The Insecure American

How We Got Here and What We Should Do about It

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and Catherine Besteman

Foreword by Barbara Ehrenreich

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To Stanley Ann Dunham

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FOREWORD

Fifty or sixty years ago, the word *insecurity* most commonly referred to a psychological condition. Some people suffered from "insecurities"; otherwise, though, Americans were self-confident to the point of cockiness. Public intellectuals worried over the "problem" of affluence, which was believed to be making us too soft and contented. They held forums to consider the growing challenge of leisure, never imagining that their own children and grandchildren would become accustomed to ten-hour workdays. Yes, there remained a few "social problems" for sociologists to study—poverty, which was "discovered" by the nonpoor in the early sixties, and racial inequality—but it was believed that these would yield easily to enlightened policies. We were so self-confident that Earth itself no longer seemed to offer sufficient outlets for our energy and ambition. We embarked on the exploration of space.

It was at some point in the late 1960s or early 1970s that Americans began their decline from intrepid to insecure. The year 1969 brought the revelation of the massacre at My Lai and the certainty that the Vietnam War would end in disgrace as well as defeat. At the same time, the war was draining federal funds from Lyndon Johnson's Great Society programs, vitiating health services and hundreds of community development projects. Then 1970 saw the first national observance of Earth Day and the dawning awareness that our environmental problems went beyond scattered cases of "pollution." For the first time since Malthus, the possibility was raised that we might someday exhaust the resources required to maintain America's profligate consumer culture.

American business, beginning with the auto industry, woke up, in the 1970s, to the threat of international competition and initiated its long campaign to reduce both wages and the number of American workers. By the 1980s, big business

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Useless Suffering

The War on Homeless Drug Addicts

Philippe Bourgois

We're not allowed to just go in to the [county] hospital and try to get help. When I start swelling up with an abscess, I gotta make sure it's fuckin' red enough and infected enough that I got a fever that's wicked enough for them to take me in and give me part of the help that I need.

—SCOTTY

[One month later]
Record of Death
City and County of San Francisco
Name: Scott . . . Age: 36 Height: 5'7" Weight: 115
CAUSE OF DEATH was determined to be: POLYPHARMACY.
. . . The body is that of a very slender young Caucasian man. . . .
Diagnoses:
1. CONGESTION AND EDEMA OF LUNGS MODERATE TO SEVERE
2. CONGESTION OF LIVER, SPLEEN AND KIDNEYS, MARKED
3. HEPATOMEGALY . . .
4. SPLENOMEGALY . . .
5. ACUTE PANCREATITIS . . .
6. INTRAVENOUS DRUG ABUSE . . . ACUTE AND CHRONIC

—CHIEF MEDICAL EXAMINER CORONER'S REPORT

When mentally ill men and women flooded onto city streets throughout the United States during the 1960s and 1970s with the closing of state-funded psychiatric facilities, the "able-bodied" homeless were not yet a common sight: Deindustrialization, the gentrification of skid row neighborhoods, the loss of affordable housing, the increased criminalization of the poor (especially ethnic minorities), and

the gutting of the welfare safety net since the 1980s turned homelessness into a regular feature of U.S. cityscapes.[1] In November 1994, with the help of a public health needle exchange volunteer, I befriended a group of homeless men and women who lived in a warren of back alleys, abandoned warehouses, and overgrown highway embankments six blocks from my home in San Francisco.[2] They welcomed me into their scene, eager to talk about their lives and teach me about survival on the street. Over the next twelve years, I developed a warm relationship with them and was joined on this project of documenting their daily lives by the photographer and ethnographer Jeff Schonberg.[3] Soon the homeless began introducing us to outsiders as "my professor" or "my photographer doing a book about us."

At any given moment, the core group of homeless that we befriended consisted of some two dozen individuals, of whom fewer than half a dozen were women. In addition to the heroin they injected every day, several times a day, they smoked crack and drank two or more bottles of Cisco Berry brand fortified wine (each one equivalent, according to a denunciation by the U.S. Surgeon General, to five shots of vodka).[4] They usually divided themselves up into four or five encampments that moved frequently to escape the police. All but two of the members of this social network of addicts were over forty years old when we began our fieldwork, and several were pushing fifty. Most of them had begun injecting heroin on a daily basis during the late 1960s or early 1970s. A separate generational cohort of younger heroin, speed, and/or cocaine injectors also exists in most major U.S. cities, but these younger injectors represent a smaller proportion of the street scene, and they maintain themselves in separate social networks.[5] According to national epidemiological statistics, the age and gender profile of our middle-aged social network of homeless drug users is roughly representative of the majority of street-based injectors in the United States during the late 1990s and early 2000s.[6]

Our street scene proved to be remarkably stable despite the precarious income-generating strategies of its members. Most of the homeless survive by engaging in some combination of panhandling, recycling, garbage scavenging ("dumpster diving"), petty theft (primarily the burglary of construction sites), and day labor for local businesses and home owners. They have subordinated everything in their lives—shelter, sustenance, and family—to injecting heroin. Their suffering is eminently visible. They endure the chronic pain and anxiety of hunger, exposure, infectious disease, and social ostracism because of their inability to control their chronic consumption of heroin and other psychoactive drugs. Abscesses, skin rashes, cuts, bruises, broken bones, flus, colds, opiate withdrawal symptoms, and the potential for violent assault are constant features of their lives. But temporary exhilaration is also just around the corner. Virtually every day on at least two or three occasions, and sometimes up to six or seven times, depending upon the success of their income-generating strategies, most homeless heroin injectors are able to flood their

bloodstreams and jolt their synapses with instant relief, relaxation, and sometimes a fleeting sense of exhilaration.

To show how the suffering and the destruction of the bodies of homeless addicts in the United States are exacerbated by neoliberal policies and values, I have selected a series of ethnographic descriptions taken from our twelve years of fieldwork notes and interviews. I have edited them to try to reveal how the intimate experience of pain, distress, and interpersonal conflict interfaces with political institutional and social structural forces that ultimately manifest in self-abuse. The homeless are superexploited in a labor market that has no long-term, stable productive use for them. They are pathologized and punished by the social services and related social welfare policies that are supposed to relieve, reform, and discipline them. They are most severely and immediately brutalized by law enforcement in its well-funded mission to protect and control public space and private property. Finally, they maltreat and, for the most part, have been maltreated by their kin since childhood. They continue these patterns of injurious behavior in most of their everyday interpersonal relations on the street despite their extreme dependence on one another. In short, the documentation of the lives of these homeless San Franciscans reveals how America's most vulnerable citizens are affected by the war on drugs, the disappearance of the unionized industrial labor market, and the dismantling of the welfare safety net.

A COMMUNITY OF ADDICTED BODIES

Indigent heroin injectors have an exceptionally intense physical and emotional relationship to their bodies. Their lives are organized around a central physical and psychological imperative to fill their bloodstream with opiates—often supplemented by alcohol, crack, and benzodiazepines. Their topmost physical and emotional priority is to obtain heroin, by any means necessary. This imperative regulates their social relations, gives them a sense of purpose, and allows them to construct moral authority and interpersonal hierarchies. It creates a community of addicted bodies. In fact, they describe themselves with ambivalent pride as "righteous dopefiends."

Ironically, opiate addiction creates order out of what appears at first sight to be chaotic lives that have spiraled out of control. Homeless heroin injectors know exactly what they have to do every morning upon awakening. All of the superimposed problems of homelessness and lifetimes of disruption—often including childhood domestic abuse—become irrelevant. A much more physically overwhelming and immediate pain must be confronted. It erupts at the cellular level every six hours, when body organs run amok and when every single cell screams for the opiate proteins it requires in order to continue operating. Showing up in court, applying for public assistance, meeting family expectations, obtaining shelter, eating nourishing food, finding a job, and seeking medical help for an infection are rendered trivial by the embodied urgency of addiction. Society's opprobrium and personal failure become the least of one's worries. Psychological insecurities, personal confusions, memories of family abandonment, unrequited love, and responsibilities to others fall by the wayside. The craving for heroin takes over.

> Felix looks horrible this morning, his eyes are bloodshot, and he complains of migraines and sweats. "I can't pick up my bones. Been throwing up all night." He has even defecated in his pants.
>
> He gives me money, pleading for me to go buy him a bottle of fortified wine "to wash out my system." Yesterday he fought with the storekeeper and is now forbidden to enter the premises.
>
> He describes how he awoke at 1:00 a.m. and could not urinate in his empty bottle because of "the shakes." He tried to stand up but fell down the embankment because his leg muscles were not responding. He had to crawl back up and spend the rest of the night with heat flashes and a revving heart.
>
> "I thought my heart was going to stop. My knees hurt; my legs are locked; I can't hardly walk; I can't hardly talk; I can't breathe; I can't even think; I feel every nerve in my fingertips, every single one, especially in my knee. I can't stand still. I can't lie down. It sucks. There is nothing enjoyable about this life."
>
> Luckily Hank comes by as Felix is describing his withdrawal symptoms to me and offers to give him a "wet cotton," i.e., the heroin residue from the filter used in a previous injection. (from Philippe's field notes)

One simple act instantly solves all Felix's problems: an injection of heroin. The homeless in the social network we have been following rarely experience the kind of full-blown "dopesickness" that woke Felix up so dramatically at 1:00 a.m. When they are beset by impending crisis they can usually find a friend or acquaintance in their social network to give them an emergency injection of a small amount of heroin to stave off withdrawal symptoms, even if it is only the residue from a pinch of used cotton, such as Hank's gift to Felix. This enables them to get back on their feet and go out and hustle more money for their next injection.

HIGH-TECH U.S. MEDICAL SERVICES

From biomedicine's perspective, injecting the dregs of heroin trapped on a used cotton filter in a filthy homeless encampment with no access to running water is a recipe for ill health. The pragmatic and even moral imperative that compels Felix and Hank to engage in this risky, unsanitary injection-sharing practice to avoid heroin withdrawal symptoms foments the spread of infectious diseases within social networks of street-based addicts. From biomedicine's perspective, homeless injectors appear ignorant, self-destructive, or even pathological. They self-inflict hepatitis, HIV, endocarditis, and abscesses on their bodies in their pursuit of an illegal substance to get high. They are frustrating patients to try to help because they refuse to stay sober

after receiving urgent medical services and often return for care a few weeks or months later with newly ravaged bodies. Intensive care units and emergency rooms of county hospitals have been increasingly overwhelmed since the 2000s by the infectious diseases of the homeless. The bodies of the baby boom generation that turned to injection drug use in the early 1970s have entered premature old age. This crisis is exacerbated by the shrinking of the welfare state during these same decades and the entrenchment of neoliberal values of self-help and punitive control. Emergency departments in public hospitals have emerged as one of the few remaining publicly funded sites where the homeless, the addicted, and the mentally ill can seek help during episodes of acute personal crisis.[7]

"FREQUENT FLIERS": HANK AND PETEY

Most of the homeless in our street scene were hospitalized on multiple occasions. Usually they were admitted because of abscesses, but sometimes it was for whole-body infections, liver failure, or cancer. They are disparagingly called "frequent flyers" by the medical staff in county hospital emergency rooms all across the country. This was the case for Hank and Petey, who were "running partners." They coordinated all their income generation and most of their drug consumption, and because they shared everything—money, drugs, needles, companionship, and misery—they passed their infectious diseases back and forth to one another. Both men had hepatitis C and drank heavily in addition to injecting heroin. Both Hank and Petey were visibly sick, but there was no place for them to seek care for their routine ills:

> Shifting his weight from foot to foot to ease the ache, Petey gags and heaves a mouthful of blood into the gutter. His gums have rotted black. He points to the three or four twisted teeth on the bottom half of his mouth. "I need to get these pulled." He thinks this might be why, for the past week, he has been throwing up when he wakes up. I offer to drive him to the homeless clinic, but he refuses to leave his panhandling spot. He is scared of being left dopesick because he thinks his bleeding gums and chronic nausea will not qualify him as "sick enough" to warrant admission into the hospital for medical care.
>
> That night as I drive home, I see Petey, still at his spot, flying his sign. He is standing on one leg, flamingo style, to relieve the ache of his swollen feet. He is wobbling weakly with his eyes closed. (from Jeff's field notes)

Finally Petey's liver shut down, and he qualified unambiguously for hospitalization:

> Hank: "He's laying there in his hammock, not moving around. I figure he's dopesick, so first thing is I give him a shot. I tell him, 'Pick up your blankets and put them behind the wall in case the police come.'
>
> "But he is stumbling, mentally gone, so I took him to the hospital. He collapsed on the bus. When I picked him up, I realized how light he was. I undressed him in the emergency room on the gurney to put on his hospital gown. He was comatose. I couldn't believe how skinny he is!
>
> "A guy can only take so much. What am I, a black widow? I can't even keep myself fixed anymore. I'm mentally fucked up. I'm physically fucked up. I'm just fucked! I don't even got a blanket. The police came again when I was visiting Petey in the hospital. I'd only had the blanket for two days. Got it at the hospital when I brought Petey in. They've found the spot where I hide my stuff [pointing to a crevice in the freeway retaining wall]. They come every day now." (from Jeff's field notes)

The county hospital deployed the full force of its remarkable technology, and Petey was admitted to the intensive care unit (ICU), where he remained for six weeks at an estimated cost of $6,000 per day:

> I go with Hank and Sonny to visit Petey in the ICU. Hank rushes to Petey's side. Petey's legs dangle like twigs from his protruding hipbones. He weighs only ninety-four pounds. Tubes run through his nose and in and out of his neck and chest to various machines. A big blue and white tube goes from down his throat to a machine that suctions his breath.
>
> Hank kneels down and places his cheek next to Petey's, pleading for "Bubba, Bubba, my Bubba" to regain consciousness. Sobbing, he gently strokes Petey's hair to make it flow neatly back over the crown of his skull. His caresses change to a playful tussle, the tips of his fingers intermittently massaging and tangling the hair. "Promise me, Bubba, that you'll hang in there. Keep your promise to me. I love you."
>
> Throughout this, Sonny is holding Hank's shoulders from behind saying, "Look, Petey, Hank loves you and he's holding you; and I love you and Hank; and I'm holding Hank; and Jeff is here too; and he loves you. Everyone's rooting for you. Lord, please protect our Petey."
>
> A pulmonary specialist enters with a resident and an intern, and they use Petey, with his pneumonia and spiking fevers, as a teaching case. The specialist removes the tube from Petey's throat and asks the intern to "reintubate" Petey.
>
> Petey lets out a rasping groan. With a Q-Tip, the nurse gently swabs his lips, tongue, and the inside of his cheeks with Vaseline. She cannot give him water because it might cause the blood clots on his lips, in his mouth, and down his throat to burst. (from Jeff's field notes)

During this same period when Petey was in the ICU, Hank was suffering from a bone disk infection in his lower back. He had sought help several times in the emergency room, but doctors distrust complaints of excruciating back pain by opiate addicts, since the standard treatment is a prescription for opiates. Hank, consequently, was refused admission to the hospital through the emergency room on three or four occasions until finally his bone disk infection spread into his spinal and brain fluid and knocked him unconscious. He was delivered to the hospital by an ambulance driver and was immediately admitted to the ICU.

Both Hank and Petey were resuscitated by the county hospital physicians and

placed on high-tech life support. To everyone's surprise they began recovering in the hospital. Unfortunately, their dramatic physical respite—eating three meals a day and bathing regularly—was cut short by the logic of managed care that has been imposed on county hospitals across the country to reduce medical costs for the indigent. In 1997, the federal government passed the Balanced Budget Act to reduce the Medicare budget by $112 billion over the next five years.[8] This initiated a cycle of decreased federal reimbursements for indigent care to local hospitals. By 1999, the San Francisco General Hospital's budget shortfall had risen to $30 million.[9] Hospital administrators conducted cost-benefit audits and a "utilization review" and ordered doctors and nurses to institute aggressive "early release plans" for uninsured, indigent patients. Ironically, neoliberal logics driving U.S. medical care render the conditions of the homeless even more expensive and even more painful, creating a revolving door between the street and the ICU as patients return to the same living conditions that made them sick in the first place. A more physically painful scenario could not have been invented on purpose. It is exacerbated by the high-tech model of emergency treatment that the market forces of a neoliberal health system promote and that inadvertently tortures homeless drug users by attempting to cure them without addressing their social problems.

> Both Petey and Hank are back living under the freeway overpass and Petey is now missing all his clinic and SSI appointments.
>
> I find Petey panhandling at his old spot by the exit ramp of the Jack-in-the-Box drive-thru. The scabs on his face have grown, presumably because the clotting factor of his once again deteriorating liver is weakening. He cannot talk above a rasping whisper because of the scarring in his throat caused by the breathing tubes from his six weeks in the Intensive Care Unit, damaged by having been used as a "teaching case" for medical students.
>
> He is soaked; his brown leather jacket, oily and slick from the rain, is taut against his shrunken, bony frame. I can see the outline of a beer bottle in the side pocket of his jacket.
>
> He is "flying" a cardboard sign: "Will Work for food . . . God Bless." The cardboard is waterlogged and limp. He does not complain of being wet or cold, but his teeth are chattering.
>
> "I don't know what the fuck to do, Jeff. They never told me to return for an appointment. And I can feel my liver going. My liver is going, Jeff! They threw me out of the hospital after two months in a coma. The doctor told the nurse that they needed my bed. 'Since he can walk around he can leave.' They gave me a prescription and told me to move on."
>
> I ask Petey if he has gone back to drinking. "Only beer," he answers. "I stay away from the Cisco." (from Jeff's field notes)

These notes were written at the height of the dot-com boom that made San Francisco one of the richest cities in the United States. The mayor of San Francisco was

celebrating a $102 million surplus even as the county hospital was instituting draconian cuts.[10] Sixteen maintenance workers at the hospital were laid off and one of the pharmacies was closed. This prompted the hospital to hire four security guards to control the crowds of impoverished patients now waiting two to four hours in line to receive their "reduced fee" prescriptions. For the first time in thirty-five years, a co-payment plan was instituted, forcing uninsured outpatients to share the cost of their prescriptions. Coincidentally, at the time I was chair of a department at the medical school that staffs the San Francisco County Hospital:

> The dean and the chief managing services officer of the county hospital present an Armageddon scenario for the crisis in the hospital's finances. They are having trouble retaining doctors and nurses because of burnout and have had to divert 41 percent of emergency ambulance deliveries due to a shortage of medical staff. There is no longer any trash pickup in nonpatient areas. They had an epidemic of antibiotic-resistant streptococcus in the ICU and had to shut down cleaning services in the rest of the hospital in order to assign all the limited cleaning personnel to the ICU. One of the ICU rooms has been closed down, and they are forced now to treat ICU patients in postoperative care rooms. An internal census revealed that 22 percent of patients sick enough to be admitted to the hospital waited eight hours in the emergency room before being assigned to a hospital bed.
>
> Just before his presentation of the "inhumane conditions at San Francisco General due to federal Medicaid cutbacks," the dean announces that the university is raising its mortgage subsidy limit for newly hired clinical and research faculty to $900,000 on the grounds that "it is a hardship to oblige someone to relocate to San Francisco and be forced to buy a $1.5 million three-bedroom home" on the open market. (from Philippe's field notes)

Upon his release from the hospital, Hank's health deteriorated even more rapidly than Petey's. Jeff attempted to broker outpatient services for Hank to prevent his bone disk infection from spreading once again into his spinal and brain fluid. Jeff also attempted, in vain, to guide Hank through the bureaucratic maze of applying for Social Security Disability Insurance (SSDI):

> I arranged to meet Hank at the pharmacy at the county hospital. Petey agrees to come with me.
>
> There are a hundred or so people waiting in snake coils of lines to get their prescriptions because the latest rounds of budget cuts have shut half of the pharmacy windows.
>
> Hank looks a wreck and he has only been out of the hospital for a week. He is back to fixing heroin every day, and today he is so drunk that he is slurring his words. I am struck by the ripeness of his smell.
>
> After about three hours in line, we finally make it to the Plexiglas pharmacy window. Hank is handed a piece of paper which outlines his "rights to medication." He does not have the $50 co-payment for his prescription—a new requirement—and neither do I.

Hank goes up to the Fourth Floor to find his doctor, the one he likes so much. He returns with his medication that his doctor somehow was able to obtain for free. This doctor has also been thoughtful enough to give Hank a letter about his physical inability to work so that his welfare check can be reinstated. Hank was cut from public assistance while in the hospital for his failure to show up for workfare requirements.

I take Hank to the hospital social worker's office and wait in front of her desk until she is able to talk to us about the status of his Social Security application. It turns out that Hank is missing yet another set of forms that can only be picked up at the Social Security office downtown. We find out that his "reconsideration hearing" for missing his last appointment and having an incomplete dossier is scheduled for the day after tomorrow. (from Jeff's field notes)

Predictably, Hank missed his hearing, and his "incomplete dossier" was rejected. He had to start the whole process of applying for SSDI from the beginning once again.

Hank is crying on the corner because Petey is back to drinking fortified wine. Hank says Petey is throwing up again and insisting that it is due to the hot sauce from the Taco Bell. Hank shoplifted some Maalox for him at the Walgreen's. Petey has not gained any weight. He and Hank are surviving primarily on the sandwiches given to them on their outpatient visits to the hospital—most of which they miss—and the fortified wine they buy on the corner.

Hank missed his appointment again today because he had the opportunity to log six hours of work with Andy, the man who owns a moving van and occasionally hires the homeless for ten dollars an hour. Andy is by far the highest-paying day laborer employer in the homeless scene, and everyone vies for his jobs. Hank is distressed: "It just hurts my back too much. I had to walk off the job. I'm not up to working for Andy anymore."

Their new camp, nicknamed "The Nest," is located on the neighborhood's main artery under the freeway overpass. It is uncannily camouflaged as a heap of dirt and garbage. Hank has gathered branches, twigs, and dried pine needles, piling them together with mud and sand, and has molded this into a circular concave structure that allows their heads to duck below the surface. Less than two feet above our heads the wheels of speeding cars and trucks reverberate against the concrete underside of the overpass.

Jeff takes out a pile of papers from Hank's new batch of SSDI applications and lays them out on the carpet padding lining the bottom of the nest. We give up because it is much too complicated to complete the forms in the candlelight. Jeff displays some photos of Petey taken while he was unconscious in the ICU with breathing tubes down his throat less than a month ago. Hank bursts into tears again. (from Jeff and Philippe's field notes)

Hank and Petey are labeled "nonadherent patients" in the politically correct parlance of medicine. Even the most devoted medical practitioners understandably feel frustrated by the ways indigent drug users repeatedly complicate their already severe medical problems. Further, homeless injectors also frequently abuse the trust of those who try to help them. They pilfer hospital supplies when the orderlies and nurses turn

their heads, and they exaggerate their need for opiate painkiller prescriptions. In other words, they are deeply enmeshed in a mutually adversarial cycle of hostile interactions with medical institutions, consistent with the bureaucratic institutional violence to which they have been prey since childhood from school to prison.

During the first five years of our fieldwork, for example, county hospital surgeons were routinely inflicting iatrogenic wounds on the bodies of homeless injectors. When heroin users arrived with infected abscesses, the doctors cut into them with a deep carving-and-scraping procedure that required an overnight stay. Subsequently, this procedure came to an abrupt end when the surgeons discovered in 2001 that most abscesses could be treated more effectively by a simple incision-and-drain outpatient procedure that does not need to be painful when adequate local anesthetic is applied. There is no national standard of care in the United States for treating abscesses. Abscesses are primarily a self-inflicted condition suffered by homeless heroin addicts. Consequently, their treatment is a low-prestige medical procedure that most researchers and clinicians have shunned. Abscesses, however, represent a veritable epidemic of physical suffering among the homeless. In the year 2000, for example, abscesses represented the single biggest admissions category (four thousand cases) at the county hospital.[11]

The hospital's drastic budget cuts and cost overruns, rather than a humanitarian concern with appropriate treatment, provided the decisive impetus for reforming the expensive, disfiguring, and unnecessary surgical procedure for abscesses that had become routine in the 1990s. To the surprise of the surgeons, the new, cheaper outpatient incision-and-drain procedure proved superior.[12] Healing occurred more rapidly, less painfully, and scarring was minimized. Some of the senior surgeons grumbled, however, that the outpatient procedure reduced the opportunities for medical students and interns to learn surgical skills on their rotations through the county hospital.

All of the homeless we followed spoke positively on the whole about the care they received at the county's hospital, but many also told us horror stories during the pre-2001 years of surgeons cutting into them without anesthesia and refusing to prescribe adequate painkillers for aftercare. Sympathetic nurses at the hospital explained to us that these exceptionally abusive clinicians were usually medical students on clinical rotations. They were not prepared to deal with intoxicated patients, and they resented injectors because of their self-inflicted infections. Until the abscess protocol was reformed, Hank responded to the risk of mistreatment in surgery by lancing his own abscesses.

With his boxer shorts to his knees, Hank juts out his hip and twists into a contrapposto stance to reach the abscess festering in his rear. He explains,

"First you feel for a pocket and if it be real kind of mushy like this one then you know it's ready.

"Yesterday I was worried that it was an inverted abscess with the pus flowing inside me. So I bled it off a little and left it overnight. Now it's ready."

He slowly inserts a pair of manicure scissors into the center of the abscess, pushing the scissors all the way up to the finger holes of the handle. He leaves the scissors pressed into the tissue for a few seconds, slowly swirling them to loosen the flesh, as pus dribbles out of the gash like a dripping eye. He then pulls the scissors out with slow deliberation, squeezing the open gash between his two thumbs.

After a few seconds of grimacing and squeezing, he grabs a toenail clipper and places it just inside the surface of the abscess, using it to grab at something.

He reassures me,

"There's not much pain and that shit basically ends the abscess. But you gotta get that poison out of your system or it won't heal."

After covering the abscess with ointment and the Sterile Pak bandages given to him by a harm reduction health care activist, he lifts a full syringe of heroin, plunging it almost up to its hilt into the side of the freshly bandaged abscess. Shortly after flushing the heroin he sits down and relaxes his whole body.

No one else in the camp thinks there is anything unusual about this procedure. This is just another day in the encampment; I am the only one who is overwhelmed. (from Jeff's field notes)

Hank's procedure looks horrible and self-mutilating, but at that time he was following an arguably effective logic of self-care in the face of the county hospital's deep carving-and-scraping alternative. Most of the injectors postponed seeking hospital treatment because of the long waits in the emergency room and the hostile triage for admission. This practice sometimes resulted in generalized blood infections that escalated into multiple pathologies throughout their bodies. In Hank's case, postponing treatment may have caused the bone infection to spread to his spinal and brain fluid.

UNHEALTHY LAW ENFORCEMENT

It is easy to criticize the inadequacy of medical care and social services for the poor in a neoliberal society. It is even easier to dismiss the homeless for being self-destructive or even pathological in the self-abuse of their bodies. These critiques, however, distract from another more important structural policy dysfunction that must be emphasized in any discussion of poverty and substance abuse in the United States: the war on drugs. Fear of arrest and eviction is a chronic condition among the homeless. The police and the laws they enforce destabilize the daily lives of all the members of the social network we followed and cause immediate negative health effects even when arrests are not made. The illegality of syringes and drugs forces homeless addicts, driven by the urgency of the physical and emotional craving for heroin, to seek out filthy nooks and crannies to make their injections on the run, hidden from public view. More directly, the police, especially the California Highway Patrol, regularly destroyed the physical shelters of the people we studied. Patrol officers purposefully confiscate the possessions most crucial for everyday survival: dry clothes, blankets, tarps, tents, food, cooking utensils, prescription medicine, and clean syringes. In short, the effects of law enforcement directly contradict the efforts of public health to stem infectious disease and up the ante of violence on the street.

There was another police sweep and Hank looks like absolute hell. His eyes are so puffy that I ask him if he has been in a fight.

"They wiped me out again last week. I went for a drink at the corner and when I returned, there was the CHP [California Highway Patrol]. I'm tempted to get my gun and shoot the next patrol car that I see."

He says that when he asked for his clothes the officer in charge threatened to arrest him. They would not return any of his clothing.

Worse yet, they took the prescription Fentynal [a synthetic opiate painkiller] a doctor at the county hospital had prescribed to relieve the lower back pain caused by the now irreparable decay of his infected bone disk.

"I saw them throw my Fentynal patches in the back of that truck. If I had a gun, I swear on my mother, I woulda shot them cops straight in their goddamn head and there wouldn't have been no proof of arrest.

"They said, 'We're teachin' you a lesson. You're on State Property!'"

Hank is shivering so hard that he is hugging himself across his chest to steady himself. I am not sure if it is his withdrawal symptoms from losing his supply of opiate painkillers or his bone infection revving up again. I urge him to go back to the hospital and offer to take him.

"Why? So they can send me right back out again?"

I suggest calling an ambulance to avoid the three- to five-hour wait for triage in the emergency room.

Instead he asks me for money to buy a bottle of fortified wine.

Max, who has now set up an encampment next to Hank and Petey, comes by. He sees Hank's condition and recognizes immediately that it is withdrawal symptoms. He puts his arm around Hank's shoulder, offering to give him a "taste" of heroin.

We walk through the back alley to the freeway, where they inject. Hank has to borrow Max's used syringe because the police confiscated his entire supply. The shot of heroin revives Hank. I offer to take him to the hospital. He agrees that he needs to see the doctor, but he is embarrassed. "I haven't showered in over thirty days."

Max nods. He has been missing his wound clinic follow-up visits for the abscess on his rear that was so deep and large that it required a skin transfer. He is too embarrassed. "My ass is too skinny." (from Jeff's field notes)

During crisis periods, such as these, when the police increased the tempo of their evictions and search-and-seizure procedures, the homeless began keeping no more than two needles in their possession for fear of being arrested. In California and many other states where syringes are illegal without a prescription, the police have the op-

tion when they catch someone with three or more needles of enforcing a discretionary rule whereby they can arrest the injector for the felony of "needle sales" rather than the misdemeanor of possession. In San Francisco, judges usually dismiss charges of needle sales. By the time addicts are processed through the system, however, they have fallen into full-blown withdrawal symptoms. The punishment, consequently, is the severe heroin withdrawal symptoms they suffer in jail while waiting to see the judge for a bogus felony arrest. As one homeless addict explained to us,

> The worst is when you're in jail. Because they don't give a shit if you die. You're in there, curled up in a corner, throwing up and shittin' at the same time.
>
> You get the heebie-jeebies. . . . It's like an anxiety attack. A million ants crawling through your skin and you just want to peel it right off. It's like someone is scraping your bones. . . . You try to sit there and grab your knees and rock.
>
> And in prison there are youngsters there in the cell with you, talkin' shit. "Oh, you dopefiend."

Faced with this risk, the homeless stopped visiting the needle exchange, which was enforcing a one-for-one exchange rule. It is simply not worth it to a homeless injector to spend the time and money to seek out a needle exchange site and obtain only one or two clean needles. As Frank explained when we asked him why he had stopped visiting the needle exchange: "Maybe I ain't got a dollar to catch a bus across town to get to the exchange. It just ain't worth it for a couple of needles, especially if you're feeling sick." They began reusing and sharing their needles more frequently, and their incidence of abscesses increased.

EXPLOITATIVE LABOR MARKETS IN STRUCTURAL TRANSFORMATION

The negative health effects and the emotional suffering caused by the U.S war on drugs are relatively easy to recognize. More subtle and complicated, and less linear, are the connections between the experience of suffering of street addicts and the less visible, macrohistorical forces of the economy, specifically the long-term restructuring of the U.S. labor market. In 1975, when the homeless in our scene were in their early twenties, the crucial age for integration into the manual labor force, a study commissioned by the City of San Francisco noted that the specific neighborhood we studied was in a "depressed state" and projected a loss of "3,000 jobs by the year 2000."[13] This was part of the long-term deindustrialization of America. For example, between 1962 and 1972, the city of San Francisco lost twelve thousand manufacturing jobs.[14] In other words, the homeless and the families they came from were the obsolete labor force of disappearing industries: dock work, shipbuilding, steel milling, metal smelting, and foundry work.

Economies going through major structural adjustment do not forgive undisciplined, poorly educated workers—especially when they drink and take drugs. As substance abusers without a college education, homeless heroin injectors are at the bottom of San Francisco's hiring queue. The low-wage service industries of the new, postindustrial U.S. economy are supplied from an enormous pool of highly disciplined immigrant laborers who are eager to work for low wages. In California these model workers are primarily undocumented Mexican, Central American, and Chinese immigrants who are fleeing poverty, hunger, and/or violence in their home countries.

The job histories of the homeless we studied reveal how they were structural victims of the changing economy as well as self-destructive in their drug use. The oldest members of our network had actually worked in unionized positions in the old industrial economy—primarily shipyards and steel mills in their early youth. In the late 2000s, however, they find themselves scrambling for day labor jobs in the dilapidated warehouse districts of abandoned factories. They load and unload trucks, or stock merchandise, or sweep in front of corner liquor stores. They strive to develop client-patron relationships with the few still-existing small business owners in order to eke out a few hours of work per day.

Local business owners often choose a particular homeless person to whom they give occasional loans of money and gifts of food. In return, the "lucky addict" checks in every morning to see if work is available. The result is an efficient delivery of the kind of "just-in-time" labor that is celebrated by the neoliberal economy. Employers obtain a cheap, flexible, and desperately dependent source of labor. The downside, of course, is that the business owners have to accommodate the vicissitudes of the lives of the homeless. For example, when Scotty (the man profiled in the epigraph) died, his employer, the manager of a construction supplies depot, was left in the lurch. He had paid Scotty in advance to shovel sandbags. Similarly, Hank walked off a moving job when his decayed lower back disk caused him too much pain.

The savviest business owners calculate the size of their favorite addict's habit and are careful to pay (or loan) only the precise amount of money needed to take the edge off of heroin withdrawal symptoms. Any extra cash might precipitate a binge on crack or alcohol. Ben, for example, the owner of a furniture liquidator warehouse, always paid Al his day's wage in the morning and made sure to remain one day in arrears. In this manner he was guaranteed that Al, driven by heroin withdrawal, would always show up on time for work each morning eager for the $10 he needed to placate his early morning withdrawal symptoms. Ben had to give Al only one more $10 bill at midday along with a pack of cigarettes and a bottle of fortified wine to complete his full day's wage.

> Al has been talking a great deal about wanting to "get clean." So just before sunset I visit him where he works, at the furniture liquidator warehouse, and offer to give him a ride to the treatment center. He is moving furniture back into the warehouse from the sidewalk where they display it in the path of pedestrian traffic.

Al is nervous because the welfare department contacted his employer, Ben, to fill out a form to confirm that he works "part time" for him so that he does not have to participate in the workfare program to receive his check. Ben has refused to sign anything for fear of being taxed, and probably also because he pays Al under minimum wage.

Al curses his boss under his breath, complaining about only getting $20 per day. "It's like I'm a dog on a leash; he knows I'll be sick before morning."

The boss is a burly man in his early fifties with a thick Brooklyn accent. Abruptly, without even saying hello, he asks, "You the guy writing stories about heroin addicts? Huh?"

The next thing I know he is shouting, "Why have they been shooting heroin for so long? At fifty years old it's their responsibility to get out off of this shit. Why should society help? It's their fuckin' problem. No one holds a fuckin' gun to their head and makes them shoot up! Who got them into the drugs? All they gotta do is look into the fuckin' mirror.

"These guys are habitual criminals. They don't need no fuckin' breaks. Leeches, bloodsuckers, and snakes. . . . They'll never change. Anything you give 'em for help they just put right back into their arms. Welfare, SSI, shoot-up, drink-up, what else they want for free?

"Get the fuck outta here! You're part of the fuckin' problem."

Throughout the harangue Al shows no emotion. He continues moving the last of the furniture inside the warehouse. He then sits on the sidewalk waiting for us to finish, as if the argument has nothing to do with him.

Later that evening, back at his encampment, Al feels compelled to apologize to me for his boss's tirade: "I don't understand why he's acting like that. I really don't. I'm sorry. He was just joking." (from Jeff's field notes)

MORALIZING SUFFERING AND ABUSE

Anthropologists and historians have documented psychotropic drug use—usually mediated in formally ritualized and religious contexts—in virtually all cultures throughout the world and throughout history. They distinguish this from the destructive forms of substance abuse that have escalated under urbanization, industrialization, and incorporation into the global market economy.[15] Modern-day homeless substance abusers bear more than their share of human anguish. This may be why they are vulnerable to self-destructive forms of addiction in the first place. In America, drug taking among the disenfranchised has become an especially destructive practice, filling urban streets with social pariahs with ravaged bodies.

In the United States, the land of immigration, opportunity, and economic abundance, popular common sense does not recognize that individual suffering is politically structured. Both the rich and the poor adhere to a puritanically inspired tradition of righteous individualism that defines poverty to be a moral failing of the individual. These judgments are even extended onto the general population of uninsured poor in the United States—more than forty million people in the year 2004.[16] Al's boss Ben, the furniture liquidator, was merely expressing in vituperative language an all-American common sense.

An analysis that allows us to recognize how larger power relations interact with individual failings at the intimate level avoids blaming victims and delegitimizes counterproductive, punitive social policies. At first sight this is difficult to comprehend because the apparently willful self-destruction of homeless heroin injectors confuses even sympathetic advocates for the poor. The lives of homeless injectors are shaped by a total social context of institutions, policies, macrostructural forces, and cultural values that they do not control. In short, the socially structured suffering of the homeless in the social network we studied has been rendered "uselessly" painful by the neoliberal turn in the United States.[17] Recognizing this unnecessary toll of suffering imposed on the lives of America's most vulnerable citizens is especially important at a moment in history when ever-increasing segments of the world's population are being marginalized by global shifts in the economy and by political ideologies intent on dismantling social services in favor of punitive neoliberal policies.

NOTES

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13

Walling Out Immigrants

Peter Kwong

Migration has always been a part of human experience—throughout history, people have moved to places that offered better conditions for survival. In doing so, new immigrant groups have typically had to confront the hostility of the groups that arrived earlier because newcomers are always seen as competitors for resources and jobs. In the United States, immigrant bashing has become a ready-made tool used by politicians to stir up popular support and distract attention from problems that are much more difficult to resolve. And since new immigrants tend to be a small minority without political representation, attacking them is a cost-free political exercise. From the days of the founding of the Republic, the United States has used immigrant bashing against the Catholic Germans, the Irish, the Chinese, other people of color, and "ethnic whites" from Eastern and Southern Europe at the beginning of the twentieth century. The attacks were usually articulated in overt racial and ethnic terms.

Anti-immigrant rage in the United States these days is focused mainly on Mexicans who enter the country illegally. In the current post–civil rights era, instead of being portrayed as inferior and unwanted, they are accused of parasitism on our already limited public social welfare and educational resources.

Congress in 1986 passed the Immigration Reform and Control Act (IRCA) to curb the entry of illegals. The act provided for sanctions against employers who hired illegals "knowingly." In practice the law did not stop the hiring of illegals because few employers could be convicted given the lack of a national identification system. But while the law did nothing to stop employers from hiring illegals, it facilitated employer exploitation of undocumented employees because, under IRCA, illegals cannot report employer abuses against them for fear of deportation. The