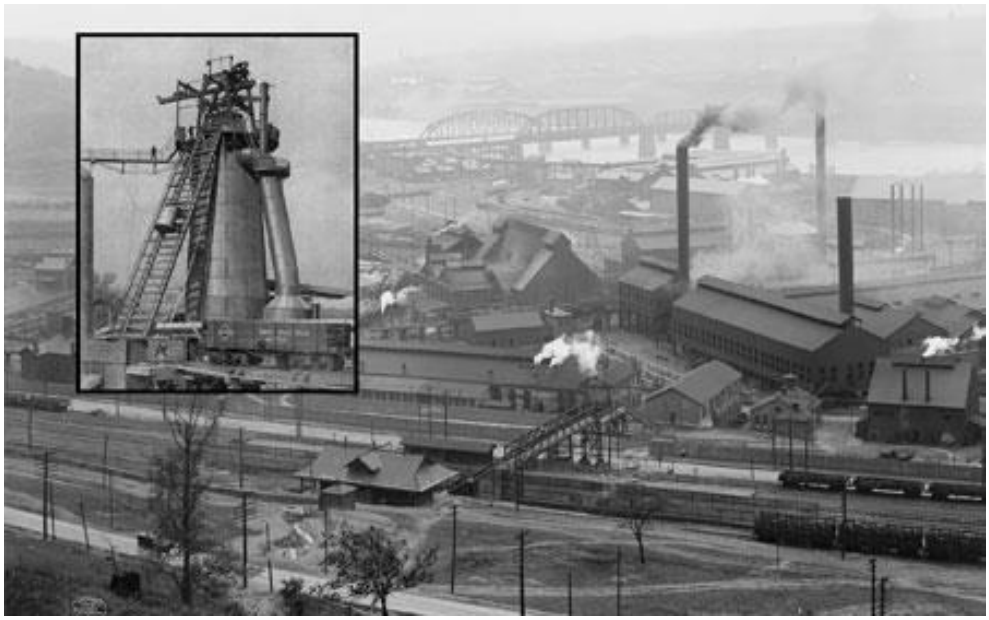


Figure 23: Aerial View of plant site and close view of Blast Furnace, c1905, Library of Congress. The Edgar Thomson Works was the first of Carnegie's large Bessemer steel plants in Allegheny county. Edgar Thomson, now owned by United States Steel, continues operation as the only plant in Pennsylvania engaged in only basic steelmaking

Figure 24: Pittsburgh's point in 1911,c. Library of Congress, shows industrial district, eroding river banks, coal barges, multiple steel mills in background.

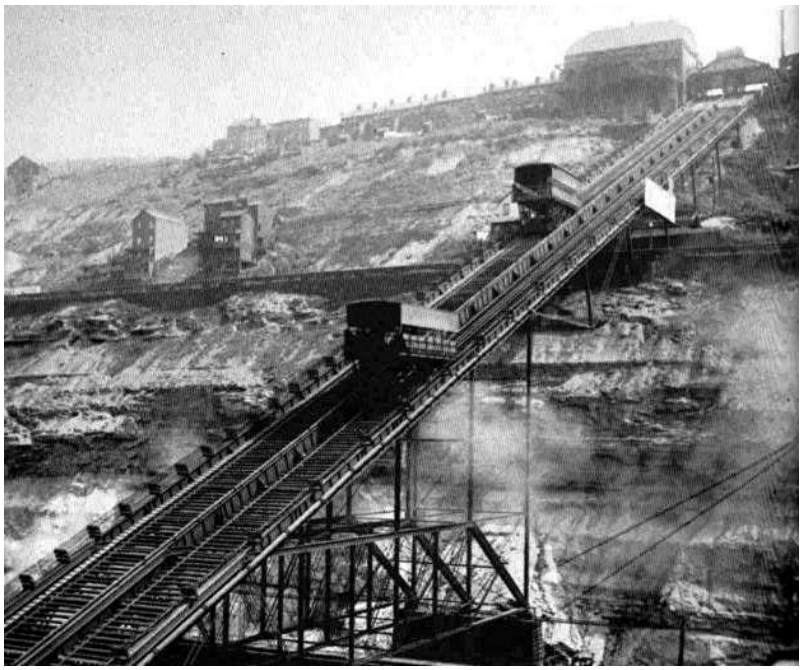


Figure 25: The Penn Incline, used to transport tons of coal from the extraction site on Mount Washington to rail cars and river barges. There are no trees and significant portions of the hill have been blasted away for coal as well as for the incline. A few houses of workers exist nearby. Library of Congress

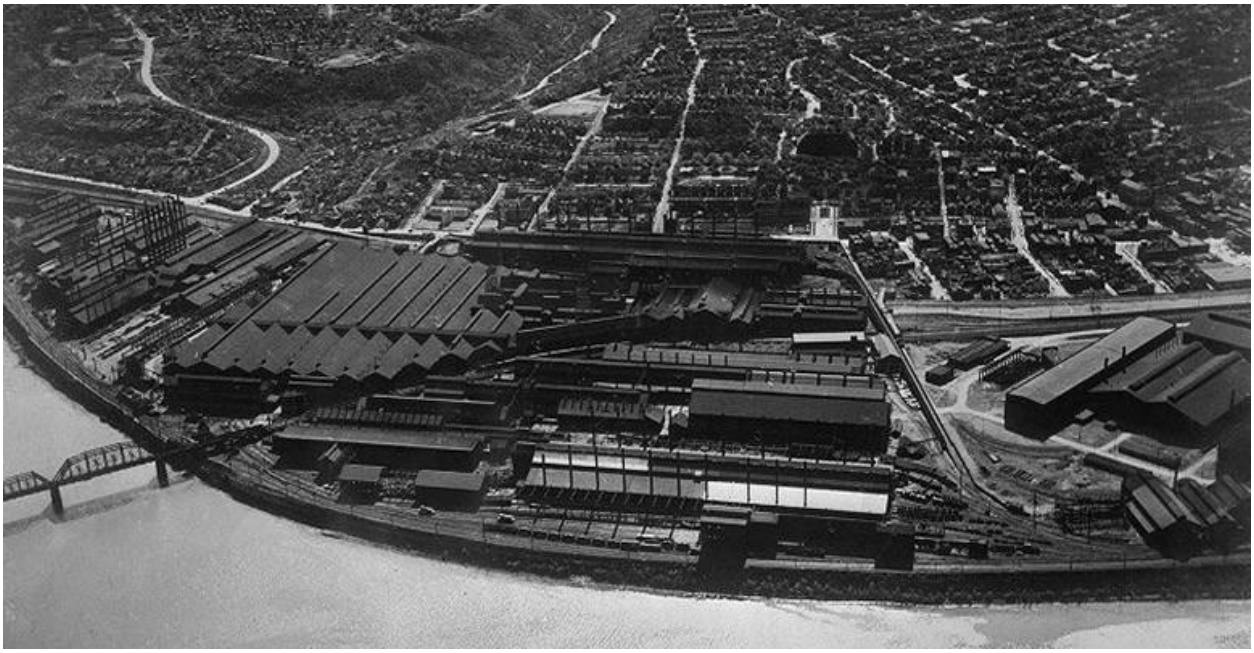


Figure 26: Steel work site in Munhall, 12 miles up the Mon River. By the 1900s, the Mon riverbanks were the site of over 10 steel manufacturing and other supportive industry sites of this scale. (source: http://www.munhallpa.us/munhall-borough-pittsburgh-pa/history-area/)

Figure 27: An aerial view of Pittsburgh in 1931 shows a sprawling Industrial metropolis. Notably, the Monongahela and Allegheny rivers are marked by industrial run off.

Figure 28: (below, top left) McKeesport Tube Plant, 1940s. Figure 29: (below, right) J & L works, Southside in 1941 (Vachon, J.) accessed through the LOC. Figure 30: (below, bottom left), Pittsburgh at noon in the 1940s.

Figure 31: Steel laborer makes their way down one of many stair streets built into the hillsides around steel, tube, and coke manufacturing plants against the backdrop of heavy smog, 1940s. accessed from PopularPittsburgh.com

Figure 32: (bottom left) Slag Mountain in West Mifflin in 1969; Figure 33: Molten slag is dumped from railway car in West Mifflin dumping area. Images from: http://www.brooklineconnection.com/history/Facts/BrownsDump.html

Pittsburgh Renaissance I, 1946-1973 and Renaissance II,

This period of Pittsburgh's environmental history was characterized by several Urban Renewal Policies intended to clean up the smog in the air, the sewer like qualities of the rivers and city water and reinvent the city. In addition to environmental clean-up, several housing projects located in the Hill District and other predominantly Black areas of the city were demolished in the name of renewal yet resulted in the dislocation of hundreds of Black families into East Pittsburgh, Rankin, and Braddock.

Figure 34: Photo of Pittsburgh taken from Goodyear Blimp in 1972 shows a reformed city absent of steel, coal and other industrial production. However, still seen is smog on the horizon and polluted waters of the Mon river. Dale Gleason, Pittsburgh Post-Gazette

Figure 34: The construction of the Pittsburgh Plate Glass building in 1981, the building is seen as a symbol of Pittsburgh's turn around in a new modern era.

Deindustrialization, 1987- early 2000s, arguably into 2020.

In the late 80s, with the passing of free trade deals by the Reagan administration, along with the depletion of natural resources, the remaining steel mills began to close, leaving behind the wreckage of industrial operations and waste. Once thriving boroughs began to be abandoned by those who could afford to go elsewhere.

Figure 35: the beginning of the destruction of the Homestead Mill; Figure 36: abandoned worker homes in McKeesport; Figure 37: Dilapidated buildings in Braddock; Figure 38: abandoned homes in McKeesport. Photos retrieved from google image search

Figure 39: Mainstreet in Clairton, with works sitting abandoned. Figure 40: Clairton Coke Works, still in production today.

This type of fracking operation is being suggested within the city limits of Braddock and is currently being contested by residents from the borough as well as surrounding boroughs. There is large concern around fracking on top of former industrial sites, whether those be former steel or coke manufacturing or coal mines.

Figure 41: Construction of Shell Chemical Appalachia's ethane cracker facility in Monaca, Pennsylvania in February (NICK CUNNINGHAM / YALE E360).

Current Environmental Issues and Impacts on Health

In the Post-World War II era, developers of Pittsburgh understood that to adapt to the progression of development, efforts to clean up industrial waste in the water and air were imperative. While the city proper some boroughs such as the Southside and Homestead have seen what are considered improvements with the reinvention of brownfields, the continued operation of industrial plants along with remaining industrial toxins that built up over 170 years of production continue to be issues.

The Penn Environment Research and Policy Center is a non-profit organization committed to protecting the state of Pennsylvania’s open spaces, rivers and streams, forests, and land. Through research and education, Penn Environment Research and Policy Center compile

data on pollutants found in the environment and advocate for policy solutions to eliminate the threat they pose to public health. Below is a screen shot of Penn Environment's website dedicated to highly pollutive sites in Allegheny County. The map shows where the top ten pollutive industrial facilities are located.

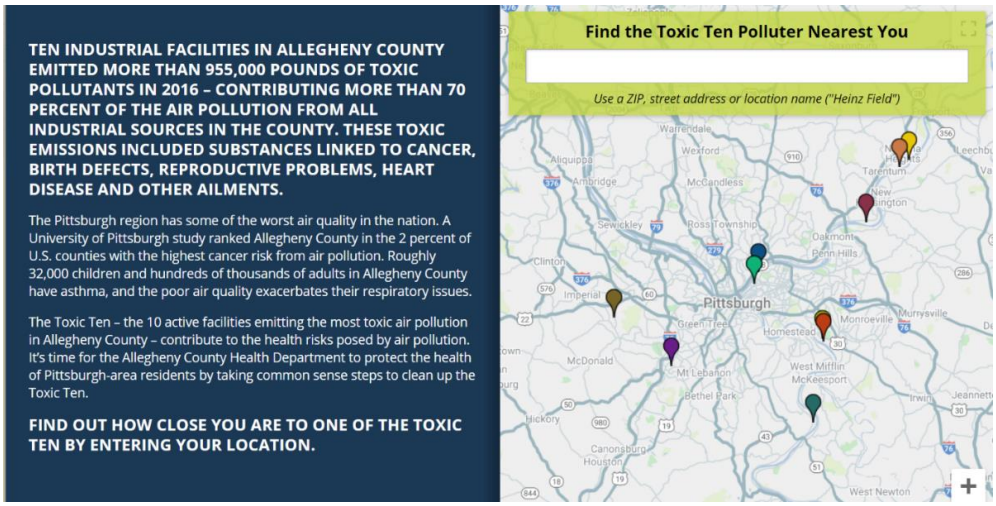


Figure 42: Screenshot from Penn Environment Research Facility Mapping of industrial facilities taken from Penn Environment Research Center.

The top ten highly pollutive sites are identified as follows: Harsco metals located in Natrona Heights, McConway and Torley Foundry located in Pittsburgh (Lawrenceville neighborhood), USS-Edgar Thomson Plant located in Braddock, ATI Flat Rolled Products located in Brackenridge, Cheswick Power Plant in Springdale, TMS International located in Braddock, Universal Stainless and Alloy Products located in Bridgeville, ATI Powder Metals located in Oakdale, USS-Clairton Plant located in Clairton, and Pressure Chemical Company located in Pittsburgh (Lawrenceville and Bloomfield adjacent).

In addition to site identification, PE has also compiled data on the composition and number of pollutants emitted by the industrial sites and their correlative health impacts. I have isolated three of these sites: USS-Clairton Plant (3rd most pollutive), USS-Edgar Thomson (10th most pollutive)/TMS International in Braddock (9th most pollutive), and Universal Stainless and Alloy

Products (5th most pollutive) located in Bridgeville. Edgar Thomson and TMS are being considered as they are right next to each other because of production processes. I chose these three sites as they relate to the opiate mortality dashboard discussed in the previous data set.

The environmental connections are important. According to the Pennsylvania Department of Health (2017) around 1 in 2 Pennsylvania residents will be diagnosed with cancer in their lifetimes, and 1 in 5 will die. Allegheny county is second on the list for cancer diagnoses and deaths, especially for Breast and lung cancers in female residents (Pennsylvania Department of Health). Additionally, Black and non-white Hispanic residents are shown to have disproportionate rates of cancer diagnoses and deaths statewide, however at the time of data collection, research did not yield a county break down of these statistics. This is interesting given that some counties, notably Allegheny county, have a higher percentage of Black residents than other counties in the state. The environmental connection to cancer is also significant in thinking about the use of opioids. Opiates are commonly prescribed in the treatment of cancers for people who have health insurance. In addition, the increased prescription of opioids for other issues of illness and pain coupled with the recent crackdown on overprescribing is something to consider in the use of non-prescription opioids, in particular heroin.

The purpose of this study was to utilize an intersectional and decolonial place-based interventional framework to examine Public Health race discourse surrounding the opioid overdose epidemic. The first data set offered presented different facets of Public Health messaging around the opioid overdose crisis, beginning with Pennsylvania state responses, followed by messaging put forth by Allegheny county, the city of Pittsburgh, the University of Pittsburgh School of Public Health and specific treatment facilities. This set also included photos

of the opioid death mapping dashboard and compared zonings to the composition of the areas in which they were measuring.

The findings show the ways in which Public Health data and discourse frames the opioid epidemic as an issue that impacts predominantly white and male identified people, there was no subsequent messaging that contended with whiteness beyond a descriptor. This is different than the ways that the categories of 'Black' or 'Hispanic' are treated as racialized factors, or social determinants, that potentially inform addiction. The second data set looks at the industrial formation of Pittsburgh as a means of giving context to place. The implications of these findings along with the connections between the two data sets will be discussed in the following chapter.

Chapter Five: Discussion

"I am convinced that the hold Pittsburgh has on me is at least partly genetic, that something in the chemicals I am made of remains ethereally linked to the energy my family invested here."
Laurie Graham, from Singing the City: The Bonds of Home in An Industrial Landscape

"Because white supremacy is so normalized in the culture and rarely examined, it is constantly looked past despite the reality that it is the central issue by which all other issues can be properly understood."
Bree Newsome Bass

In this chapter, the findings that emerged from the three data sets in the previous chapter are discussed through the theoretical framework offered in the first chapter. This project began by presenting the ways in which mainstream understandings construct the opioid epidemic as a crisis that predominantly impacts the "unlikely" victim, in particular white, suburban middle-class people characterized as either "soccer moms" or men who are "down on their economic luck". This master narrative was justified by quantitative data compiled by Public Health entities showing that most people dying from opioid overdose are identified as white. At the same time, the white mortality data was being discussed, Public Health experts suggested that opioid addiction is an affliction "that sees no color" and "cuts across all social categories". However, it was shown through specialized reports that this framing has resulted in racialized and gendered disparities that exist within approaches and treatment to opioids because of the negation of the ways opioid addiction impacts Black and brown people differentially.

Through the literature review process, it was found that Public Health's dominant approaches to addressing opioid overdose are standardized, medical models that focus on ending the over prescription of opioids, the "misuse" of opioids, access to Naloxone/Narcan, medication assisted therapy (MAT), and addiction related counseling. The literature review also explored the

social determinants of health concept, which are the considerations of the ways in which societal issues inform health outcomes, which has largely been taken up in practice by harm reduction, which is a subfield within Public Health. Within harm reduction, the literature review focused on a study concerned with opioid addiction in McKeesport, which is a borough of Pittsburgh that remains economically distressed following the closure of the steel tube works in the 1980s. This study was of specific focus for both its location and its application of the risk environment framework, which utilizes the social determinants of health within a place -based framework of understanding. The research attempt to understand how place plays a role in opioid addiction was the space in which this project found its footing.

Guided by an interventional framework comprised of intersectional feminism, the Indigenous concept of place, and Fanon's sociogeny, this case study was concerned with the ways in which Public Health's dominant discourse concerning white opioid users coupled with a colorblind ideology has resulted in the reiteration of racially stratified public health discussions, strategies, initiatives, and treatment both nationally and in the Pittsburgh region. This research was guided by two questions: RQ 1): How is whiteness talked about in Pittsburgh Public Health discussions and solutions directed at the opioid epidemic? and RQ 2): How are the histories of race and place in Pittsburgh considered within local Public Health discussions around opioid addiction? To answer these questions, a discourse analysis of public documents and media coverage of the opioid epidemic was conducted.

From the data, this case study found that within both the dominant Pittsburgh Public Health and harm reduction approaches, whiteness was either reduced to a descriptor or completely omitted in discourse. Following, Pittsburgh Public Health discourse omitted the consideration of place, in that it was reduced to a backdrop in which opioid addiction and

overdose occurs or was discussed as a distressed economic situation. As a result, Pittsburgh Public Health has adopted standardized approaches to the opioid epidemic that does not take into consideration the role and relationship of and between whiteness and the uniqueness of place. To illustrate and draw connections between these findings and their implications, the data is discussed in sections as they relate to the data organization and research questions.

Omission of Whiteness

In the consideration of how whiteness is omitted from the discourse, I recall Lipsitz's quote offered in the introduction: "White power secures its dominance by seeming not to be anything in particular. As the unnamed category against which difference is constructed, whiteness never has to speak its name, never has to acknowledge its role as an organizing principle, its social and cultural relations" (Lipsitz, 1995, p. 69). Although the opioid epidemic is talked about overall as being a white middle class problem, the discourse analysis in this study shows that when within the state, county, and Pittsburgh specific reports and presentations that give an overview and breakdown of the epidemic, population totals for overdose mortalities are presented together, with the simple conclusion that more white people die from opioid use. The following steps for addressing the crisis make no mention of racial considerations in expanding prevention policy and practices, which is interesting given the reality of residential segregation and other factors of racial inequality that are apparent in Pittsburgh.

For example, within the state discourse regarding the scope of the problem, racial demographics are outlined in the following way by the DEA of Pennsylvania in a 2016 report:

> "The key findings of this study show: The percent increase in drug-related overdose deaths between 2015 and 2016 was larger in rural counties (42 percent) compared to urban counties (34 percent); In 2016, 70 percent of drug-related overdose decedents were male, consistent with 2015, but not consistent with the population distribution across Pennsylvania; Males were more likely to die from a fentanyl and/or heroin overdose compared to females; Females were more likely to have alprazolam, clonazepam, and/or

> oxycodone present in overdose deaths, while males were more likely to have fentanyl, heroin, cocaine, and/or ethanol present in overdose deaths.; In 2016, **77 percent of decedent were White, 12 percent were Black, 4 percent were Hispanic, and 7 percent were identified as Other**, consistent with 2015 and the population distribution across Pennsylvania.

In the last line, the racial demographics of the epidemic are described, followed by the suggestion that these totals are consistent with the population distribution. What is not said, but is implied however, is that because these numbers are on par with the population distribution, there is no distinguishing racial factors to the epidemic, which ignores 'white' as a racialized category, which then allows the consideration of race to disappear from the discourse almost entirely. This is reflected in the state sponsored approaches that were adopted by Governor Tom Wolf when he declared a state of emergency in Pennsylvania three years later. The federal government gave the state $75 million to address the crisis which led to the following approaches:

> "Area where the funding will help with prevention include: Increased collaboration with county and municipal health departments; additional naloxone training for first responders; staffing the program's Patient Advocacy Unit; Provide individualized, one-on-one education to opioid prescribers; and Offering continuing medical education to providers on evidence-based approaches to opioid prescribing and addressing substance use disorder; Work to address the opioid crisis focuses on three areas: prevention, rescue, and treatment; Efforts over the past four years, working with state agencies, local, regional, and federal officials, have resulted in significant action to address the opioid crisis. Recent efforts include: The Prescription Drug Monitoring Program has reduced opioid prescriptions by 27 percent and has virtually eliminated doctor shopping; the Opioid Data Dashboard and Data Dashboard 2.0 is providing public-facing data regarding prevention, rescue, and treatment; the waiver of birth certificate fees for those with opioid use disorder has helped close to 2,700 people, enabling easier entry into recovery programs; A standing order signed by Dr. Rachel Levine in 2018 allowed EMS to leave behind nearly 1,100 doses of naloxone; More than 6,000 health care professionals have been visited and provided training on how to prescribe opioids cautiously and judiciously; 813 drug take-back boxes help Pennsylvanians properly dispose of unwanted drugs, including 482,000 pounds of unwanted drugs in 2018; The Get Help Now Hotline received more than 26,000 calls, with nearly half of all callers connected directly to a treatment provider; **the state prison system** has expanded their Medication-Assisted Treatment (MAT) program, which is viewed as a model program for

> other states; More than 100 licensed physicians or prescribers have been disciplined for wrongful practice over the past two years; Several agencies have worked together to collaborate on the seizure and destruction of illicit opioids across Pennsylvania; The coordination with seven major commercial providers has expanded access to naloxone and mental health care, while also working to make it more affordable; 3,055 cases **of neonatal abstinence** syndrome have been reported to the Opioid Command Center; Naloxone has been made available to first responders through the Commission on Crime and Delinquency, with more than 25,000 doses made available and more than 4,500 saves through that program. In addition, EMS have administered more than 25,000 doses of naloxone and more than 7,000 doses were made available to members of the public during the state's naloxone distribution last year."

In this approach for use of funding, there are no mentions of whiteness even though the state declared that more white people were dying from opioid overdose. Further, what is interesting to note is that in the discussions around giving money for MAT treatment to prisons, there is no consideration for the racial disparities that show on average, Black and Brown opioid users are incarcerated for their opioid due to the criminalization of drug use of racialized populations through the drug wars (Netherland & Hansen, 2016). This shows that, again, because the decedent totals are on par with population demographics, race is considered a non-issue. Going in further, this discourse is repeated in Allegheny county specific information. In the report titled *Opiate-Related Overdose Deaths in Allegheny County Risks and Opportunities for Intervention, July 2016,* Allegheny Health Authorities reported the following:

> "Race: Each year, **a greater number of white than black residents died from an opiate-related overdose; white residents accounted for 91 percent of opiate-related overdose fatalities in 2014.** While fatal overdose rates are higher for whites each year, the increase in rates of overdose during this period were comparable. **No statistical differences** were observed in the overdose rates between white and black residents during this period."

In this discourse, population demographics are presented with stronger signifiers, as seen in the describing phrase "a *greater* number of white than Black", later stating that there are no statistical differences observed between white and Black residents. The issue here is that talking

about race through quantitative means ignores the power differentials that lie within the designated categories. Despite there being no statistical differences within numbers, there are disparate differences in how White and Black users are treated within the instances of overdose due to several factors that stem from racism. This includes access to overdose prevention sites or naloxone distribution as well as racial bias held by first responders if they are called in the instance of overdose (James & Jordan, 2018; Netherland & Hansen 2016). Whereas, in Pittsburgh, most treatment centers and Naloxone access and training can be found in predominantly white spaces, such as Monroeville. In this way, while using quantitative means to describe difference seems benign, it erases the differences in these experiences and once again, assumes race as a descriptor rather than a category attached to power and histories. This is again evidenced in the treatment practice guideline issued in the summary section of this article:

> "Practice guidelines: As a result of the current epidemic, the Pennsylvania Physician General and the Department of Health, with support from DDAP, developed prescribing guidelines for emergency departments, pharmacists, dentists and physicians specializing in chronic non-cancer pain, geriatrics and OB/GYN. **These guidelines provide guidance for safer, more effective pain relief practices, with greater emphasis on non-opioid therapies and greater caution to prevent addiction and diversion**. The Physician General has identified plans to develop prescribing guidelines for sports medicine, pediatrics, and benzodiazepines in the near future. In addition, Community Care Behavioral Health Organization has developed best practice guidelines for MMT, Vivitrol® and Suboxone®, and managing benzodiazepines in MA

Like state approaches, Allegheny county has taken up universalized approaches that do not consider the nuanced social differences that stem from race and the focus is on managing pain relief practices that do not have adverse impacts on people. This also ignores the reality that generally within pain treatment, Black people are severely undertreated for pain, thus what is really being said here is that there is a focus on managing pain relief practices for white populations (James & Jordan 2018). Another example of whiteness not being named as anything

in particular can be found in the reporting of Pittsburgh's NPR Affiliate. In an article entitled "Allegheny Health Network Takes New, More Holistic Approach to Addiction Treatment", published April 16th, 2019, Sarah Boden writes:

> "If patients have opioid dependency issues, in addition to medicated assisted treatment, they might also be referred to AHN's holistic pain management program, which the health care network is expanding. **A person can develop opioid dependency after receiving a prescription to manage pain from an injury or surgery, so their addiction might be entangled with chronic pain issues. AHN wants to replace powerful medications with more holistic treatments.** "These interventions include massage, acupuncture, behavioral health and physical therapy," said pain medicine specialist Dr. Jack Kabazie."
>
> "Allegheny County Health Department Director Karen Hacker said she's pleased by these AHN initiatives, "**From my perspective [the opioid crisis] is not all that different from the HIV [epidemic,**]" said Hacker. "We have to address this issue from multiple angles."

Here, this article and the doctor being interviewed are doing the work of naturalizing opioid use while discussing holistic ways of dealing with chronic pain treatment. The opioid epidemic is then compared to the HIV epidemic in which multiple angles need to be addressed. However, the angle that is not being addressed here again is whiteness, since the opioid epidemic is framed as a white problem. There appears again to be no discussion of what treatment for whiteness entails or that it is even needed. This also again omits the issue of race as an angle entirely which brings the comparison of the HIV epidemic into scrutiny given that the HIV epidemic disproportionately impacted Queer and Transgender communities of color who were left to die at the height of the crisis. In this way, the opioid epidemic is not like the HIV epidemic and the suggestion that they are the same further erases differences and assumes universality of experience which informs approaches to treatment. This is not the only comparison that was

found that does this. The article*, "*Will Lessons from The Opioid Crisis Be Retained for the Next Drug Epidemic?" explores the parallels of the current opioid crisis to past drug crisis:

> "While this current drug crisis is certainly the deadliest in American history, responses to previous epidemics ruined lives in other ways. For example, in the 1980s and '90s, **the crack cocaine epidemic was especially devastating to black communities, in large part because aggressive laws that targeted drug users led to the fracturing of many families through incarceration.**
>
> "The response to crack cocaine was calamitous," said David Herzberg, a historian at the University of Buffalo, State University of New York. "I mean it was a catastrophe. The idea being that while these are just a bunch of criminal animals and we need to lock them up. We're still paying for it today."
>
> **In contrast, policy makers today are more likely to view a person with opioid use disorder as having a serious illness, rather than as a criminal or junkie**. Public health experts agree this change is rooted in the demographic makeup of the communities most impacted by opioids.
>
> **"It was really when the news increasingly was carrying reports of whites succumbing to overdose, that as a nation … we engaged in a sympathetic response, and began responding constructively**," said Caroline Acker, co-founder of Prevention Point Pittsburgh and Professor Emerita of History at Carnegie Mellon University"

This comparison is explicitly about racial demographics. The experts in the interview outwardly admit that a change in treatment policy occurred when mainstream discourse showed that white people were most impacted by opioid overdose. However, they do not describe or explain why there are differences of treatment between the Black population through the Crack epidemic and the white population in the current opioid crisis beyond mentioning that "lessons were learned". There is no mention of what current carceral statistics look like in terms of opioid arrests in the area, and a discussion of whiteness beyond describing death rates is again absent. In this way, white users get to remain the victims of a naturally occurring disease and whiteness remains uninterrogated, as it is attached to a naturalizing discourse, while the criminalization and pathologizing of Black and brown populations lays untouched. This lack of interrogation is also

reflected in the research projects being conducted by the School of Public Health at the University of Pittsburgh. The School of Public Health was given millions in grants to research the opioid epidemic, again from "all angles". The study that is celebrated as the most promising line of inquiry concerns age as a predictor of use. In the article "Pitt Study Finds Birth Year Helps Predict Drug Overdose Risk" by Sarah Boden, published on May 11, 2020, the research is described as such:

> "Researchers looked at data from 661,565 drug overdose death reports from the Centers for Disease Control and Prevention from 1979 to 2017. They found that since World War II, the more recent a person's birth year, the more likely they are to die from drug use.
>
> **"If you are born after 1945, then your risk of overdose death increases exponentially from one birth year to the next,**" said lead author Hawre Jalal, whose research expertise includes mathematical modeling on the opioid epidemic.
>
> **Also, the more recent the birth year, the younger someone is likely to be if they die. For example, a 25-year-old is more likely to fatally overdose today, than his or her parents were at the same age.**
>
> **"Those patterns are too regular to be random. There is some driving force, there's some reason why drug overdoses are transmitting from one birth year to the next," said Jalal.**
>
> Jalal, an assistant professor at Pitt, said that while drug overdoses are increasing, it does not explain why younger people are so dramatically affected. He noted while age is often examined in epidemiological research, birth years are an understudied topic.
>
> **"We have to unravel those causes. And we have to understand why this pattern is happening to be able to curb the overdose epidemic," he said."**

Here, the Public Health researchers are attempting to isolate the variable of age as a determinant of opioid overdose. This isolation from other social factors such as race, class, gender, sexuality, and other social locations that inform lived experience has resulted in a disconnected line of inquiry. Again, this follows from the discourse around white people and the negation of whiteness as a racialized identity that rendered race as a non-issue. This is the mystification process at work. The identification of a pattern that stems from some "driving force" and the

isolation of birth years is concerning as age cannot be decontextualized from their relationship to social factors that have longstanding legacies that are articulated through power.

This is evidenced in the work on intergenerational trauma done by many Black, Indigenous, Latinx, Asian-American and various scholars of color that shows the ways in which the subjection through the violent processes of racial formations into the corresponding racial categories, as well as gender, sexuality, and class results in trauma that is passed down from generation to generation (Brave Heart & DeBruyn, 2015; Menake, 2017). For example, Indigenous populations in the United States experienced the impacts of historical and ongoing settler colonialism have resulted in the highest rates of suicide for youth ages 9-14 (Dorgan, 2010). Therefore, in omitting whiteness as a racialized category, the line of inquiry for racialized trauma that stems from the *participation* in white racial formation and whiteness which occurs through the subjugation of people of color, is not taken up. This reinforces the notion that only people of color are racialized, reifying white and whiteness as normative.

Further, in using sociogeny as a social diagnostic to see how the larger social structure plays out in everyday interactions, discourse from Public Health service entities who carry out the determined Public Health approaches in overdose mitigation shows similar patterns. Prevention Point Pittsburgh serves a major role the organization has played in public health discussions and efforts in the opioid overdose crisis. It is mentioned in several articles due to its partnerships with city and county entities to mitigate opioid overdose deaths. In the "about" section they describe themselves as a leading harm reduction center in Pittsburgh as such:

> "Prevention Point Pittsburgh (PPP) is a nonprofit organization dedicated to providing health empowerment services to people who use drugs. **PPP is deeply rooted in a concern for the well-being of the individuals we provide services to and for the general health of the entire community**. Prevention Point Pittsburgh was founded in 1995 when James Crow and Caroline Acker, along with a handful of other dedicated volunteers, began providing needle exchange services once a week on a street corner in

> the Uptown neighborhood of Pittsburgh to prevent injection-related health problems. In April 2002, PPP established a county-authorized needle exchange site in Oakland. Since that time, over 5,000 injection drug users have enrolled into our program for critical prevention services. **PPP now has three outreach sites located in East Liberty, Perry Hilltop, and the Hill District.** In addition to needle exchange services, PPP has grown to include comprehensive case management services, assistance to drug treatment, **individualized risk-reduction counseling,** health education, condom and bleach distribution, overdose prevention with naloxone distribution, and free HIV, Hepatitis C, and STD screening in collaboration with Allies for Health + Wellbeing, formerly the Pittsburgh AIDS Task Force.

In PPP's response to state Public Health Declaration made by Governor Tom Wolf, the organization states:

> "A declaration of a public health emergency is designed to allow Pennsylvania officials to "temporarily override any rules or regulations they perceive as hampering the state's ability to address the epidemic." This is an extraordinary step to meet an extraordinary public health crisis. It would be a shame for this historic opportunity to be squandered. **In 2018, we know what an effective public health strategy looks like. To address this epidemic, we must take immediate steps to remove impediments and provide adequate resources to expand access to evidence-based treatment, expand syringe access programs, expand programs providing naloxone to those most likely to be on the scene of an overdose, and removing obstacles to establishment of safe consumption sites."**

Once again, absent in this discourse of an epidemic that predominantly white people is the discussion of white people. It is also important to note that PPP has three locations in East Liberty, Perry Hilltop, and the Hill District, all of which are predominantly Black areas that are struggling economically. Despite the declarative statement of being concerned for the individuals and the general health of the entire community, PPP does not offer services beyond needle exchanges, safe injection sites, and general drug use focused services. There is no word of advocacy for racial justice issues, no policy discussion of socioeconomics or environmental 'social determinants of health'. The 'individualized risk-reduction counseling' is a point of interest because of the lack of discussion around systemic issues in relation to opioid use.

Another example of the omission of whiteness in opioid overdose preventative services is in the messaging of The Institute for Research, Education and Training in Addictions (IRETA).

This organization is an independent 501(c)3 nonprofit located in Pittsburgh, PA with the mission of helping other organizations and the people within them, respond effectively to substance use and related problems. They describe themselves as **"**a nonprofit geared toward improving individual and system-level responses to addiction. We take a boots-on-the-ground approach to problem solving and we don't mind if they get muddy" (IRETA). In describing their purpose, they offer 'Broadly, IRETA offers three types of services: we educate, we evaluate, and we guide. Our services are modular (that is, they can be used independently or together), but the nexus of all three is where the most powerful changes occur." The website offers many resources including webinars. Within three of the offered webinars in relation to addiction counseling/psychotherapy, two mentioned race, gender, and SES. However, they then offered individualized approaches that severed these connections from a person's identity/social location to their experiences with opioid use and motivations/barriers for recovery. Whiteness is not addressed in 'racial factors', as race is characterized more so as Black and 'other'. This is ironic given the statement that is shared in their blog section around the Black experience in the war on drugs in response to the resurgence of the BLM movement over the summer of 2020. The blog post connects the reality of racial discrimination in policing when it comes to drug use, however, there are no connections made elsewhere in the resources or webinars on the site. There is also no discussion of how Black people experience opioid use or recovery, so the focus largely stays on policing. Thus, there is seemingly a disconnect of what counts as a "system level response" in their larger operation.

Even within McLean's research, which is the study that made space for this one, race is not considered as a factor because there are more white people who participate in the study, which is justified through the mainstream explanation of total population demographics as well as population totals of overdose fatalities. However, paying attention only to collapsed death totals has allowed for the differences in which opioid use is increasing in communities of color at higher rates than for white populations to be. This data has been reflected in national research publications concerning Black and brown users of opioids such as the Substance Abuse and Mental Health Services Administration: The Opioid Crisis and the Black/African American Population: An Urgent Issue released in 2020. This means that *special issues* of research that focused on the racialized impacts of the opioid epidemic had to be issued. Generally, the way that field of Public Health has attempted to contend with how race and other social factors play a role in public health issues have been through the 'social determinants of health' concept which points to social conditions that create disparate health outcomes. However, the framing of race, class, gender, sexuality, and ability as social determinants misses the mark in the ways they do not contend with the power that informs the socio- historical processes that form those identities and social locations. This framing, along with discussions and research that render only Black, Indigenous, and people of color as racialized, further supports the idea of white people as a non-racialized group, which reaffirms whiteness as normative.

This means that in Pittsburgh Public Health discourse, as well as mainstream national public health discourse, whiteness is not seen as a factor of experience or a social determinant that informs 'risk behaviors' that inform drug use. In returning to Fanon's theorizing of whiteness as a process of mystification, the omission of whiteness works to mystify researchers engaging with the epidemic, as evidenced in statements made such as "there's a larger force at

work here" or "this issue is now completely separate from overprescribing". Whiteness becomes further mystified through the efforts to frame addiction as a naturally occurring and insolvable disease. While the intention of naturalizing opioid addiction as a disease is to address the stigma and moralizing judgement around addiction, the unintended consequence of naturalizing addiction as a disease coupled with the invisible workings of whiteness reinforces racialized notions of biological determinism, in which white users are sympathetic victims while Black and brown users are deviant and inferior. This ignores the clinical considerations of an entire history of white racial formation that is place based. In addition, it appears that whiteness and race generally is not pursued further in discussions, research, or initiatives designed to mitigate addiction and overdose deaths

Thus, the depiction of the opioid epidemic as a white, male, and middle-class problem has created a range of barriers, as identity and social location informs emergency care, incarceration, state surveillance, funding for treatment, kinds of treatment, and community support (SAMSHA; Jordan & James 2018; Mendoza, Rivera & Hansen, 2018; Pouget, Fong & Rosenblum, 2018). The implications of difference within the opioid crisis are then left to the researchers and community members who share common identities and social locations that are pushed to the margins. As such, these realities for communities of color are well understood and documented, as they are reiterations of systemic racism within health institutions (Jordan & James 2018; Mendoza, Rivera & Hansen, 2018; Pouget, Fong & Rosenblum, 2018). Similarly, there are community efforts dedicated to the gendered implications of opioid addiction and overdose death, as seen in the data collected about the Sojourner House. However, what lays untouched is how whiteness remains intact to continually obscure the discourse, which has ramifications for both crisis responses and long-term mitigation efforts.

deaths to show where in the Pittsburgh area opioid overdose death is occurring. In In addition to the omission of whiteness in Pittsburgh Public Health discourse, the mainstream discussions being had by Pittsburgh Public Health entities do not include any consideration of the place in which they occur. In the mainstream discussions of the opioid epidemic, the only consideration of place exists as geospatial mappings of opioid Pittsburgh's harm reduction entities, mentions environment merely as the place in which drug purchases, drug use, and drug overdoses occur. In McClean's study which specifically uses a place-based risk framework, place is conceptualized in the economic sense by both the researcher and the participant. In particular, place is described as "nothing" by a participant in their reasoning for drug use in McKeesport, as they state, "nothing is here". This shows that conceptions of place are not tied to land and relationships, but rather an economy that offers material privileges and community relationships through industrial jobs that no longer exist.

In analyzing this omission of place, Sociogeny requires going beyond an interactionist perspective of social relationships to the larger origins of social relationships that not only create meaning, but also a material experience (Fanon, 1959; Urena, 2019). Returning to Basso, it is through the lens of Indigenous theories of place, that we are reminded that social relationships and material experiences begin with and are based in the land, as he contends,

> "places possess a marked capacity for triggering acts of self-reflection, inspiring thoughts about who one presently is, or memories of who one used to be, or musings on who one might become. And that is not all. Place-based thoughts about the self-lead commonly to thoughts of other things - other places, other people, other times, whole networks of associations that ramify unaccountably within the expanding spheres of awareness that they themselves engender." (P.55)

Again, what Basso is offering through an Apache epistemological understanding of place is that is more than just a thing in which other things happen on or occur. Place is conceived of as a

living collection of multidimensional relational experience and therefore the omission of place or the framing of place as merely geographical area where opioid overdose occurs erases a deep history of the relationships that formed the place of Pittsburgh. This further builds on the omission of whiteness, in that the place of Pittsburgh is built through a history of white racial formation that occurred through settler colonialism followed by industrial labor. While the narrative around Pittsburgh's steel labor is supplanted by a historical narrative of heroic place-based identity, it is worth interrogating through the lens of racial formation for the purposes of a sociodiagnostic and the considerations of white formation in a clinical sense.

Prior to the construction of Pittsburgh and its surrounding metro area, the lands of the Ohio River valley were hunting and camping grounds for several tribes including the Lenape, Susquehannock, Haudenosaunee, Erie, Shawnee, and others (Dunbar-Ortiz, 2014; Buck, 1969;). In *The Wages of Whiteness*, David Roediger offers that the early usage of 'white' as a way of designating European settlers from Indigenous and enslaved Africans appeared before any permanent settlement (Roediger,1991, p.21). In this way, he contends "the prehistory of the white worker begins with the settlers' images of Native Americans" (Roediger, 1991, p. 21). These settler images, which were used to rationalize dispossession of Indigenous land, are based in Calvinist settler ideologies of work and discipline, which cast Natives as "lazy Indians" who had failed to "subdue the resources God had proved and thus should forget those resources" (Dunbar-Ortiz; Roediger,1991, p.21). Thus, Roediger offers, "settlers whether they worked harder or more steadily than Native Americans, came to consider themselves as 'hard working whites' in counterpoint to their imagination of Indian styles of life" (Roediger, 1991, p. 21).

Looking deeper into the origins of white settlers, it is important to note that the first settlers of Pittsburgh were the Ulster- Scotts, or Scotch-Irish, beginning in 1630 (Buck, 1969).

Having perfected scalping prior to their contact with Indigenous people in the Americas, the Ulster -Scotts exercised violent removal practices of Native tribes and were described as a "veritable human shield of colonial colonization" (Dunbar-Ortiz, 2014, p.51-53; Degler,1959). In 1680, William Penn began purchasing small parcels of land from the Lenape and continued until his death (Minderhout, 2017; Buck 1969). In 1737, the Penn family along with other English land proprietors secured a fraudulent deal known as the *Walking Purchase,* which dispossessed the Lenape of their ancestral territory (Minderhout, 2017). Throughout this time, settlers from France, England, and the Scotch-Irish continued to move into Indigenous lands, setting up small farms and further pushing out Indigenous tribes (Minderhout, 2017). Many of these white settlers were indentured servants of the white wealth class (Dunbar-Ortiz, 2014; Roediger,1991; Hinshaw, 2002). The Ohio valley area was highly coveted by settlers for its strategic location on the confluence of the Allegheny, Monongahela, and Ohio rivers which led to constant land disputes between settler colonists as well as the Indigenous people resisting land dispossession.

The French constructed the first large settlement structure, Fort Duquesne, in 1754 which escalated tensions between the French and the British. Later in the year, the tension over global primacy between the two resulted in the Seven Years War, which was fought on the ground in both Europe and North America (Dunbar-Ortiz, 2014; Buck, 1969; Lorant, 1999). In the United States this war is known as the 'French and Indian' War due to conflict being carried out by British colonial militias comprised mostly of Scotch-Irish fighting Indigenous people who had allied with the French (Dunbar- Ortiz, 2014, p. 53). These militias burned down Indigenous villages and murdered the inhabitants, events that are crystallized as settler colonial victories in historical markers in and around the city (Lorant, 1999; Meislik & Galloway, 1999). In 1758, the

French abandoned Fort Duquesne under retreat and the British constructed the larger structure of Fort Pitt. In 1763, the Odawa leader Pontiac mounted a rebellion built from a confederation of tribes to resist dispossession (Meislik & Galloway, 1999; Baldwin, 1971). Fort Pitt was a primary focus of the uprising, which resulted in a two-month long siege in which Pontiac was defeated in 1763. Following, the Iroquois signed the Fort Stanwix Treaty of 1768, ceding the remaining Indigenous lands to the British (Baldwin, 1971; Graham, 1998).

Thus, the city of Pittsburgh first began as a series of massive forts which were used to keep the Indigenous people of the Ohio river valley out. As Indigenous populations were removed from their lands through treaties and increased settlement, white contact with Native peoples lessened which impacted the ways in which white workers defined themselves (Graham, 1998; Roediger, 1991). While conquest and private ownership of land remained central to the political project of white economic independence, the narrative of the disappearing Native did not present a "yardstick in which white labor could measure its own position" in the ways that enslaved or freed Black labor could (Roediger, 1991, p. 23). However, the remaining imprint of these forts is a symbolic marker of the settler colonial foundation of Pittsburgh and its white working-class culture.

As the colonial period gave way to a period of rapid industrialization, extractive practices, and immigration of people from Eastern and Southern European countries increased (Baldwin, 1971; Buck, 1969). Pittsburgh's early industry mostly consisted of glass and small iron operations. Anthracite coal mining began in the outer regions of the forming city and bituminous coal production, which led to the expansion and development of rail and river transportation facilities to the west, set the stage for the emergence of the steel industry (Graham, 1998; Baldwin, 1971). The point of coke production marked an important shift in iron and steel

manufacturing and “Pittsburgh grew up as the heart of industry” (Graham, 1998). In 1859, coke-fire smelting furnaces were introduced to the Pittsburgh region which enabled production on a larger scale (Lorant, 1999; Muller, 2001; Meislik & Galloway,1999). With the demand of mass coke production, coal mining and coke processing increasingly became mechanized, resulting in the creation of large-scale plants that took the place of dense deciduous forest, the native population of plants, and many animal species (Tarr, 2003; Baldwin, 1971). During the Civil War, the demand for iron and armaments increased production and by the end of the war Pittsburgh produced one half of the nation’s steel and one third of the nation’s glass (Graham, 1998; Baldwin, 1971; Meislik & Galloway, 1999).

In 1875, Andrew Carnegie drastically changed steel production with the opening of the first Bessemer process steel plant, the Edgar Thomson Steel Works, in the borough of Braddock (Meislik & Galloway, 1999; Graham, 1998). As massive integrated steel mills began to open along the riverbanks, a complex urban landscape emerged around a dominant central city, with residential communities, mill towns, satellite cities, and hundreds of mining towns forming around it (Muller, 2001). The proliferation of mass industrial factories resulted in the loss of vast acreage of trees, plants, and animals important to the river valley ecosystem (Meislik & Galloway, 1999; Graham 1998; Tarr, 2002). By 1911, Pittsburgh was known globally as an industrial and commercial powerhouse, a reputation that included iconic images of dense black smoke that stretched for miles (Meislik & Galloway, 1999). Leading into the 1920s, Pittsburgh produced one third of the United States steel supply and by the second world war was central to the “arsenal of democracy” through its role in supplying 95 million tons of steel to the war efforts (Graham, 1998; Meislik & Galloway, 1999). At its height, Pittsburgh was a leader in glass and aluminum manufacturing and was home to the world's largest tube and pipe mill,

structural steel plant, rail mill, wire manufacturing plant, as well as a bridge and construction fabricating plant (Meislik & Galloway, 1999). This mass scale of industrial production required a substantial labor force, which is a key point of pride in Pittsburgh's cultural history.

A major component of the city's industrial landscape were the ethnic enclaves the labor force called home, which formed Pittsburgh's "colorful quilt" of European nationalities (Kleinberg, 1989; Hinshaw, 2002; Graham, 1998). Between 1860 and 1920, Pittsburgh's population grew exponentially as immigrants from poor rural areas in southern and eastern Europe immigrated to Pittsburgh in search of economic opportunities (Kleinberg, 1989; Hinshaw, 2002; Meislik & Galloway, 1999). These new immigrants, both men and women, were ridiculed by the dominant Northern European population for their languages, traditional customs, and willingness to work in the least desirable, low-skill jobs in construction, mining, steel mills and factories (Graham, 1998; Kleinberg, 1989; Hinshaw, 2002). However, the Italians, Poles, Slovaks, Ukrainians, Carpatho-Rusyns and others successfully established their own communities in Bloomfield, Lawrenceville, the Northside and Southside, Shadyside, Duquesne, McKeesport, and Braddock (Kleinberg, 1989). These communities were sustained by ethnic churches and beneficial organizations which provided social and financial support in a time when discrimination kept them from accessing credit and insurance (Graham, 1998; Hinshaw, 2002). Despite this, Pittsburgh's diverse array of European ethnic heritages is regarded as a rich contribution to the 'great melting pot' of Pittsburgh culture and American life. However, often left out of the revered discussion of this colorful ethnic quilt are the Black laborers who also called Pittsburgh home.

The Black experience in Pittsburgh is not a departure from the Black experience anywhere else in the United States. During the colonial period, the founding regional elite of

Pittsburgh such as the Rankin's, the Neville's, and the Craig's, brought enslaved Africans to the area to do unpaid domestic and agricultural labor as they laid out their estates (Rishel, 1990; Dickerson, 1986). Pennsylvania's Gradual Abolition Act was passed in 1780, however, this legislation did not grant immediate freedom for enslaved Africans. Rather, the act reformed chattel slavery into generational indentured servitude and had many loopholes that allowed white owners to trade or sell the enslaved down south as well as enabled southern slave catchers to kidnap indentured of freed Black persons without consequence (Hinshaw, 2002; Dickerson, 1969). These loopholes, along with applied enforcement, were closed in subsequent legislation in 1788 (Hinshaw, 2002). Throughout the Civil War and reconstruction, Black people escaped from rural towns and cities in the south to the north in a mass movement later called the "Great Migration" (Kendi, 2016 p.308). From 1880 to 1940, Pittsburgh's Black population grew from 8,000 to 37,700 as Black people sought economic opportunities through jobs in the steel, glass, and coal industries, as well as access to education (Dickerson, 1986; Hinshaw 2002). Most significantly, Black migrants sought political and social freedom and to escape the violent racial oppression of the south (Dickerson, 1986; Hinshaw 2002; Kendi, 2016).

However, as noted by Ibram Kendi, Black migrants arrived in northern cities only to face the same racist discrimination they were attempting to get away from (Kendi, 2016:308). Kendi offers, "they looked at their families as dysfunctional. And they called these migrants, who had moved hundreds of miles seeking work and a better life, lazy" (Kendi, 2016; 309). In 1875, Black male laborers first entered the Pittsburgh labor scene as strikebreakers in the puddler strike of the Pittsburgh Bolt Company.[3] White puddlers who were striking responded violently until the

[3] Puddling is a process in crucible iron in which pig iron is converted into wrought iron with the use of a reverberatory furnace. A puddling crew could produce about 1,500 kilograms (3,300 pounds) of iron in a 12-hour shift. The strenuous labor, heat and fumes caused puddlers to have a short life expectancy, with most dying in their 30s. This process was never mechanized.

other white workers joined the strike, leaving the Black workers alone on the lines (Wright, 2004; Hinshaw, 2002; Dickerson, 1986). This would be a repeated instance until the 1930s. In 1876 the merger of the Amalgamated Association of Iron and Steelworkers formed with a strict 'whites only' policy, which was later reversed in attempts to discourage strike breaking (Hinshaw; Dickerson).

Despite these efforts, this initial integration did not reduce the hostile racial antagonism of white members as Black workers were continually used by management as strikebreakers (Dickerson, 1986; Hinshaw, 2002). This occurred most notably in the monumental Homestead Strike of 1892 and the great steel strike of 1919. Following labors defeat in 1919, angry white immigrant workers were heard saying "the n----- did it" (Wright, 2004, p.220). In the *Negro Wage Worker*, J. Ernest Wright contends, "The contribution of the Negro worker to the advance of American labor has been grudgingly admitted, if at all. His role has been strategic in every industrial status that began at the close of the Civil War. In Pittsburgh, the Negro worker has been a major factor in such situations" (Wright, 2004, p.217). Thus, the construction of Black labor as the adversary competitor of white labor, coupled with white supremacist ideology created a sustained foundation of significant and violent barriers for Black people in Pittsburgh in all areas of life.

Despite this, the Black people of Pittsburgh created their own communities with their own institutions including churches, social clubs, fraternal orders, newspapers, restaurants, and barber shops (Trotter, 2010). These Black neighborhoods sprang up in between the European ethnic enclaves, the most famous being the Hill District, which was revered as a mecca of Black culture and a center for jazz and black business (Dickerson, 1986). Additionally, Black sporting clubs formed as the foundation of Pittsburgh's current sports culture, a reality that is not

mentioned often (Dickerson, 1986). Nevertheless, housing and buildings within these areas were run-down, dilapidated, and overcrowded, a reality that posed many health risks for Black residents (Hinshaw, 2002; Dickerson, 1986).

In the early 1900s, most Black men were limited to jobs as porters, chauffeurs, and janitors while Black women were employed in domestic services (Graham, 1998; Hinshaw, 2002; Dickerson, 1989). For the Black laborers who were able to enter the steel and manufacturing industries they were relegated to unskilled labor in the lowest rungs of the economic ladder where "semi-skilled and skilled work fell to them only when it was distasteful to white workers, or too dangerous, or during labor troubles" (Graham, 1998; Dickerson, 1986; Hinshaw, 2002; Wright, 2004, p.219). Thus, Black workers were laid off more frequently and experienced higher accident and illness rates (Dickerson, 1986). Union discrimination was both de jure and de facto, as Wright illustrates, "the policy of exclusion has not always been openly stated, but it has nevertheless been definitely practiced" (Wright, 2004, p.223). Up until 1931, there were twenty or more unions with constitutional clauses discriminating against Black workers, including 11 A.F.L affiliated organizations (Wright, 2004; Dickerson, 1986; Hinshaw, 2002).

During the great depression, Black people made up 8.4 percent of the total population but comprised 17.4 percent of the unemployed, which was alleviated by New Deal work programs. In the late 1930s, an AFL conference established a program for unionization of Black steel workers, opening the trade unions for Black membership (Wright, 2004; Hinshaw, 1986). This shift of acceptance was shown in the Black participation of the 1937 strike at the J & L Mill. By World War II, Black laborers entered all the manufacturing industries of Pittsburgh, however kept in the hardest, most dangerous of jobs. With the end of the war, many Black workers found

themselves unemployed as industry cleared the lines for white workers returning from the war. Post-war, Pittsburgh city planners made movements to bring the city into modern times with federal funding. Known as Renaissance I, the city began cleaning up the infamous black smog, building new highways and suburbs, and implementing redevelopment project in neighborhoods deemed "unfit" for living (Trotter, 2010).[4] The neighborhoods described as unfit were the predominantly Black neighborhoods of the Hill District and East Liberty. The city destroyed all 95 acres of homes, displacing over 8,000 people to build a cultural center including Civic Arena for professional hockey (Trotter, 2010). Black People displaced by these projects were pushed into the surrounding white ethnic boroughs including Wilkinsburg, Rankin, Homewood, Duquesne, and Braddock, which were simultaneously being abandoned due to white flight (Trotter, 2010).

These boroughs, along with East Liberty, remain predominantly Black areas, with concentrations of Black neighborhoods dispersed throughout the southside slopes and Mt. Oliver (Trotter, 2010). In the late 1960s and into the 1970s, Black Pittsburghers joined national Civil Rights and Black Power movements in protesting Pittsburgh's practices of racial redlining, inequity in housing, education, health, political representation, and continued barriers faced in steel and manufacturing industries (Trotter, 2010). Despite some civil rights gains, racial animosity in policy and interpersonal relationships and a diminished quality of life for Black people in Pittsburgh is a reality that continues into today.

[4] "The Hill District of Pittsburgh is probably one of the most outstanding examples in Pittsburgh of neighborhood deterioration... There are 7,000 separate property owners: more than 10,000 dwelling units and in all more than 10,000 buildings. Approximately 90 per cent of the buildings in the area are sub-standard and have long outlived their usefulness, and so there would be no social loss if they were all destroyed." Evans, George E. (July–August 1943). "Here Is a Postwar Job for Pittsburgh... Transforming the Hill District". Greater Pittsburgh. Archived

While redevelopment was in progress, Pittsburgh's industrial base continued to grow in the face of increasing competition with foreign produced steel and globalization movements. In the early to mid-1980s the steel industry collapsed, leaving half of the nation's steelworkers unemployed and a majority without pension due to the bankruptcy of steel corporations (Hoerr, 1988). The impact of the closures on the Pittsburgh landscape was devastating, as heavy industry closed their doors the city suffered significant population loss as those, mostly white residents, who could afford to left for the suburbs (Hoerr, 1988). In the 1990s, Pittsburgh experienced its second 'renaissance', as it shifted from industrial to service industry, medicine, higher education, tourism, banking, corporate headquarters, and high technology (James & Jordan, 2018). However, this only ensured jobs for white collar workers, leaving many former mill workers, both Black and white out of the fold. The city also began addressing the brown fields, which were the miles of decaying industrial plants and waste dumps, by dismantling the mills and building new retail or warehouse sites in their place. Currently, the state of Pennsylvania has opened itself to investment and operations in the hydraulic fracking of the Marcellus Shale that sits underneath Pittsburgh and the surrounding boroughs (Cunningham, 2019). Some of these hydraulic fracking sites are as large as pre-existing mills and the resulting pollution from the hydraulic fracturing process is rightfully giving community members and scientists heightened concerns, as dependency on extraction industry is cyclic and harmful to the environment and people that live in it (Cunningham, 2019).

In the last decade, the city of Pittsburgh has been recognized as the 'beacon of hope' for rust belt cities still trying to crawl out of the decimation of deindustrialization in the 1980s. However, this narrative has been challenged by many who realize the narrow scope of focus solely on Pittsburgh itself has left out the still struggling boroughs. Many of these boroughs have

been placed under austerity measures under the Distressed Municipalities Act, which severely limits possibilities of addressing the decaying buildings collapsing into streets let alone reinvigorating economic opportunities (Pennsylvania Department of Community and Economic Development, 2020). Recently published research also shows that the remnants of deindustrialization, both economic and environmental, have had long lasting disparate impacts livability along racial, gender, and class lines (Howell, Goodkind, Jacobs, Branson, & Miller, 2019). However, these implications, as well as the research done on the racialized inequality in the opioid epidemic responses, have yet to be picked up by Pittsburgh Public health experts examining the opioid epidemic in the area. This omission has severe consequences in that the inability to address whiteness within the Opioid epidemic, allows it to function, which means the proposed acute solutions will not solve any of the deeper underlying factors.

Conclusion

The omission of white racial formation in Pittsburgh has implications for treatment because the violent organizing principles of whiteness goes unaddressed and thus intact. The mystification of whiteness thus enables a mutually constitutive macro and micro system of racial stratification to stay in place, in that Public Health policies, research, and initiatives ignore racial inequalities, and white opioid users can remain vessels that enact racial violence, whether covertly or subtlety. Public health experts contend that a key component in addressing the opioid crisis is to better understand pain and pain treatment. Pittsburgh is an area that has undoubtedly experienced various and long-lasting forms of pain. However, historically, and currently, Black people have been undertreated for pain, while White people have just been offered ways to numb their pain rather than deal with it explicitly. Therefore, I argue that this simplification of white racialized identity is a critical component that maintains white supremacy within Public Health

discussions and strategies addressing the opioid crisis. In simplifying whiteness to a descriptor, rather than a central organizing principle, the violent socio-historical, place-based, and co-constructive processes of white racial formations that creates alienation between the land, body, mind, and spirit that enables and encourages violence against Black, Indigenous, and people of color as well as the self

This sits in contrast to the ways in which non-white people are discussed within small portions of Public Health literature as racialized populations in which the historical implications of race, designated as social determinant of health, are issues that *need* to be addressed. Thus, I argue the omission of whiteness as a racialized identity and central organizing principle in a place-based understanding of opioid addiction gets veiled behind a colorblind approach, leaving whiteness invisible and intact within Public Health opioid crisis responses. I argue that if Public Health approaches are to be truly effective, discussions of the opioid epidemic in relation to white people must include considerations of the sociohistorical legacy of participating in white racial formations. The collective historical memory holds the key in addressing the deeply seated underlying causes of pain.

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