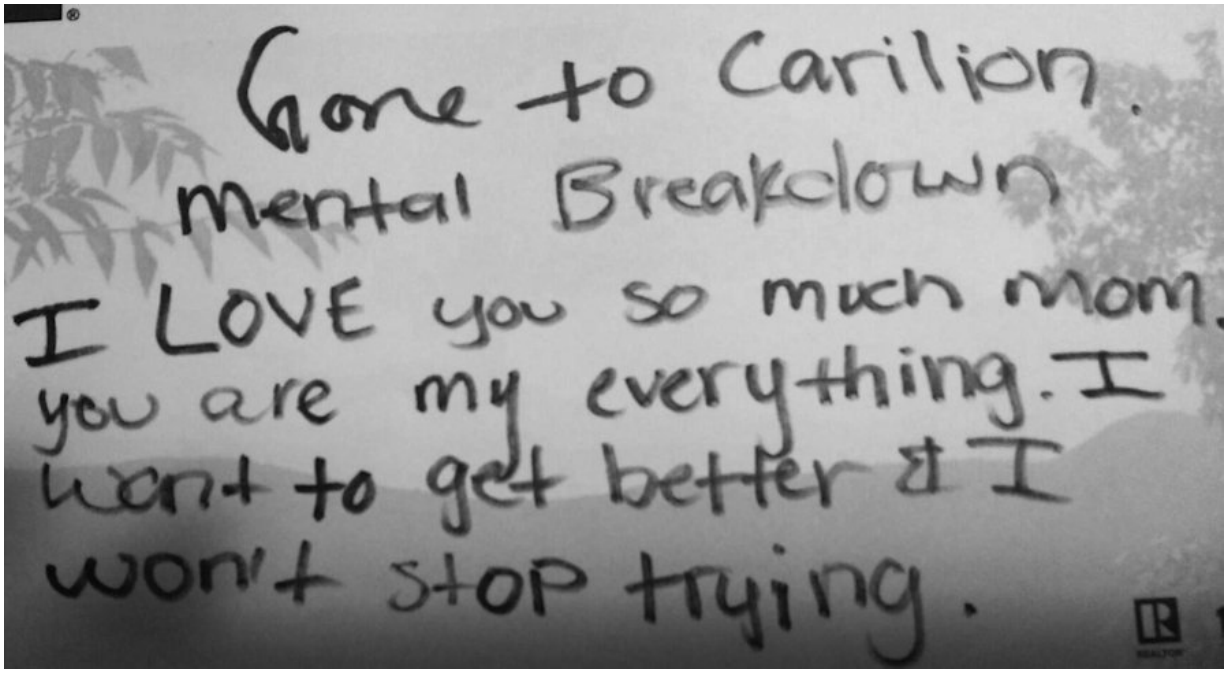

Note from Tess Henry, Roanoke, Virginia

Chapter Nine

Whac-A-Mole

By 2014, the suburban heroin-dealing scene had become entrenched in Roanoke's McMansion subdivisions and poor neighborhoods alike. But the largest dealers weren't twice-convicted felons like Ronnie Jones with elaborate dope-cutting schemes, multiple cars, and hired mules. They were local users, many of them female, dispatched to buy the heroin from a bulk

dealer out of state, in exchange for a cut. And they were as elusive as hell to catch.

Among Roanoke's first long-haul drug runners was a pretty brunet in her midtwenties whose name reflected her Hawaiian heritage: Ashlyn Keikilani Kessler. What distinguished Ashlyn as one of the region's top mules, according to the prosecutor who sent her to prison, wasn't just the volume of drugs she was transporting; it was also her body's astonishing ability to metabolize the drug without overdosing. ("Generally speaking, there are people who overdose all the time, then there are people like me who have *never* overdosed," she told me.) At the peak of her addiction, Ashlyn was using fifty to sixty bags a day. "She had a remarkable liver," her prosecutor said.

She was an unlikely addict, a young mom and paralegal with a criminal justice degree from Jerry Falwell's Liberty University. But her descent into drugs followed a familiar story line: After the birth of her son, in 2008, she was prescribed Lortab for mastitis, an infection not uncommon among breastfeeding mothers. She had lingering lower-back pain, too—the baby's head had been resting on her spine throughout her last trimester. When the Lortab ran out, her obstetrician wrote her another script, for oxycodone. Within six weeks of giving birth, Ashlyn said, she was hooked. When her doctor left town after a few months and his replacement refused her refill requests, she bought black-market OxyContin through a friend of a friend. She occasionally stole Lortab from her disabled octogenarian grandfather.

She switched to Roxicodone in 2010, when OxyContin became abuse-resistant, then to heroin when the black-market Roxys became more expensive and harder to get. "It's unreal how many people followed that same pattern: Oxys-Roxys-heroin," she told me. "If you ask me, OxyContin is the sole reason for all this heroin abuse. If I had the choice between heroin and Oxys, I would choose Oxys.…With pills, you always knew what you were getting."

By the time her son learned to talk, Ashlyn was doing heroin and/or heroin business with most of the Hidden Valley users. She had grown up in the north Roanoke County suburbs, but she had made lots of friends from Hidden Valley and Cave Spring. "Places like Hidden Valley are where you can get some of the best heroin because those are the kids with parents that have money," she said.

From the Kentucky federal women's prison where she was serving a seven-and-a-half-year sentence for distributing between thirteen thousand and twenty-three thousand bags of heroin, Ashlyn charted out, via email, the trajectory of heroin's suburban sprawl, with intersecting spheres of users she knew who were now dead or doing time. She pointed out news articles I'd missed about people she'd once used drugs with, including a young mother named April who'd recently overdosed in the parking lot of a Roanoke Dollar General store, with her infant found crying in the car seat. She knew Spencer Mumpower and Colton Banks. At the height of her addiction, she'd wept through Scott Roth's funeral Mass.

She mapped out her spiral from user to dealer, from patient to criminal. Two years into her addiction, she was fired from her job for too often being late or absent. Her co-workers had no idea she'd been shooting up in a stall of the law-firm restroom where they worked. (She had to have surgery once after a heroin needle became stuck in her arm but told colleagues "some crazy lie that I'd cut it on a fence.")

After her dismissal from the firm, Ashlyn stole from her family to buy drugs: credit cards, checks, even heirloom jewelry from her Hawaiian-born grandmother, who was now, at eighty, raising her elementary-school-age son. A relative visiting from Wahaii had predicted when she was a little girl that "Ashlyn is gonna break your heart," her grandmother Lee Miller told me.

And, sure enough, Ashlyn did. "We enabled her," her grandmother conceded; her grandparents paid for rehabs she typically left after only a few days. They sometimes gave her money to buy Suboxone on the black market, "because she'd get sick and have to turn to heroin if she didn't have it."

It was the car her grandparents bought, a 2013 Nissan Sentra, that led to Ashlyn's undoing and eventually—once she was forced, behind bars, to get clean—her saving grace. A dealer approached Ashlyn about driving him back and forth to New Jersey for three bundles (or thirty bags) of heroin; he had a Newark "connect," a relative with a source willing to sell to them in bulk. When they progressed to bricks, or fifty-bag allotments, they bought them for $100 each, then sold them back in Roanoke for six or seven times

that, she said, and made the fourteen-hour round-trip trek three, sometimes four times a week. Her dealer typically sent his girlfriend along on these runs to keep an eye on Ashlyn, who was known to inject the heroin, swiping bags from their mutual stash, at rest stops en route to Roanoke.

"I now know that he enlisted me because I am a well-spoken, young white girl that drives a nice car, therefore it didn't look [to police] like we were there for what we were really there for," she wrote. More important, her craving for the drug was so insatiable—her skinny, desperate look practically screamed *white female addict*—that no Newark dealer would mistake her for an undercover cop.

When Ashlyn first landed in downtown Newark, heroin was so easy to get that the moment she left her car, a man approached her, wanting to know, "Hey, baby girl, what you lookin' for?"

By 2014, when DEA agents and federal prosecutors caught up with her, the government's case laid itself out in the fifteen thousand text messages recovered from her phone—enough evidence to map out a pyramid of addiction, from her New Jersey source to dozens of Cave Spring and Hidden Valley kids. The exchanges were marked by logistics, deals, and despair:

Can you meet me at Sheetz
on Peters Creek Road?

Whatcha got? Can you do two?

Yeah.

You got ten more? Can I owe ya?

Ashlyn was almost home when Virginia state police pulled her over on I-81 just north of Roanoke, ten minutes from the end of another Roanoke–Newark round trip. Unbeknownst to her, drug task force officers were following her movements with the help of a GPS tracker they'd hidden on the undercarriage of her car. She'd been on their radar six or seven days, ever since a former classmate overdosed on the heroin Ashlyn sold him. He lived, selling her out to an undercover cop in exchange for avoiding jail time.

Now, a week later, DEA agents were searching the trunk of her Nissan,

beginning with her purple paisley Vera Bradley purse. They found the 722 bags of heroin, not so carefully hidden inside the monogrammed bag. (She and a friend had already blown through half a brick.) Now they were handcuffing the former paralegal and reading her her rights.

Ashlyn realized there was no story to tell herself that didn't begin with the first of the Twelve Steps, she told me: She was powerless to overcome her addiction. She was about to lose her son, who was six at the time, because she had chosen heroin over him.

She watched as officers extracted her belongings from the car, including her Narcotics Anonymous book, left over from two earlier rehab attempts, which had been there all along, next to her purse.

As the interstate traffic roared by, the agents waved the NA book around, laughing about it. Then they tossed it on the ground, next to Ashlyn's other stuff. It was windy and unseasonably brisk that September day, and she remembered shivering by the side of the road in her flower-print skirt, wedge sandals, and shirt, purple to match her purse.

The man in charge of prosecuting Ashlyn Kessler keeps a portrait of the American president James Garfield above his desk. Before he was named brigadier general in command of twenty-five hundred U.S. Army Reservists nationwide, Andrew Bassford was tasked with the job of laying a wreath on the grave of each one of the eight Ohio-born presidents on the anniversary of his birth, then delivering a speech. Bassford viewed it as tedious but important work, the challenge being to say something inspiring while not repeating what he'd expounded on the year before.

Compared with the other Ohio presidents, Garfield is, in Bassford's view, an overlooked gem. He was a beast of a worker, his rags-to-riches story so inspiring that Horatio Alger penned his campaign biography. Among Bassford's favorite Garfield quotes: "Most human organizations that fall short of their goals do so not because of stupidity or faulty doctrines, but because of internal decay and rigidification. They grow stiff in the joints. They get in a rut. They go to seed."

Bassford is also the assistant U.S. attorney in charge of prosecuting many of western Virginia's heroin-distribution and overdose-death cases.

That's his primary job, the brigadier general position being a part-time gig that takes him out of town on weekends twice a month. He takes being a prosecutor seriously, this important but sometimes tedious business of sending people like Ashlyn Kessler and Spencer Mumpower to prison—though he's the first to admit the system is inept and flawed.

From his high-and-tight haircut to his dress cowboy boots, Bassford exudes law and order, communicating in staccato sentences and wry one-liners, like a character from the television series *Dragnet*. On the timing of illicit drug sales, for instance: "Heroin is morning, crack is night."

On the federal judge who halved the prison time specified by Ashlyn's plea agreement, saying he was impressed by her perseverance, after her arrest, in a jail-based treatment program: "I think Judge Urbanski is trying to save those that he thinks can be saved." (In 2017, Urbanski knocked Ashlyn's sentence down even more.)

On what he thinks of law enforcement's efforts to quell the opioid epidemic: Not much.

The system is too rigidified, as Garfield would say, not nimble enough to combat heroin's exponential growth. The drug's too addictive, the money too good. "You whack one [dealer], and the others just pop right up, like Whac-A-Mole," Bassford said.

Bassford prosecuted Ashlyn and her dealer in 2015, but only after putting away her first heroin dealer, from southeast Roanoke, the white working-class neighborhood where heroin initially took hold in the city. Thirty-year-old Orlando Cotto had enlisted his girlfriend, his twin brother, an uncle, and a next-door neighbor to help him transport 60 grams of heroin every two weeks for distribution and use. They took turns meeting their supplier in the parking lot of a Burlington Coat Factory in Claymont, Delaware, clearing nearly $60,000 a month.

After Ashlyn went to jail, "I whacked four more," Bassford said of subsequent dealers, all intertwined with Ashlyn's and Cotto's networks.

But the demand for heroin persisted, predicated on the evangelical model of users recruiting new users, and Bassford's whacks could not keep pace. "We'll score a huge drug bust that we've been working on for maybe a year, and all that does is create a vacuum in the market that lasts maybe five to seven days," said Isaac Van Patten, a Radford University criminologist and data analyst for Roanoke city police. "And because the amounts of money

involved are so vast, we're not going to stamp it out.

"We don't enjoy the cooperation of the supplier nations," Van Patten explained, referring to drug-cartel production in western Mexico, South America, and Afghanistan, with profits estimated at more than $300 billion a year. "Their attitude is: 'Tell your people who are wanting to consume our product, we're going to supply it.'"

While Roanoke's quietest heroin users were privileged and upper-middle-class—Van Patten called them the café crowd—it didn't take long before suburban users like Ashlyn were casting their lot with former OxyContin addicts from the working-class Southeast who were already tapped into illicit networks, he said. "In the suburbs, heroin started out as a trendy drug that people believed they could control. But the rich kids spiraled right down with everybody else and then, suddenly, you couldn't tell between the two."

The rich kids were crashing alongside the poor kids on friends' couches (the lucky ones, anyway), all of them cowering before the morphine molecule and beholden to its spell. Fifteen years earlier, Art Van Zee had predicted that OxyContin would eventually be recalled—but not until rich kids in the suburbs were dying from it. Now they were, and that pained him equally, he told me. "I was absolutely dead wrong."

I thought of Tess Henry, the young mom I met in late 2015. The daughter of a local surgeon and a hospital nurse (they divorced when she was ten), Tess had grown up in multiple homes—one in the nicest section of Roanoke, with mountain-biking trails and the Blue Ridge Parkway abutting her backyard, the other on secluded Bald Head Island, North Carolina, accessible only via ferry.

Tess was a high school track and basketball standout, an honor-roll kid who would go on to study French at Virginia Tech and the University of North Carolina–Asheville, though she didn't complete a degree. Among the things she loved to do before she fell into a raging, $200-a-day heroin habit were writing poetry, painting, reading, and singing to her dog, a black rescue mutt named Koda. (The two were particularly happy when Tess belted out the words to Train's "Hey, Soul Sister" in the car.) Her favorite

author in the world was David Sedaris; she'd run into him once in a local coffee shop after a reading, she told me, and he was so, *soooo* unbelievably nice.

Of Patricia Mehrmann's four kids, Tess was the quietest, the one who voluntarily walked the dogs with her on the beach. Patricia emailed me a beach picture of the family Labrador, Charlie, and a ten-year-old Tess, all freckles and a toothy smile, with both arms wrapped around the dog. They liked to head out early at low tide to look for beach treasures. "She was the queen sand-dollar finder," Patricia said.

But Tess struggled with anxiety from a young age, her relatives told me, recalling a panic attack she had as a young teenager on the way home to Roanoke from the beach. ("She thought she was dying," Patricia remembered. "She was throwing up and calling me from the back seat of the car.") At her private Catholic primary school, where students wore blue and khaki uniforms, Tess was stressed that her shoes weren't right.

Tess was twenty-six when we met, a waitress-turned-heroin-addict. With a ruddy complexion and auburn hair, she wore leggings with long sweaters and liked to apply makeup cat-eye style, at the edges of her eyes, which were luminous and shifted color from brown to green depending on the light. She had consorted with most of the Hidden Valley crowd mentioned in this book, working not as a runner or mule but as a lower-level "middleman," as she called herself. She did worse than that, too.

Perhaps she was genetically predisposed to addiction, her mom theorized; there were alcoholic relatives on both sides of the family. Tess's older sister had been in recovery for five-plus years and was a devoted member of Alcoholics Anonymous. Perhaps, during Tess's college experimentation phase, it was the twenty-five Lortab pills a friend gave her, left over from a wisdom-tooth extraction, that set her up for the ultimate fall. Tess knew only that her daily compulsion for opioids began in 2012, the same way four out of five heroin addicts come to the drugs: through prescribed opioids. For Tess, a routine visit to an urgent-care center for bronchitis ended with two thirty-day opioid prescriptions, one for cough syrup with codeine and the other for hydrocodone for sore-throat pain.

“When I ran out, I started looking for them on my own, through dealers,” first through the drug-dealing boyfriend of a fellow waitress at the restaurant where they worked, Tess said. Asked how she had known what to do, she told me she Googled it. “Because I was sick. Jittery. Diarrhea. All of it. I looked up my symptoms and what I’d been taking, and I realized, holy crap, I’m probably addicted.”

She could get anything she wanted from her dealer. In the beginning, she snorted five pills a day, usually Dilaudid, Roxicodone, Lortab, or Opana. Then, several months into the routine, almost overnight, the pill supply dried up. Tess blamed it on the DEA’s reclassification of hydrocodone-based drugs into a more restrictive category. “That made it harder for my dealer to get pills,” she said.

In October 2014, hydrocodone-based painkillers such as Vicodin and Lortab were changed from Schedule III drugs to Schedule II, the same category as OxyContin. Regulations now limited doctors to prescription intervals of thirty days or less, with no refills permitted, and patients who needed more had to visit their doctors for a new prescription, as opposed to having it automatically called in to a pharmacy. Before the rule took effect, patients could have their pills refilled automatically as many as five times, covering up to six months—one reason narcotic prescriptions quadrupled from 1999 to 2010, and so did deaths.

The so-called upscheduling had been controversial, with public opinion weighing in pro (52 percent) and con (41). Chronic-pain patients complained loudly about the added cost and inconvenience. “Just because the DEA cannot figure out how to control the illegal use of these drugs should not be a reason to penalize millions of responsible individuals in serious pain,” one critic wrote in a published letter to pharmacist Joe Graedon, *The People’s Pharmacy* columnist.

On a website set up by the DEA for public feedback, several patients warned that rescheduling the drugs would limit their availability and drive people to street drugs—particularly heroin.

Tess’s dealer adapted swiftly to the switch. “He said, here, try this—it’s cheaper and a lot easier to get,” she told me. Tess took her first snort of the

light brown powder, same as she'd done with the crushed-up pills. He was a serious dealer, she said, an African American who sold the stuff but was strict about never using himself. "Not to sound racist or anything, but typically black opiate dealers do not use heroin. Good dealers don't use what they sell because they know they would just use it all," she said.

With the legalization of marijuana in a growing number of states, drug cartels were champing at the bit to meet the demand for heroin, a market they needed to grow. "They were looking at a thirty to forty percent reduction in profits because of legalization," explained Joe Crowder, a Virginia state police special agent and part of the federally funded High Intensity Drug Trafficking Area program that designated Roanoke a heroin hot spot in 2014. "Between the pill epidemic and the less liberal prescribing of pain meds, cartel leaders said, 'Guess what's purer, cheaper, and we can make it all day long?'"

Some dealers encouraged underlings to "hot pack" their product, giving superhigh potencies to new users to hook them quicker. Once the user is hooked, the product gets titrated back, forcing the person to buy more.

Tess said she didn't consider herself a true addict until six months after she started snorting heroin, when she began injecting it. After three shots, though, she knew she'd never return to snorting. She showed me the scars inside her right elbow; right-handed, she learned to use her left hand to mainline the drugs into her right arm because that vein was usually a sure hit.

For a while she was able to keep waitressing at a trendy, upmarket bistro featured in the likes of *Southern Living* and *Garden & Gun*. She wore long sleeves to hide her track marks and was still able, if she concentrated hard, to remember orders without writing them down.

Around this time, a family friend told her mother, "Your daughter's an opiate addict," and Patricia Mehrmann had a reaction not unlike that of many other parents faced with the same accusation: She fumed, incredulous. After all, Tess never missed a day of work. "She did everything she was supposed to do," Patricia said. We were sitting in her comfortable sunroom, surrounded by woods. Patricia was way past denying

it now: She'd spent the last six months navigating treatment hurdles, and worse.

"I worked just to use, and I used just so I could work," Tess explained. "There was no in between." But that phase was brief, and neither Tess nor her mom had any idea what was coming next. Or that the molecule had another even higher card to play.

No matter how low Tess got, it seemed there was always a deeper and fresher hell awaiting her.

The addiction would out Tess eventually, as it always does. Even though she was earning $800 a week at the restaurant, even though she'd started middlemanning—recruiting and selling to new users in exchange for her cut of the drugs—she needed more money because she required ever-larger quantities of heroin to keep from feeling shaky and dopesick. She was arrested twice early on—once when officers picked her up for being drunk in public downtown and found an unprescribed OxyContin in her pocket, and again when police caught her stealing gift cards from a store. The first charge was pleaded down from a felony to a misdemeanor, and Tess was sentenced to a year's probation and a weekend in jail. The second was treated purely as a theft. "I begged her public defender: 'This is not what it looks like; send her to drug court!'" remembered her father, Alan Henry, from whom Tess was sometimes estranged.

On May 15, 2015, an employee manning the security cameras at a Roanoke Lowe's alerted police to Tess. The camera caught her palming a copper plumbing implement and stuffing it into her purse. She'd done it before: stolen an item from one Lowe's, then returned it to another Lowe's, which would issue her a gift card for the value (since she lacked a receipt). But this time they caught her before she left the store.

"I was already in withdrawal at the time" of her arrest, she said.

At the Roanoke city jail that night, with every pore on her body aching and every muscle spasming, a female jailer greeted her with a tiny cup.

"Here, take this," the jailer instructed. The woman handed Tess the medicine, which had been ordered as a result of a routine urine screen.

Inside the cup was a low dose of Tylenol with the opioid codeine. It was

designed to keep the fetus growing inside Tess from going into sudden, potentially fatal opioid withdrawal. Twenty-five and five foot seven, Tess was down to 120 pounds. She hadn't had a regular period in two years. She had no idea she was at the end of her second trimester of pregnancy.

At least in jail, for the immediate future, she and the baby were safe.

Six weeks later, the region's new HIDTA task force issued a warning about a spike in opioid-overdose incidents. Between May 1 and June 23, 2015, the local drug task force would investigate eleven overdose calls, four of them fatal. The culprit was fentanyl, once a popularly diverted opioid prescribed in patch form for advanced-cancer patients that was now being illicitly imported from China and mixed with heroin or manufactured into pills. (Some arrived from China via Mexico and, to a lesser extent, Canada.)

A synthetic opioid considered twenty-five to fifty times stronger than heroin, mail-order fentanyl had been arriving direct to residences across the United States, and so were the pill presses that local dealers used to turn the powder into pills. One quarter-ton press arrived in Southern California inside a package labeled HOLE PUNCHER. Cartel lieutenants were setting up clandestine fentanyl labs across America, mixing the powder with heroin to increase the high, in products stamped with names like China Girl, Goodfella, Jackpot, and Cash. "Some of the companies shipping this stuff from China will send you a free replacement package if it gets interdicted on the way to your home," a prevention worker in Baltimore told me.

News that people were dying from fentanyl-laced heroin didn't intimidate heroin addicts, according to several I interviewed. On the contrary, the lure of an even stronger high drew them to it more.

Later that year and again in 2017, China began banning, at the request of the DEA, the manufacture of several fentanyl analogs, which had previously been unregulated. But each time a derivative was banned, a DEA spokesman conceded, new spin-offs emerged from underground Chinese labs, some more potent than the originals. Law enforcement interdiction of the packages is tricky, because it's hard to tell whether the shippers are illicit labs labeling the envelopes "research chemicals," complete with phony return addresses, or legitimate companies providing the powder for

pharmaceutical research.

Back in 2015, Roanoke police chief Chris Perkins, forty-six, knew immediately fentanyl was going to be a game changer. It meant more teenagers would be drawn to the ever-potent blends, able to get high simply by snorting the drug and avoiding the stigma new users have about injecting and, later, the telltale track marks. It meant some would buy counterfeit pills that were sold to them as Xanax or oxycodone but were actually fentanyl.

In his earliest days of working undercover drugs, Perkins had gone by the name Woody Call and wore the classic Serpico look, with a goatee and longish dark hair. It was the mid-1990s, when heroin dealers used to "step on," or cut, their product with baby powder. He remembers finding a pair of Radford University coeds at one bust, naked on a couch in a Roanoke drug house, enveloped in a heroin fog. They'd exchanged sex for the drug, injecting it between their toes so their friends and professors wouldn't know. Stunned, Perkins remembers calling their parents in the Washington suburbs and saying, "I can't tell you this over the phone. You just need to come."

But now the cut had switched from baby powder to fentanyl, from mild to often lethal. "The market is so saturated, I can't say it enough: There is so much heroin out there," sold not only by former crack dealers eager to diversify their product but also by subordinates, or subdealers, Perkins said. So much that Roanoke police seized 560 grams of the stuff in 2015 alone—the equivalent of 18,666 doses or shots.

It was Whac-A-Mole on steroids: When police took one source out, there would be a short lag until the next source presented itself. Meantime, the overdoses kept stacking up. And that was before the worst spike in fentanyl hit.

Perkins had long championed community policing in Roanoke, wherein officers engage with teenagers in high-crime areas (often patrolling on bicycle) while always refining where they need to be, using real-time data. Violent crime in the city, much of it previously crack-related, had dropped 64.5 percent and property crime 39.9 percent since 2006. A 2011 program Perkins pioneered called the Drug Market Initiative offered nonviolent

offenders the opportunity to bypass jail and receive job training if they agreed to leave the drug trade.

But the cellphone had put an end to open-air drug markets, enabling the coordination of drug buys in gas-station and shopping-mall parking lots. Hotels situated along the perimeter of Roanoke on I-81 and near Interstate 581, which cuts through the city center, were also prime drug-deal spots because higher-level distributors could sell there and quickly get back on the road.

Experienced dealers were hiring addicted middlemen like Tess to conduct street-level business for them, lowering the dealers' risk. And shoplifting fueled by users like Tess had nearly doubled in the past five years. Violent crime was edging upward, too: A thirty-four-year-old woman was murdered at a rent-by-the-week airport motel known to be a hangout for the heroin-addicted. A woman Jamie Waldrop had been coaxing toward treatment for months was found dead of overdose at a Howard Johnson's next to I-81.

"She's next on the list" to be admitted, a rehab intake counselor texted Jamie the next day.

But it was too late. "She died in a motel last night," Jamie wrote back.

It was time to get nimble again.

On the eve of his retirement, Chief Perkins vowed to do something about Roanoke's surging heroin problem. A data geek as well as an incessant worrier—nights and weekends, Perkins had crime reports emailed to his phone every hour, one of the reasons he retired early, after twenty-four years on the force—he was eyeing a program he hoped to implement, if he could just get buy-in from the disparate health care and criminal justice agencies. "This is what I'm going out on!" he told me, almost manically, in late 2015.

He hoped to follow the path of Gloucester, Massachusetts, police chief Joseph Campanello, who'd recently told the growing number of heroin users in his town: Turn in your drugs, and I'll hook you up with treatment instead of handcuffs. By early 2017, the Gloucester model, called Police Assisted Addiction and Recovery Initiative, had been adopted by two

hundred police agencies in twenty-eight states.

The Hope Initiative, as the PAARI program in Roanoke would be called, was the impatient police chief's swan song. "We want the carrot to be: We'll treat it like a disease, and if you stay clean, we'll go away," Perkins said.

The idea was to create a public-private partnership where "angels," or trained volunteers, helped funnel addicts into treatment, mentoring them during the cumbersome and usually relapse-ridden march toward sobriety—kind of like an on-call NA sponsor, only with the skills of a social worker able to take advantage of the city's housing, mental health, and job resources. The program would be located at the Bradley Free Clinic, a long-running program for the working poor staffed by physician volunteers and located in Old Southwest, a burgeoning heroin hot spot.

The clinic's executive director, Janine Underwood, wasn't a doctor. In the fall of 2015 she attended the first Hope Initiative meeting not because she ran a nonprofit medical clinic but because her twenty-eight-year-old son, Bobby Baylis, was among the four who died of fentanyl-laced heroin that June, while Tess was in jail.

Janine had spent the previous seven years floundering as she watched Bobby seesaw between rehab and jail after initially becoming addicted to OxyContin prescribed in the wake of ACL surgery following a snowboarding accident. He'd gotten clean—finally, she thought—during a three-year prison sentence, during which he'd participated in drug treatment and become a certified journeyman in heating and air-conditioning. On probation back in Roanoke, Bobby was excelling at his new job, living in her basement, and doing well after his release. "You could see the sparkle again in his eyes, for the first time in years," she said. Three months after leaving prison, a visit with some old Hidden Valley friends led to a single dose of fentanyl-laced heroin. Janine discovered Bobby's body, cold and blue, laid out on the basement floor, the evidence cleaned up and his user-dealer friends long gone from the scene.

Still raw in her grief—Bobby had been dead only six months—Janine could draw a detailed mental map of the flaws in the treatment landscape, from health care privacy hurdles and other treatment barriers to the lack of guidance about what to do the moment you realize your twenty-one-year-old is injecting heroin: Janine had found a box of hypodermic needles

hidden in a box in the back of Bobby's closet. He'd wrapped them up in his baby blanket, sandwiched between soccer trophies and Boy Scout patches.

What Janine did was sob. "It was the worst moment in my life. I didn't understand yet the connection between pills and heroin. I kept thinking, 'He's gonna get better; it's *just* pills.'

"I'm in health care, and there were just so many things I didn't know," she said. "It's almost impossible the way the systems are set up, for a parent to get good treatment for their child."

Janine was the first Hope Initiative angel to tell the chief, "I'm in."

The second was Jamie Waldrop, Christopher's mom—the one who'd personally accompanied her addicted son to the Montana rehab. By now, so many in the Hidden Valley circle of heroin users had become intertwined: Jamie's boys had known Bobby, Janine's son, who'd been in the same court-ordered halfway house as Spencer Mumpower. And Jamie's older son had at one point dated Tess.

"It was like we had a Dementor from *Harry Potter* who was swirling around the households of Hidden Valley, going, 'I want you and you and you and you,'" Jamie told me.

The third volunteer was Terrence Engles, a former pro baseball player who'd progressed from taking injury-prescribed OxyContin to scamming pain-management doctors on Manhattan's Upper East Side to overdosing on a Staten Island ferry in 2011. He'd just landed in Roanoke as a treatment consultant for American Addiction Centers, with three years of sobriety. He spent most of his time in Roanoke trying to persuade addicted twentysomethings to go to treatment, whether it was to one of his company's dozen centers across the United States (for those with insurance) or to the scant few regional or charity options, most of them faith-based and abstinence-only. "I get about twenty calls a week from people in crisis," he said.

In Chief Perkins's ideal world, Carilion Clinic, the region's largest employer with nonprofit hospitals and a new research center already known for its work on addiction research, would provide much-needed inpatient treatment. No comparable treatment was available locally, only short-term

detox programs and one privately owned facility that accepted only insurance and cash (a twenty-eight-day stay ran around $20,000), and it didn't allow patients to take maintenance medications.

Unlike Campanello's Massachusetts, Virginia could not rely on anything close to RomneyCare, the 2006 initiative signed into law by then–Bay State governor Mitt Romney, guaranteeing insurance coverage to 99 percent of the state. Virginia's legislature had repeatedly turned down attempts to pass Medicaid expansion in the wake of the Affordable Care Act, sacrificing $6.6 million a day in federal funds and insurance coverage for four hundred thousand low-income Virginians—a frequent source of frustration for opioid-affected families and health care advocates.

In states where Medicaid expansions were passed, the safety-net program had become the most important epidemic-fighting tool, paying for treatment, counseling, and addiction medications, and filling other long-standing gaps in care. It gave coverage to an additional 1.3 million addicted users who were not poor enough for Medicaid but too poor for private insurance.

But in Virginia in June 2014—one year before the first fentanyl spike—statehouse Republicans shut down the Democratic governor's proposal to expand it in a political plot that seemed lifted from *House of Cards:* Democratic coalfields senator Phillip P. Puckett abruptly resigned to give the Republicans an expansion-quashing majority. Alleged motivations for his action included making his lawyer daughter eligible for a judgeship—the senate's policy forbids judicial appointments of relatives—and also allowing him to nab a job with the commission that oversees economic-development investments from Virginia's slice of the tobacco settlement.

The last Democratic legislator west of Roanoke, whose Russell County region in Appalachia remains among the state's hardest hit by the epidemic, Puckett eventually removed himself from consideration for the tobacco post, citing "family matters," while a six-month federal investigation into corruption claims went nowhere.

Perkins hated political maneuvering. In his ideal world, the economics of securing help worked like this: Since addicts would be diverted from jail,

the cost savings from their empty jail beds could be put toward treatment. “The problem is, it’s easier to give money to the corrections system—to the tune of one billion in the state of Virginia—than it is to take a couple of million dollars and provide inpatient treatment for our problem,” he railed, blaming politics and the tendency among jailers and sheriff’s departments to cling to bloated incarceration budgets championed during the War on Drugs, even though two hundred of the city jail’s eight hundred beds were typically empty.

But Frederick Douglass had it right when he said, “Power concedes nothing without a demand.”

Perkins pointed out that most addicted users return to the streets from jail with more drug contacts than they had when they arrived. “I said it all a thousand times, but I couldn’t get anybody to listen because the sheriffs are elected officials with powerful lobbyists, and a poor old appointed police chief doesn’t stand a chance,” he said.

At the first Hope Initiative meeting, stakeholders were so focused on hurdles to treatment that Jamie worried the project would die before it ever got under way. Privately, she reached out to Police Chief Campanello in Massachusetts and asked him to do a conference call with the working group. She even suggested exactly what he should say: that if they waited till they solved all the obstacles, the program would never begin; meanwhile, people were dying every day. By the end of 2015, fifty-one thousand more Americans were dead of drug overdose—a thousand more than died from AIDS in 1995, the peak year. And the epidemic displayed no signs of trending down. In fact, HIV, spurred by the sharing of dirty heroin needles, was on the rise again, with sixty-five new cases reported that year in rural southwestern Virginia alone.

It was exactly what Art Van Zee predicted in one of his first letters to Purdue. “My fear is that these are sentinel areas, just as San Francisco and New York were in the early years of HIV,” he had written of Lee County back in November 2000. Van Zee had no idea then that the OxyContin epidemic would become a heroin epidemic, which itself would lead to more deaths from HIV and hepatitis C.

From a distance of almost two decades, it was easier now to see that we had invited into our country our own demise.

Methadone dispensing room, Gray, Tennesse

Chapter Ten

Liminality

I watched the Hope Initiative take hold in early 2016 at the same time I began following Tess Henry and her cheerful five-month-old son. I hoped that one day their stories would converge. But as loved ones and advocates

eager to help heroin users navigate treatment have shown me, threading a needle blindfolded over a hot bed of coals might have made for a less complicated odyssey.

Tess was nearly seven months pregnant when she left jail in June 2015. For a month, she lived with her mom and tried to make a go of it with her boyfriend, the baby's father—"disastrous," Patricia and Tess agreed—before they found a private treatment center two hours away that would take Tess during her final month of pregnancy. Private insurance covered most of the $20,000 bill while her dad paid the $6,500 deductible, using the remainder of Tess's college-savings fund. The Life Center of Galax was one of the few Virginia facilities that accepted patients on medication-assisted treatment (methadone or buprenorphine). Tess was now taking Subutex, a form of buprenorphine then recommended for some pregnant mothers. (Suboxone is typically the preferred MAT for opioid users because it also contains naloxone, an opiate blocker; Subutex, which is buprenorphine with no added blocker, was then considered safer for the baby but more likely to be abused by the mom.)

After spending the first half of her pregnancy in the throes of heroin addiction and the second half on Subutex, Tess was nervous about the possibility of delivering a child with neonatal abstinence syndrome, a painful state of withdrawal that sometimes requires lengthy hospital stays. The syndrome is common even among so-called Subutex babies, about half of whom require neonatal intensive care and methadone treatment to facilitate their withdrawal from the medication.

An NAS baby is a portrait of dopesickness in miniature: Their limbs are typically clenched, as if in agony, their cries high-pitched and inconsolable. They have a hard time latching on to either breast or bottle, and many suffer from diarrhea and vomiting. When neonatologist Dr. Lisa Andruscavage showed me the hospital's NAS services, nurses who had just spent the better part of an eight-hour shift coaxing an opioid-dependent baby girl born four weeks early to sleep greeted us, only half joking, with "If you two wake that baby up, we will kill you."

While Tess's son was born two weeks early, he entered the world

astonishingly healthy, showing zero signs of distress. He was not among the fifty-five babies born with NAS at Roanoke's public hospital that year, a rate well above the state's average. He was not among the children seen at the region's NAS clinic, where dependent babies released from the NICU come back for weekly check-ins while being very slowly weaned from methadone under their mother's or another family member's watch; despite such attention, around 27 percent of the clinic babies end up in foster care.

In fact, Tess's son was a calm baby, happy to sit on your lap looking at a board book or gumming a teething ring or playing peek-a-boo. He had his mother's intense eyes, and his grin was captivating, bell-shaped and wide. Back then, Tess was fiercely protective, to the point of not letting strangers hold him, even for his first picture with Santa. She held him on her own lap instead, saying she was worried Santa might drop the baby or give him germs—a common reaction among drug-addicted new mothers, an NAS nurse told me. "These moms are so over the top after they deliver because they're trying to show everybody how much they care," Kim Ramsey, the hospital's neonatology nurse specialist, explained. Many have been stigmatized by their friends and families, even by members of the hospital staff.

"Our staff used to be really ugly to them," Ramsey admitted. "They'd say, 'This is ridiculous. These moms need to quit having babies and quit doing drugs,' myself included. We had no understanding that these women's brains have been altered, and what they need now more than anything, for the sake of the baby, is our support."

Asked what her goal was in early 2016, Tess told me: "To be a good mom to my son. For right now it's just to get some good sober time, and eventually go back to school and live a normal life. Luckily, I have a nice family, and I'm not dead or serving prison time. I've been given second and third chances, so…"

The buprenorphine made her "feel normal," as Tess thought of it, with insurance covering 80 percent of the medication's costs. Visits to her addiction doctor were cash only, though, requiring $700 up front and $90 to $100 per follow-up visit, as many as four a month, in order to be monitored

and receive the buprenorphine, which prevents dopesickness and reduces cravings, theoretically without getting you high. “It’s a real racket,” Tess’s mom, Patricia, said of cash-only MAT practices. “And there are waiting lists just to get into most of these places.”

At the time, federal Health and Human Services rules prevented MAT-certified doctors from treating more than 100 patients at a time, a cap adjusted to 275 later that year in response to the opioid crisis. Access to MAT in Virginia would broaden greatly in 2017, thanks largely to the efforts of Dr. Hughes Melton, a Lebanon addiction specialist tapped to help lead the state’s Department of Health opioid response. Every week, piloting his own airplane, he would make the round trip between his Suboxone clinic, Highpower, in Lebanon, Virginia, and his office in Richmond. Melton also worked with state Medicaid officials to broaden reimbursements as well as to include payment for mandatory counseling and care coordination, partly as an incentive for cash-only clinics to begin accepting insurance, including Medicaid.

Some eventually did, but the vast human need for treatment was slow to be recognized, and even slower to trickle down to most communities.

As a work-around to the Republicans’ refusal to expand Medicaid in Virginia, the Governor’s Access Plan, initiated in January 2015, would provide additional addiction treatment and services to fourteen thousand Virginians—but only to a fraction of those in need, and not until 2017, leaving most families to continue navigating wide treatment gaps on their own. “When calling facilities there is rarely a sense of urgency for capturing the addict,” Patricia explained, in the middle of a subsequent crisis with Tess. “An application process has to be completed. How many addicts on the streets have insurance, Medicaid, or ability to fax lengthy applications, or access to large amounts of cash?”

For now, Tess and her mom had to pay cash, up front, at every visit.

Among public health officials, buprenorphine is considered the gold standard for opioid-use disorder because it reduces the risk of overdose death by half compared with behavioral therapy alone. It also helps addicts get their lives together before they very slowly taper off—if they do. One

researcher recommended that MAT users stay on maintenance drugs at least twice as long as the length of their addiction, while others believe it's too risky for long-term addicts to ever come off the drugs.

But black-market dealing of buprenorphine, especially Subutex, is rampant. And the drug *can* get you high if you inject or snort it, or take it in combination with benzodiazepines, a sometimes fatal blend.

Though I'd visited several Suboxone clinics considered to be best-practice beacons in addiction medicine—including Hughes Melton's in Lebanon and Art Van Zee's in St. Charles—a plethora of shoddy prescribers in rural Virginia and elsewhere in Appalachia had given the good clinics a bad name. Operating at clinics often located in strip malls and bearing generic-sounding names, some practitioners defy treatment protocols by not drug-testing their patients or mandating counseling, and by co-prescribing Xanax, Klonopin, and other benzodiazepines—the so-called Cadillac high.

"Their treatment is a video playing in the lobby as a hundred patients walk through to get their meds; it's insane!" said Missy Carter, the Russell County drug-court coordinator who has dealt with widespread Suboxone abuse among her probationers as well as in her own family.

Overprescribing among doctors specializing in addiction treatment was rampant, according to several rural MAT patients I talked to who unpacked how Suboxone doctors prescribed them twice as much of the drug as they needed, fully knowing they would sell some on the black market so they could afford to return for the next visit. Others traded their prescribed Suboxone for illicit heroin or pills.

Almost every Virginia law enforcement official I interviewed for this book despised Suboxone, and most Virginia drug-court judges refused to allow its use among participants. (Nationally, roughly half of drug courts permit use of MAT, though the scales seemed to bend toward acceptance as the crisis deepened.) Critics compared the British makers of Suboxone with Purdue Pharma because of their zest for market saturation and noted that clinic operators have a financial incentive not to wean someone off the drug. "We have people shooting up Suboxone and abusing it every which way," Mark Mitchell, the Lebanon police chief, told me. "For a town of just thirty-four hundred to have three Suboxone clinics—that's absurd."

"People [outside of Appalachia] don't believe me," said Sarah Melton, a pharmacy professor and statewide patient advocate who helps her husband,

Hughes, run Highpower, their Suboxone clinic, which mandates strict urine-screening protocols, with on-site group and individual counseling. Suboxone, with its blocking agent naloxone, “is a wonderful medicine, but we were seeing actual deaths from Subutex here, where people are injecting very high doses of it. And it comes down to these physicians wanting to make so much money, just like they did with the opioid pills!” Subutex is the monoproduct version of buprenorphine; lacking the added naloxone blocker, it is therefore more coveted among some of the addicted, who like the option of being able to take additional opioids such as Percocet at night to get high, multiple users told me.

In Johnson City, Tennessee, just over the Virginia border—where several of the nation’s top buprenorphine prescribers have offices—one cash-only prescriber admitted as much in a public forum, saying, “We give ’em enough so they can sell it and stay in treatment,” Melton recalled.

Buprenorphine is the third-most-diverted opioid in the country, after oxycodone and hydrocodone.

Hope Initiative angels like Jamie Waldrop and Janine Underwood were opposed to buprenorphine because, based on their sons’ experience, it was too easily diverted and abused. Patricia wasn’t initially a fan either, because of the expense and the lack of accountability on the part of Tess’s doctor, whose drug-testing and counseling protocols seemed lax.

She texted me after taking care of a twenty-five-year-old IV Suboxone user at the hospital where she worked who claimed that 90 percent of all Suboxone was abused. To which I gently replied: “I know Suboxone abuse is awful, but at least no fentanyl is in it, so it’s somewhat safer than street heroin.”

Tess, too, had clearly figured out how to abuse the drug meant to keep her off heroin—Patricia found spoons and Subutex powder among her things, and Tess told me she doubled her dosage when stressed. Patricia fumed, too, because all but one of the treatment centers she’d called when Tess was pregnant refused to accept her until she’d been detoxed from all drugs, including buprenorphine. Even the hospital where she delivered the baby refused to give her a script for MAT. Instead they arranged for Tess to

be seen at a local methadone clinic after Patricia refused for a day to take Tess and the baby home, complaining that it was an “unsafe discharge.” They landed at the clinic moments before it closed, with the newborn in tow.

“I’m walking around the methadone clinic parking lot for two hours with a four-day-old baby,” Patricia said. “And it was loaded with addicts. It was a place where Tess’s circle of addicts would become even bigger than it already was.” On days when Patricia had to work, her octogenarian father, who walks with a cane, drove Tess to the clinic.

“It’s a broken system,” said Ramsey, the nurse clinician. Too few obstetricians chose to become waivered to prescribe Suboxone, and very few drug-tested their pregnant moms, afraid of offending upper-middle-class patients and hiding behind their American Congress of Obstetricians and Gynecologists’ recommendation that a verbal screening suffices.

“We need to test all pregnant moms,” Ramsey said in a heated NAS-unit policy meeting I sat in on that pitted pediatric against obstetric staff. “We’re doing pregnant moms no favors by denying them the proper screening. It’s why movie stars and musicians get the crappiest health care—because no one wants to tell Prince he has an opioid problem.”

Tess relapsed not long after giving birth, Patricia discovered when she came home from a walk in the woods to find a man lurking around her mailbox. He told Patricia he’d come to return thirty dollars he owed Tess, but Patricia guessed, correctly, that he was a drug dealer. Tess went back to treatment in Galax for another month while the grandmothers kept the baby, then around six weeks old.

By the time I met Tess, she had just returned home and was hoping to transfer to a sober-living or halfway house—but the problem was, many didn’t allow MAT, and none of the available facilities would allow her to bring the baby. So she was back at her mom’s house and on MAT.

Though she didn’t agree with Tess’s MAT doctor’s protocols and cash-payment restrictions, Patricia was grateful she took Tess on as a patient when all the other area prescribers had long waiting lists.

Tess’s problems were growing worse by the minute, and the systems designed to address them were lagging further behind, mired in bureaucratic indifference.

For several months in early 2016, I drove Tess and her baby to Narcotics Anonymous meetings, recording our interviews (with Tess's permission) on my phone as I drove and walking the baby around the back of the meeting room when he cried.

But Tess was edgy and distracted at the meetings, compulsively taking cigarette breaks and checking her phone. She was glad to leave her mother's house but complained about the first meeting we attended, in white working-class southeast Roanoke, pointing out familiar drug dealers lingering outside the church where the group met. In the past, she'd preferred going to meetings in black neighborhoods because participants there were funnier, tended to have more clean time, and were "way more real," she said.

She had been to twelve-step meetings before, both AA and NA, but felt stigmatized for being on buprenorphine, which many participants perceive as not being "clean," or simply as replacing one opioid with another—a cultural gulf that only seemed to widen in the two years I followed Tess. Although NA's official policy was accepting of MAT, longtime NA members who were asked by the meeting leader to sponsor or mentor Tess politely declined—a shunning that must have "felt like daggers" to her, a relative later said.

If you were drawing a Venn diagram comparing Suboxone attitudes among public health experts and criminal justice officials in the Appalachian Bible Belt communities where the painkiller epidemic initially took root, the spheres would just barely touch.

It had been that way since the birth of methadone, a synthetic painkiller developed for battlefield injuries that was discovered in—or rather, recovered from—German labs shortly after World War II. American researchers soon learned that methadone quelled opioid withdrawal, but the Federal Bureau of Narcotics (precursor to the DEA) was rabidly against using drugs to treat drug addiction. The FBN framed methadone as "unsafe"—read: and maybe even pleasurable—after studies revealed that morphine addicts liked it. The FBN also harassed the handful of doctors

who used it in the 1960s to treat morphine and heroin addiction. Such controversies continue to this day and illustrate the blurry line between lethal and therapeutic, between the control of pain and suffering and the pleasure of a cozy high.

Over the next decade, into the 1970s, that criticism spurred researchers to improve on methadone and to develop compounds that would both block the euphoric feelings and the dangerous respiratory depression brought on by opioids, including methadone. Such compounds led to the development of next-level maintenance drugs: buprenorphine and naltrexone (now known by the brand name Vivitrol).

Vivitrol, an opiate blocker and anticraving drug given as a shot that lasts around a month, has no abuse potential or street value, and would therefore later become the favored MAT of law enforcement. While naltrexone was approved for treatment of opioid and alcohol addiction in 1984, it was slow to gain social acceptability among doctors or addicted patients despite one researcher's belief that it was the "pharmacologically perfect solution." It wasn't widely used until its maker began aggressively marketing the injection to drug courts and jails, beginning around 2012.

Buprenorphine also blunts cravings, and it's less dangerous than methadone if taken in excess, which is why regulators allowed physicians to prescribe it in an office-based setting rather than clinics that have to be visited on a near-daily basis. "I don't think anyone thought the street value of bupe would be significant," the historian Nancy D. Campbell told me. "That is generally thought of as quite a surprise."

But the long shadow of "the heroin mistake," as researchers thought of Bayer's 1898 development for most of the twentieth century, was not forgotten by the medical or criminal justice communities. They remained wary of the notion of treating opioid addiction with another opioid and sought opioid antagonists for that very reason.

Looking back, it was almost quaint how, for most of the last century, the underdeveloped pharmaceutical industry was dominated by governmental agencies like the National Research Council and the Committee on Drug Addiction. These organizations were composed of university researchers and regulatory gatekeepers who focused most of their energies on preventing new addictive compounds from coming to market in the first place.

As early as 1963, progressive researchers conceded that designing the perfect cure for addiction wasn't scientifically possible, and that maintenance drugs would not "solve the addiction problem overnight," considering the trenchant complexities of international drug trafficking and the psychosocial pain that for millennia has prompted many humans to crave the relief of drugs.

When complicated lives need repair, and even the best-intentioned doctors are rushed, it was as clear then as it is now: Medication can only do so much.

While methadone remained on the fringes of medical respectability for decades, the Nixon administration sought it out as a way to control crime and respond to concerns over the fact that 20 percent of Vietnam veterans (at a rate of fourteen hundred soldiers per month) were returning home addicted to opium or morphine. Doctors weren't trusted, though, to both dispense the drugs *and* control for their illicit diversion in an office setting, so highly regulated, stand-alone methadone clinics became the norm.

Such skepticism toward the medical establishment seems extraordinary now, viewed through the more recent prism of hospital hallways dotted with PAIN AS THE FIFTH VITAL SIGN wall charts and embroidered OxyContin beach hats, hallmarks of an era when doctors were encouraged to prescribe high-powered opioids for months at a time. But as liberally as doctors could prescribe opioid painkillers up through 2016, they remained regulated as hell when it came to treating opioid addiction with methadone and buprenorphine—the latter of which only came to market in 2002, after a thirty-year quest for a new addiction-treatment drug.

The battle lines over MAT persist in today's treatment landscape—from AA rooms where people on Suboxone are perceived as unclean and therefore unable to work its program, to the debate between pro-MAT public health professionals and most of Virginia's drug-court prosecutors and judges, who staunchly prohibit its use. Those unyielding viewpoints remain, I believe, the single largest barrier to turning back overdose deaths. In 2016, not long after a Kentucky appeals court mandated its drug courts to allow MAT, President Obama's Office of National Drug Control Policy announced it

would deny funding to drug courts that cut off access to it.

The following spring, President Trump's Health and Human Services Secretary Tom Price would release the first half of the $1 billion appropriated by Congress in the 21st Century Cures Act for treatment and prevention, including expanded access to MAT. But a month later, Price disappointed treatment advocates by publicly dismissing MAT as "substituting one opioid for another." A Tennessee public health official told me Price changed his stance on MAT after NIDA director Nora Volkow showed him the scientific facts: "She worked on him in a hurry." Price resigned a few months later amid a scandal over taxpayer-funded charter flights. In February of 2018, Price's successor, Alex M. Azar II, signaled the administration would significantly expand access to MAT.

Drug courts remain among the country's models for preventing recidivism and relapse, with intensive daily monitoring of participants—randomly, at all hours of the day and night—and swift consequences, such as being thrown in jail when they fail a drug test or commit another crime. Most of the country's three thousand drug courts drop the charges when offenders complete the twelve- to eighteen-month program. Graduates are roughly a half to a third less likely to return to crime or drugs than regular probationers. Drug courts remain, then, an almost singular place where prosecutors, defense attorneys, judges, and mental health advocates gather around a table to coordinate care and punishment, and discuss the daily challenges of the addicted.

The success rate is so good in opioid-ravaged Russell County that Judge Michael Moore told me strangers approach him at the Food City, begging him to place their addicted children in his drug court, even when they haven't been arrested for anything.

But in a place where illegal diversion of Suboxone dominates the court dockets as well as the landscape—I saw a billboard along I-81 for BRISTOL'S BEST SUBOXONE DOCTOR: MOST PATIENTS ARE IN AND OUT IN 30 MINUTES; CALL TO GET ON THE ROAD TO RECOVERY!—only a handful of Virginia's rural drug-court judges permitted participants to be on MAT. "We've had thirteen babies born to mothers on MAT, and not one of those babies had NAS," Tazewell County judge Jack Hurley told me.

"So tell me: How do you put a price tag on that?"

“The best research says counseling doesn’t help: ‘Just give ’em the pill. Give ’em the fucking pill,’” said a local addiction counselor, Anne Giles, who was furious about cultural biases against MAT. According to an analysis of international studies published in the *Lancet*, the best treatment for opioid addiction combines MAT with psychosocial support, “although some benefit is seen even with low dose and minimum support.”

Giles firmly believes that “courts should not be practicing medicine,” and yet, amid growing national consensus about MAT’s benefits, criminal justice too often trumps science, she fumed. People buying illicit Suboxone were self-medicating because federal regulators didn’t permit enough physicians to prescribe it, in her view, and privately operated clinics accepted only cash because Medicaid reimbursements were delayed and covered only a sliver of the costs.

“We should let doctors be doctors,” Giles said. “Because this crisis is a lot like Ebola, where we sent helicopters.” Given opioid-related spikes in deaths, HIV, and hepatitis C, she added, “we should be sending helicopters!”

Fury about the fundamental skepticism toward MAT is not restricted to the medical community. Don Flattery, a member of the Virginia Governor’s Task Force on Prescription Drug and Heroin Abuse, compared anti-MAT judges and police officers to climate-change deniers. He’d lost his twenty-six-year-old son, Kevin, to an opioid overdose and tortured himself for not insisting that Kevin stick with MAT. His son had been on Suboxone before but abandoned it prematurely, after feeling stigmatized for it, in favor of abstinence-only treatment, Flattery said.

Art Van Zee, too, struggled with law enforcement complaints about buprenorphine, though he conceded that too many Suboxone providers in rural America had lax practices that spawned diversion and abuse. To fix the problem, public policy makers should, in Van Zee’s opinion, incentivize more doctors to go into addiction medicine, and MAT should be predominantly expanded in the nonprofit realm of health departments, community service boards, and federally qualified health centers, where salaried doctors are less motivated to overprescribe.

“I think taking an opioid-addicted person and expecting them to do well

in drug court [without Suboxone] is almost cruel and unusual punishment," Van Zee said. "In the legal sphere, all the police and judges see is the worst, ugly part—the trafficking, the kids put into foster care because the mother's found injecting Suboxone." A patient had arrived at his St. Charles clinic recently on her sixteenth birthday, only to learn that she'd acquired hepatitis C from injecting black-market Subutex.

It was simple observation bias: MAT opponents failed to see the distinction between people who abused buprenorphine and those who took it responsibly. "They don't see all the patients I have who are going through college, getting their master's degrees, getting jobs and their kids back, some of them drug-free now for ten or twelve years," Van Zee said.

A few of Van Zee's long-term patients had tapered from 16 milligrams of Suboxone to as little as a half-milligram a day, but he hesitated to wean them entirely because, in his experience, it often led to relapse. Though there was scant data about the efficacy of long-term Suboxone treatment, one study showed that 50 percent of users relapsed within a month of being weaned from the drug; the lower the dose at the time of weaning, the better the outcome. Another study, conducted over five years, showed that roughly a third of buprenorphine patients were drug-free after eighteen months, a third were still on MAT, and most of the remainder were back on heroin or illicit opioids.

When a person is weaned too soon, his or her relapse feeds the perception that MAT is ineffective, reinforcing unfair and faulty notions about the treatment, said Nora Volkow, the NIDA official. "All studies—every single one of them—show superior outcomes when patients are treated" with maintenance medications such as buprenorphine or methadone, Volkow told me. She pointed out that most patients buying black-market Suboxone are really trying to avoid dopesickness—"and that is so much safer for them than going back to heroin."

One Roanoke woman was so desperate to avoid relapse that she prepared for an upcoming two-week jail stint by stuffing a vial of Suboxone strips inside her vagina, knowing local jails didn't allow MAT. "Then, in the middle of the night, she pulled the bottle out, took one, then quickly put it back," said her Roanoke psychiatrist and MAT doctor, Jennifer Wells, who treats indigent pregnant women before and after delivery.

That patient's continued recovery, Wells added, "speaks to the fact that

MAT works. And that patients will go to any length not to relapse. They know what they need!”

But the divide between MAT opponents and proponents only deepened as I followed the travails of the Hope Initiative and users like Tess. While treatment providers, police, and family members were arguing about the best way forward, lives hung perilously in the balance.

It was hard being Tess. After four NA meetings, she stopped wanting to go, often texting me just as I was leaving to pick her up. The baby was sleeping, or she was too tired because he’d kept her awake the night before. His father was in jail after an alcohol-related arrest. And though his mother stepped in often to babysit, she was planning to move to North Carolina and hinted that she wanted to take her grandson with her.

Having grown up in an alcoholic household, I knew what it felt like to live on the periphery of addiction—the potential danger of being neglected, taken advantage of, or even raged against. And being with Tess sometimes brought up memories of a much darker time. I worried about her son and felt sorry for him. There were instances when journalistic boundaries blurred, such as the night Tess texted me from an unknown location:

Can yoi please come gwt me.

I was in the middle of organizing taxes, with the help of my spreadsheet-whiz niece, and didn’t see the text immediately. An hour later, I weighed what to do, talked to my husband, and ultimately forwarded Tess’s plea to both Patricia and Jamie Waldrop, who was Tess’s Hope volunteer. The next time I saw Tess, neither of us brought it up.

It was February 2016, and Patricia believed Tess was using again—items from the house started vanishing, including a laptop, and she discovered empty heroin baggies in her bathroom trash—but Tess vehemently denied it.

Family stress was high. Tess’s parents had different opinions about the best course of treatment, and Tess believed her siblings looked down on her as the black sheep. Her dad, Dr. Alan Henry, begged her to enroll in a

twelve-month residential recovery program at the faith-based Roanoke rescue mission, but the mission banned stimulants of all kinds, from cigarettes to MAT, and Tess was not only still on buprenorphine and a heavy smoker, she was also a proud atheist. “The one thing that becomes clear is, there is misunderstanding with the siblings and with me on the distinction between helping and enabling that remains very murky,” Alan Henry told me later, suggesting that whereas he and Tess’s siblings preferred a tough-love approach, Patricia and her father were too easily manipulated by Tess, he thought.

Tess’s older sister, an AA proponent, begged Tess to adopt the Twelve Steps as she had done, arguing that the program emphasized spirituality over religion. “I told her, ‘Use Koda [Tess’s dog] as your higher power, for all it matters; just pray to *something.*’” But Tess laughed and said, “That’s ridiculous.” Soon after, a dopesick Tess asked her for money to buy buprenorphine, and her sister, believing Tess would spend it on heroin, offered her a ride to a meeting instead.

“I’m not trying to go sit in an AA meeting and listen to that bullshit,” Tess told her. “And you’re not my sister.” They stopped speaking.

When Patricia proposed that Tess consider other long-term treatment programs, MAT or not, she refused, turning argumentative and sharp. Her mom had a full-time hospital job with irregular hours; her shifts often ran longer than twelve hours, leaving Tess home alone with her son. Patricia had a security system installed in her home. But two cameras weren’t nearly enough.

In March, Patricia arrived home to find Tess stumbling around the house, seemingly high, and clothes from one of the bedrooms vanished—pawned, presumably, for drugs. “I’m meeting with my attorney,” Patricia told me, shortly after this incident. “I can’t just kick her out because she’s been here awhile.” A guardian ad litem would be appointed by the court to weigh in on what was best for Tess’s son.

“Everything’s such a mess, and in the middle of it is this gorgeous, beautiful boy,” Patricia said. Now seven months old, he was ahead of developmental schedule and before long he would babble his first word: *Mama*.

Tess maintained she was not using, but evidence to the contrary kept presenting itself. Patricia sometimes arrived home from work to find her security cameras turned to the side. Once, awakened by the baby's cry in the middle of the night, she found him on the couch, "only he could barely sit up, and he's leaning over, and he's crying. He had a piece of a bottle, a plastic tube, and he could have choked."

And where was Tess? "She was in the bathroom putting on makeup! She was superhigh," with her baby about to tip onto the floor. "It is so embarrassing and so painful, trying to make this work," Patricia said. "Your giving starts to give out."

The guardian ad litem saw what was happening, and by late March, Tess lost custody of her son. A judge awarded shared custody to the grandmothers, and Tess was no longer permitted to live at Patricia's, though she could visit her son when Patricia was home.

That spring Tess moved into a cheap motel, a known haven for drug users and dealers, with no car. To regain custody, she had until July 18 to find a job and a place to live, and prove her sobriety. She was mad at her dad for not loaning her money for an apartment down payment and furious about being unfairly painted as an unfit mother in court. "Even if I did take a Xanax when I was with [my son], I've never been fucked up. I've never not changed his diaper," Tess insisted. Asked if it was difficult to stay away from other heroin users, Tess said, "When I'm angry and I have nothing, it's really hard."

She was trying to switch to a Suboxone doctor who accepted Medicaid, which she was now enrolled in, but that physician had long ago reached his federally mandated cap (then a hundred patients). A hundred dollars in debt to her Blacksburg psychiatrist and cash-only MAT provider, Tess had to pay the balance before she could be seen again, and meanwhile she was down to just a week's supply of MAT. She'd tested positive for marijuana on her last doctor's visit: "I was having really bad anxiety, and I thought pot would be better because at least it's herbal," she said.

By May, Tess was couch-surfing in low-rent apartments in southeast Roanoke and using heroin daily. She posted a cry for help on her Facebook

page, ending with a quote from a Lil Wayne/Eminem song: “Been to hell and back / I can show you vouchers.” She went by the street name Sweet T.

Though the Hope Initiative was still months from opening its doors, Jamie reached out to Tess on Facebook: “Call me if you need help. I might just know of something right up your alley, Girl. Much love.”

Tess called immediately. She wanted to hear how Jamie’s older son, whom Tess had once dated, had gotten sober. They made plans to meet the next day, but Tess canceled at the last minute.

By early June her son’s dad was out of jail. They squabbled, it turned violent, and Tess went deeper underground.

Patricia and Jamie worked their contacts to find her. Jamie’s son showed her where they’d once done drugs together while Patricia, worried that Tess was seriously hurt, filed a missing-persons report.

They distributed flyers across the region and on Facebook with a smiling picture of Tess and her description: “Last seen June 11, 2016. Brownish/red hair, green eyes, 5' 7", 130 lbs. Tree of Life tattoo on left shoulder blade.” Two days later, police received a report that Tess had stolen a car and a credit card—she’d been sent out for groceries by a woman she was staying with and never returned. Police found and arrested Tess later that day.

Patricia texted Jamie the news: For the first time in months, she told her, she could go to sleep knowing that, at least for that night, her daughter would not die.

The baby was a toddler now, and Tess hadn’t witnessed a single one of his steps. He was living with his other grandmother in North Carolina, and Patricia made the twelve-hour round-trip trek to see him monthly, texting me pictures of their visits: her grandson playing on the beach, wearing a silly sock monkey hat.

Summer turned into fall as Tess bounced between the streets, jail, the battered women’s shelter, and the psychiatric wards of two local hospitals, the last of which she knew were prevented by federal law from turning suicidal patients away regardless of insurance status or ability to pay. “It’s so costly and ineffective,” said psychologist Cheri Hartman, another Hope volunteer. “If only [politicians] understood that getting access to Medicaid

would actually save money and lives!”

Tess wanted Jamie to find a long-term rehab program for her. “But we all know once her withdrawal gets bad enough she will want to be released and get her fix,” Jamie said in July. “Pray that this time we can get her somewhere before that happens.”

The moment an addict is willing to leave for treatment is as critical as it is fleeting, Jamie said; she called it the liminal phase. “You only have a very small amount of time; you have to strike while the iron’s hot.”

But Tess disappeared, again, before they could meet.

The next time Patricia saw her daughter, she was nearly naked, posing for an ad on a prostitution website under the headline SWEET SULTRY SEXY 26. The baby’s father had discovered the ad through Tess’s cellphone number and told his mother, who alerted Patricia to it.

A half hour for sixty bucks. There were pictures of Tess, crudely posed with her face cropped out, and a cellphone contact. “I looked at it as a way to contact her and let her know I still love her and support her. There’s nothing more I can do for her” until she’s ready to accept help, Patricia said.

She was covertly tracking Tess via instant messenger now, a holdover from months earlier, when Tess signed onto Facebook using Patricia’s phone but forgot to sign out. She’d read heartbreaking exchanges between Tess, her drug dealers, and her friends, including another young woman from Hidden Valley, Jordan “Joey” Gilbert. Tess and Joey compared notes about dopesickness and black-market Subs (Suboxone or Subutex). They’d arranged to meet once to trade Xanax for crystal meth.

Joey had had earlier success with the monthly naltrexone shot, Vivitrol, which is expensive but also impossible to abuse or to divert. Among the thirty-one states that had then expanded Medicaid under Obamacare, some improved access to naltrexone, even giving Vivitrol shots to people before they left prisons and jails, since they understood that addicted users were most vulnerable to overdose death just following a period of nonuse, when tolerance is low. But Joey lost access to the shot when she turned twenty-six and was no longer on her father’s insurance. “Without insurance, it would have cost us fifteen hundred dollars a month,” her father, Danny Gilbert, said.

Joey eventually transitioned to buprenorphine, prescribed by Dr. David

Hartman, the same Roanoke psychiatrist with the mile-long federally mandated waiting list that had stymied Tess. “Dr. Hartman would not write the prescription unless she passed her weekly drug test,” Danny Gilbert said. “And I held all her medication and gave it to her daily so there was control over it,” at an average price of around $700 a month.

But there were still so many hurdles Joey faced in her quest for treatment, from the waiting lists that kept her from starting rehab to the byzantine rule that she had to be drug-free upon entry, not to mention her continued drug usage with people like Tess—all of which put her perilously close to relapse and death.

In late October 2016, Jamie Waldrop and I visited Tess in the psych ward of a local hospital; she’d checked herself in, complaining of anxiety and suicidal thoughts. There was an outstanding arrest warrant out for her from a fraudulent seventy-eight-dollar credit-card charge earlier in the year. Her son was now fourteen months old, and Tess hadn’t seen him in eight months.

She’d asked me to bring her a copy of my latest book, *Truevine*, which she’d read about in a *People* magazine at the psych ward. She thanked me for it and said it was OK when I asked to take notes. Her writer hero, David Sedaris, was about to publish a new book, and I promised to try to get her an autographed copy when it came out.

Tess told us she was no longer using heroin, that she now favored crack cocaine. “I thought the cocaine would help me get off heroin,” she told us. “And it did, actually…but it’s very mentally addictive.”

Asked if it was a relief to be off the streets, Tess nodded. “When it starts getting cold out, I’m ready to come in for help.” She’d been beaten by a drug dealer, she said, but didn’t want to go into details. Jamie recommended an Asheville rehab that she had sent other people to, with good results, she said, but it would not accept patients on MAT or the antidepressant Cymbalta, which is sometimes not recommended for people with substance abuse disorder.

“That’s the one I’m on,” Tess said. But Jamie remained relentlessly upbeat throughout our visit and promised to double-check on the Cymbalta,

and Tess seemed brighter and more hopeful than she had in months. The Asheville rehab featured a regimen of horticultural work during the day and intensive group therapy at night.

"It's kinda hippie-ish," Jamie said, knowing that would appeal to Tess.

"Like Warren Wilson?" Tess said, hopefully, referring to the liberal-arts college nearby.

She would not be allowed to talk to anyone back home for six months. It would drive her crazy not to see her son or hear about him, she said, "but my goal is, I want to get him back."

But the liminal window passed, as it usually did, when Tess checked herself out of the hospital before the Asheville rehab bed, or any others, could be secured. "She's back out again," her mother said. "All it takes is one contact, one blinging on the cellphone, and there they go, spiraling again."

The flood of street fentanyl had not slowed. From September to November 2016, Roanoke claimed the highest number of emergency-room overdose visits in the state, most fentanyl-driven. EMS workers reported having to give people as many as five doses of the anti-overdose drug, naloxone, to reverse its effects. One such call ended with a young mother dead in her bedroom, her baby beside her in the bed, cooing.

A week before Christmas, Patricia showed me a card she was mailing to Tess, with pictures of her son tucked inside. She'd found what she believed to be her current address from a series of Facebook exchanges between Tess and her drug dealers, some angry ("Damn man. You stole shit from me") and some matter-of-fact. She was staying in another apartment in southeast Roanoke, catty-cornered from the church where I'd first taken her to NA.

Patricia wanted to tell her about a new Beck song that began:

> I met you at JC Penney
> I think your nametag said "Jenny"

It was their favorite department store, the place where she bought Tess a

new wardrobe every time she left a hospital or rehab stint—only to return home, months later, with just the clothes on her back.

"It scares me now when she comes home," Patricia admitted. She'd locked up her shotguns; a sport shooter, she was afraid they'd end up pawned the way her laptop did. All but two of her spoons were missing from the house, swiped for heroin mixing, she assumed. "It's like there's a demon inside her," Patricia said. "I do get mad at her, and there are times I want to say, 'I quit.' But the truth is, and I want her to know this, I'll never give up on her."

Tess had made her way home briefly at Thanksgiving and insisted on cooking for the entire family, never mind the bandage on her arm, an abscess from a dirty needle that required emergency-room care. But in spite of her efforts, Tess felt her contributions to the meal went unrecognized by her siblings, and she got high the following day on pills and alcohol Patricia had hidden in her shed.

That weekend Patricia bought matching bracelets for the two of them with the inscription "Your heart is my heart." The saying was inspired by an e. e. cummings poem Tess admired and adopted as a kind of mantra about her feelings for her son. Tess had won a national high school poetry competition in 2001; Patricia still kept her winning poem displayed in her kitchen. Over the next several months, whenever she texted me with updates, she referred to Tess as "our poet."

They made an appointment to get Tess's hair highlighted. They were supposed to pick her little boy up from his other grandmother's North Carolina house. It would be his second Christmas, and Tess was eager to see her son. They'd already bought his Christmas presents along with clothes for his Santa picture, complete with a matching sweater and pop-a-collar shirt set, bought used from Once Upon a Child.

"We had all these plans, and then suddenly the switch just goes," Patricia said.

On her way out, the week after Thanksgiving, Tess left a note on her mom's kitchen counter:

> Gone to Carilion [psychiatric ward]. Mental Breakdown. I LOVE you so much Mom. You are my everything. I want to get better & I won't stop

trying.

Portrait of Bobby Baylis, held by his mother, Janine Underwood, Roanoke, Virginia

Chapter Eleven

Hope on a Spreadsheet

Tess's best chance for recovery, everyone thought, came down to a five-page spreadsheet. The volunteers at Roanoke's new Hope Initiative had

spent months crafting it—a list of thirty-six rehab and aftercare providers in the southeastern United States they could contact to arrange treatment, depending on the patient's finances and the centers' availability of beds. A few volunteers also helped arrange outpatient MAT, but the angels were divided on its effectiveness, many believing it was wrong to treat drug addiction with another drug, despite scientific evidence to the contrary. Users could drop in at the Bradley Free Clinic on the second Monday of every month and, if police officers found no outstanding warrants against them, pair them with trained volunteers who would troubleshoot their care. Social service workers would be on hand to help those who qualified apply for Medicaid.

It was now early 2017, and fentanyl-overdose calls were coming in at a rate double that of the same period the previous year. In a region of three hundred thousand people, emergency-room doctors were now seeing drug overdoses daily—sometimes as many as three opioid-involved "gold alerts," or severe trauma cases, at a time. In a single hour that April, three such patients would turn up in the ER of Roanoke Memorial Hospital, including a taxi driver found unconscious along the side of the road and a tree trimmer who'd been dropped off by a friend after injecting himself with two fentanyl-laced shots of heroin; he'd taken a second dose because he didn't think the first one had worked. Emergency-room physician Karen Kuehl begged him not to leave the hospital after he was resuscitated: "I don't want you climbing trees today."

Once revived, the man got up, politely thanked her, and left, saying, "I've got to go to work." An older woman was expecting him to trim her trees that morning, he said, and she'd be disappointed if he didn't show.

In one weekend the following month, a local seventh-grader died of a probable overdose, the region's youngest victim so far. The wife of Janine Underwood's building manager at the clinic was getting her hair done only to be interrupted by the sound of a spectacular crash in the parking lot outside—a middle-aged professional man had passed out while driving, a heroin needle stuck in his arm, and crashed into her car.

Kuehl was studying opioid-related hospital protocols in Ontario, where overdose patients are automatically referred from emergency rooms to outpatient medication-assisted treatment and counseling. "We need to do a smooth handoff here," she said. She was helping local psychologist Cheri

Hartman, one of the Hope Initiative coordinators, set up a similar transfer in Roanoke, but they were stymied by bureaucratic, financial, and legal hurdles, including a shortage of MAT providers and not enough opioid-detox and treatment beds.

Both were hopeful about a grant they were applying for to make the handoff smoother. Until then, Kuehl said, hospital social workers were referring revived overdose cases to Hope—among them an increasing number of people who were passing out while driving.

The state was concurrently working, through Carilion and other hospital networks in the state, to free up money to train peer recovery specialists who would facilitate the treatment handoff among overdose patients and others seeking treatment for both opioid-use disorder and mental illness, but the program wouldn't be operational for many months. "Right now everyone is running around in crisis mode, trying anything they can, but there's a lot of mismatched interventions, and no sense to it," one health-system insider told me.

"In the meantime," Kuehl told me, sighing, "I'm definitely getting a bigger car."

Four months later, the women were crushed to learn they did not get the grant.

Though she was still grieving her son's fentanyl-overdose death—Bobby had been dead now for fourteen months—Janine Underwood thrust herself into the Hope project with vigor. She wasn't a believer in harm-reduction strategies or MAT, but she was trying to keep an open mind. When users shot up in the parking lot at the clinic—"getting their last hurrah," she called it—police declined to take action, knowing it would inhibit users from coming.

Like most of the angels, Janine allowed participants to contact her on her personal cellphone. Texts and calls came by the scores, ranging from grieving mothers who wanted the ear of another mom who'd lost a child to a young heroin user named Matthew who'd heard about the program and just wanted to talk. He was suicidal, he said, and they spoke multiple times over the course of several days.

When Janine learned that Matthew had hanged himself the day before he was scheduled to come in, she fell apart. “Before I knew it, I was becoming a crisis center,” she told me, a month into the program. “I was in over my head.”

The following week, a young woman escorted to the clinic by police staggered indoors, then exhibited signs of overdose in the clinic foyer, necessitating a 911 call and several doses of naloxone to bring her back. And though Janine left follow-up messages with her, she never called or returned.

A conservative Rotarian, Janine realized that barriers to treatment were more formidable than she’d understood, as was the epidemic’s scope. It wasn’t just the money and limited treatment capacity that waylaid people; it was the morphine-hijacked brain, the scrambled neurotransmitters that kept people from thinking clearly or regulating their pain with nonnarcotic substances, or imagining the possibility of feeling happy again.

Janine wished for a way to force users into treatment, a detention order for the heroin-consumed brain. Bills to involuntarily commit users were increasingly being introduced in state legislatures from Kentucky to Massachusetts, but there were civil liberties concerns, and patients-rights groups and many experts believed coerced treatment backfired more often than not.

Twenty-two people walked into the Hope Initiative in the first month, and the angels felt they were making progress with some, the ones who expressed repeated interest in getting help and continued to text and call. Still, exactly zero of them had entered residential treatment, and only a handful had been able to access outpatient MAT. Janine was so mentally exhausted that her colleagues had to call EMS after she passed out from stress-related vertigo at work one Saturday.

Looking back now, the spreadsheet the angels had so carefully created seemed naive, akin to spraying citronella oil on a termite infestation and expecting your home’s crumbling foundation to magically reconstruct itself.

The first Hope Initiative success came months into the program and took weeks of life-and-death negotiations—dozens of phone calls, days of hand-

holding, and thousands of dollars, eventually, to arrange residential treatment placement for a single patient. Janine had personally spent eight straight hours in the emergency room with the family of “John” (not the person’s real name), a ten-year heroin user who had been a friend and fellow user with her son Bobby. John had tried detoxing at home, but his parents took him to the hospital when he became too sick, partly from needle-stick abscesses on his hands and arms, his temperature soaring to 103.

Janine wiped the young man’s dopesick sweaty brow, rubbed his back when he writhed in pain, and comforted him when nurses could not find a vein receptive to a medication IV. His parents sat nearby, paralyzed in their fear and unable to help. “I want to get this out of me,” John told Janine, between screams. “It’s like a demon, and I want to get it out.”

Janine had pulled strings to have John directly admitted from the hospital into detox, a rare handoff with no waiting—only to be slammed by the emotional wallop of visiting John the next day and walking the same corridor where she’d once delivered clothes to her son. “Because of his connection with Bobby, I feel like he’s listening to me, but the truth is, he could walk out any time,” Janine said. By day three of detox, John was already calling his parents and pleading over the phone, “Dad, come pick me up.”

A Hidden Valley couple, his parents were unable to direct his care or even process what was happening to him. They’d been enabling John’s addiction for ten years, supporting him and allowing him to live in their home. “They were completely frozen,” Janine said.

John’s dad, a retired law enforcement officer, told Janine he’d given many tough-love lectures to parents on the job, but when it came to his own son he was helpless, even denying that the constellation of scars on his son’s arms were track marks.

“They couldn’t even call the detox center from the hospital; they needed someone to do it for them,” Janine said.

And: “They have the disease, too.”

When it came time to discharge John from detox, a Hope volunteer working with John’s father arranged for him to fly to an out-of-state treatment center, but it was up to Janine to make the transfer work. To do that, she coaxed the detox center to keep John an extra day, then arranged

for an intervention between John and his family members off-site. (Detox managers would not allow the meeting to take place there, not even in their parking lot.) “I was starting to panic; I had that sick feeling in my stomach again,” Janine said. The liminal window was beginning to close.

John’s father hired an “interventionist,” a retired cop whose job was escorting, by force if necessary, reluctant patients into treatment. Another local agency offered a conference room, and everyone involved lied to John to get him there, saying it was outpatient counseling he was signing up for on his way home, not residential care.

“I played the Bobby card,” Janine admitted the next day on the phone.

And yet it had still taken four hours to persuade John to go, the volunteer angels sighing, finally, when he got on the plane.

As soon as one bureaucratic gap was stitched up—and that could take days—another rip appeared. Government help was on the way in many states, but the national treatment tapestry remained a hodgepodge, divided not only along geographical but also firm ideological lines.

In late 2016, Virginia State Health Commissioner Marissa J. Levine declared the state’s opioid crisis a public health emergency, noting that three Virginians were dying every day from drug overdose and that emergency departments across the state were seeing more than two dozen overdose cases a day. Levine also issued a standing order, or blanket prescription, allowing any resident to buy the opioid antagonist naloxone (brand name Narcan), the overdose-reversing drug.

Public health officials in Vancouver were miles ahead of most of America in so-called harm reduction, a social justice movement aimed at reducing the negative consequences of drug use—without necessarily ending the use—and, more broadly, treating users with dignity and respect. The basic theory being: Users can’t get sober if they’re dead, and it’s cheaper and more humane to give them clean syringes, say, than it is to pay for HIV and/or hepatitis C treatment. Vancouver officials launched supervised injection sites where nurses stood by to revive overdosed users, fostered the free exchange of used needles for clean ones, and distributed naloxone. Sites in Toronto and Ottawa were also approved.

Several liberal-leaning American states and cities have used Vancouver as a model, including Seattle, where officials in 2017 approved the nation's first safe-injection program for users of heroin and other illegal drugs, even though it was still illegal under federal law. In Massachusetts, where the opioid death toll now claimed five lives a day, some Bostonians carried naloxone kits, signaling their ability to administer it by placing a purple ALLY patch on their backpacks. Prevention workers were piloting fentanyl test strips so users could gauge the potency of the drugs before they used them, then take smaller doses, avoid using alone, and have naloxone at the ready in case of overdose.

In San Francisco, Seattle, Philadelphia, and even Greensboro, North Carolina, drug-user unions were working to combat the stigma of addiction and advocate for harm reduction, pushing for wider naloxone distribution and needle exchanges, and even negotiating with drug dealers when batches of fentanyl entered the local supply. "Our goal is to end the drug war and to hold treatment providers accountable," said Louise Vincent, who runs a Greensboro needle exchange paid for by state and private funds. "When you pay fifty thousand dollars for treatment and rehab, I believe you should get the gold standard of care," including MAT, she said. She also argued for stricter regulations of "cash-cow Suboxone clinics."

But there is still only one treatment bed available for every five people trying to get into rehab, and at a cost far beyond the financial reach of most heroin users. And for all the treatment money paid by people like Tess's octogenarian grandfather, rehab isn't standardized, nor does it often dovetail with what science says is the gold standard for opioid treatment: medication-assisted therapies. (Only about a third of all U.S. treatment centers allow MAT.)

"It's really going to take doctors standing up for this, and it's going to take going against the very vocal twelve-step recovery community, which is most at odds with the work the harm-reduction movement is trying to do," said Vincent, a recovering heroin user who pays $480 a month, cash, for daily methadone maintenance.

In Baltimore, where the overdose death rate was six times the national average (and where much of Roanoke's heroin supply originates), the health department has long deployed a needle-exchange RV to heroin hot spots six

days a week, offering disease testing in addition to clean needles, naloxone training, wound care for injection abscesses, and prenatal care. The initiative is credited with reducing needle-injected HIV instances from 64 to 8 percent. Conservative then–Indiana governor Mike Pence responded, albeit reluctantly, to the 2015 Scott County HIV outbreak that infected 175 people with a limited needle exchange.

In San Francisco, recovering heroin user and certified addiction specialist Tracey Helton Mitchell launched her own renegade harm-reduction movement in 2003 by mailing out free packages of clean needles and naloxone vials. In the opioid-minded Reddit forum where she became known as the Heroine of Heroin, Mitchell still shared counseling and intervention strategies, answering some fifty emails a day.

She continues to receive calls from frantic users in large swatches of the country eager for clean needles, information, and naloxone. “We’re in the absolute dark ages in most of this country for syringe exchange,” she told me, describing users with worn needles broken off in their arms, or people who reuse needles found in the gutters and then sharpened with matchbooks. “We’re years behind catching up, and the drug deaths haven’t even peaked yet.”

And yet the ideological gulf I witnessed between the criminal justice establishment and families like Tess’s seemed to grow wider by the day. Kevin Coffman, a drug task force member who’d worked the Ronnie Jones case, told me he firmly believed we could end the opioid epidemic with a single stroke of Trump’s pen: imprison heroin users *for life* the third time they got caught with the drug, and that would have a chilling effect on remaining users, who would logically, he believed, give up their drugs.

We were sitting in the same room where Coffman and Bill Metcalf had mapped out Jones’s heroin ring. It was next to the kitchen, where a TRUMP–PENCE sticker was pasted on the refrigerator door. Not only did the detective have zero empathy for the addicted, but he also lacked any scientific understanding of the morphine molecule’s pull.

Nor did some of my dear friends, longtime members of AA, who remain staunchly opposed to harm reduction and MAT for those working its

twelve-step program. “There’s a reason why some people think NA and AA are cults,” said Mitchell, who used methadone, needle-exchange programs, and a secular support program called LifeRing to treat her heroin addiction. “They can’t take in any other information because it throws a different light on their own personal recovery.”

As Trump-appointed attorney general Jeff Sessions said in March 2017: “We need to say, as Nancy Reagan said, ‘Just say no.’ Don’t do it.”

Two months later, the Trump administration proposed gutting the office of the White House drug czar, reducing its budget by $364 million, despite Trump’s campaign vow to combat the nation’s growing opioid epidemic, and backed health care changes that would have put the most vulnerable users at risk. After a backlash, Trump rolled back his proposal to relatively modest trims. But more than a year after his inauguration, the office still lacked a permanent director, Trump remained more focused on law enforcement than public health strategies, and a comprehensive list of recommendations written by his own presidential commission remained a work in progress or unaddressed.

Harm reduction remained slow to catch on in most of the Bible Belt, including Roanoke. When I told Janine about an idea hatched at an opioid brainstorming session in Boston—to segregate users on a boat in international waters, where they could legally inject under medical supervision, ideally then transitioning to counseling and MAT—she was repulsed. “That’s crazy! We’ve created this problem, and now we decide we’re just going to continue to let it happen, and that’s the answer?”

And yet she was miles ahead of most leaders in her conservative community. She’d told her son’s story recently to the local school board and county officials, hoping to raise money for the county’s risk prevention council, which was currently running on fumes and a few small federal grants. She’d explained how she’d pulled strings to get her kids into the Hidden Valley school zone because she considered it a superior place to raise children. But the affluence she believed would protect her family had instead allowed the festering of shame and inaction. Almost daily the Hope Initiative took a call about a heroin user from Hidden Valley or nearby Cave

Spring, and police data showed that the problem was worse by far in those two communities than in other, less affluent areas of the county.

"I was just a mom trying to make them aware of what's happening here, that they should be aware. But there was dead silence in the room," Janine said. "Nobody asked me a question. I just spoke, and I sat down."

The school board declined to support the program, and the county gave its usual $2,000.

Of the fifty-seven people who came seeking treatment in the Hope Initiative's initial months, the volunteers had persuaded only two people to begin residential treatment. About fifteen were referred to MAT outpatient programs—seven of whom were still in recovery a year later. Neither Tess nor her friend Joey was among the successes, though both were regularly in touch with Hope volunteers.

Tess seemed to be nowhere close to accepting help, Patricia told me, in early 2017. We sat next to each other at a drug-prevention forum put on at Tess's alma mater, Cave Spring High, as judge after cop after grieving parent talked about rising overdose calls (thirty in the first six weeks of the year), more than a doubling of Narcan administrations, and increasingly potent seizures of fentanyl-spiked heroin.

Janine told Bobby's story publicly for maybe the twelfth time. She finished by describing a recent visit to an urgent-care center with her teenage daughter, who'd sprained her thumb playing softball. After an X-ray and an exam to rule out a break, the doctor wrote her fifteen-year-old a prescription for a twenty-five-day supply of oxycodone.

"I tore it up," Janine said. She also called clinic official Dr. John Burton, who said of the incident: "This was a provider who was still doing things the way we used to do them five years ago, and he didn't get the memo." A come-to-Jesus ensued, with Burton reminding the doctor of the hospital system's ER policy of no more than three days' worth of oxycodone or hydrocodone per prescription, sans refills.

During the Q&A at the end, Patricia stood in the audience and described Tess's descent from Cave Spring honor-roll student and athlete to heroin addict and prostitute, preyed on by a growing network of drug dealers and

pimps.

“I never saw it coming,” she told the crowd. “And I don’t know what the answer is, but I know it’s important we take heroin out from under a dirty rug. We should be talking about it the same way we talk about cancer.”

At the moment, Tess was back in the psych ward of a local hospital, Patricia said later. Hope volunteers Jamie and Terrence Engles were trying to coax her into a long-term rehab center in Nevada, but they were concerned, again, about the problem of the fleeting liminal phase—having a bed available the moment Tess was released from the hospital, not to mention coming up with the $12,000 she still needed for treatment, less the last bit of her college fund. She considered asking her eighty-five-year-old father for an early release of the inheritance he planned to leave for Tess, knowing the money would be no good to her dead.

Patricia had visited Tess at the hospital the night before, taking her grandson with her, and Tess beamed at the sight of her boy. It was the first time she had seen him in ten months.

But she had a methamphetamine rash on her face, and track marks extended from her biceps to her wrists. She was newly diagnosed, too, with hepatitis C, her weight down to ninety pounds. When Tess got on the hospital floor to crawl around with her son, Patricia saw abscesses on the back of her head. “She’s the sickest I’ve ever seen her, but she has no idea how sick she is!” Patricia told me.

After the forum, Tess’s onetime track coach walked up as we were talking and told Patricia he was stunned by her remarks. “She was such a good kid, I mean…Tess was just an awesome kid.”

The latest research on substance use disorder from Harvard Medical School shows it takes the typical opioid-addicted user eight years—and four to five treatment attempts—to achieve remission for just a single year. And yet only about 10 percent of the addicted population manages to get access to care and treatment for a disease that has roughly the same incidence rate as diabetes.

But Patricia wasn’t giving up on her father’s generosity, and she wasn’t giving up on Tess. Neither was Jamie. “We all knew that if we didn’t

actually have a car waiting to take her to the airport from the hospital, she'd never go," Jamie said.

Tess had lost her ID, and Patricia persuaded a kindly hospital employee who happened to be a notary public to create a new, makeshift one for her so she could get on the plane. Hope volunteer Terrence Engles, in recovery for five years, coordinated the transfer between the hospital and the cab that ferried Tess to the airport on February 26, 2017. The Nevada treatment center did not accept patients on MAT. Tess had quit Suboxone months earlier—she'd lost her Medicaid coverage when her son was removed from her care—and was mostly now using crack and heroin.

Tess would end up being the Hope Initiative's fifth person to be funneled into residential treatment, though only time would tell if the Nevada attempt would be her last. "I feel like a spectator watching a movie and just hoping and praying it ends well," Jamie said.

Patricia compared the precariousness of the situation to a balloon with a pin poised a millimeter from the edge. "It's like, dear God, please *please* do not pop this balloon," she said. "Because there is no love you can throw on them, no hug big enough that will change the power of that drug; it is just beyond imagination how controlling and destructive it is."

After an initial hiccup—Tess transferred in her second week to a smaller women's facility nearby called the We Care House, saying the first place wasn't a good fit—Patricia said she was "doing great" a month in, and would soon transition to aftercare. Her granddad had stepped in with her early inheritance, putting $12,000 toward her treatment.

Jamie Waldrop and I both sent cards of encouragement, and I included a copy of Mitchell's *Big Fix: Hope After Heroin* because it offered the clearest framework for getting sober that I had read. The author, in recovery for nearly two decades, was not opposed to MAT (even though replacement medication had not been her ultimate path), and her book was full of hopeful data like this:

If Tess could remain sober for a year, she had a 50 percent chance of relapsing. If she stayed sober five years, her chance of relapse was less than 15 percent.

At the Hope Initiative, triaging Tess now shifted to triaging her friend Joey Gilbert. The two had couch-surfed together in southeast Roanoke, trading intermittent texts about dopesickness, Xanax, and crystal meth. Joey had arrived at Hope with her mom in early 2017. She tried going cold turkey during a brief stint at the abstinence-only rescue mission program—and didn't last twenty-four hours before fleeing, telling Jamie she was too sick and couldn't handle it. "She told me, 'As long as I can use the Suboxone, I can wean myself down,'" Jamie said. Her goal was to become someone who helps other people get off drugs.

"I know I can do it," she'd tell Jamie.

"I know you can, too," Jamie said.

A beautiful young woman, with long blond hair and blue eyes like crystal orbs, Joey had graduated from Hidden Valley High in 2007, the same year as Tess. She excelled in art and music, and once had a three-year string of near-daily Goodwill shopping fueled by a personal style rule that every accessory or piece of clothing had to match the color she'd chosen that day—if her outfit was green, then her earrings, shoes, and tights had to all match, down to her rings. Joey liked to share her opinions on everything from Freddie Mercury to eye makeup to the best dance moves when making a Facebook workout video to the Prince song "When Doves Cry."

"She's the funniest person I've ever known; she's literally a ball of fire," said her best friend, Emma Hurley. A boyfriend had introduced Joey to pills in high school, then heroin shortly after that. They were part of the Hidden Valley group of early opioid users that included the late Scott Roth and Janine's son Bobby. Over the next decade, Emma would lose three close friends and ten acquaintances to opioid overdose. A friend of many of the Hidden Valley users told me he no longer asks what happened when people phone him to say that another friend has passed. "I already know," he tells them.

"Hidden Valley was where it all started with my friends," Emma said. "I just happened to say no to the harder stuff. You'd be at a party, and it was, 'Hey, try this, have a beer, pills, cocaine, anything you could use to get a little bit higher.'" She separated herself from the group when IV heroin became part of the mix, she said.

"It was just overwhelming, the ups and downs of clean Joey and relapsed Joey," Emma said, recalling that supposedly sober Joey had talked her into

sharing an apartment in 2013, and swore that she no longer used heroin. “I wouldn’t have let her move in with me if I had known,” Emma said. “Eventually, she’d do it [heroin] right in front of me; it was tough.” They parted ways over a missing six dollars, and for six months they didn’t speak.

“This too shall pass,” Joey had written around that time on her Facebook page. “It might pass like a kidney stone, but it will pass.”

Joey was not only still using, but she had also allowed an abusive drug dealer and the dealer’s girlfriend to move in with her in exchange for drugs, unbeknownst to her dad. “She was ashamed of how low she’d gotten herself in her own eyes,” Jamie said. She and Cheri Hartman, a Hope volunteer, worked to find Joey a residential-treatment bed, according to the new Hope policy of volunteers working only in pairs, which allowed them to share the heartache as well as the tasks.

Several interventions later, including a visit with her at the emergency room, the women persuaded Joey, battered and with bruises around her neck, to move away from the dealer. As Jamie helped her pack up, they found some of Tess’s clothes.

Cheri Hartman talked her psychiatrist husband into taking Joey on again as a Suboxone patient. (He’d once prescribed her Vivitrol, during an earlier period of sobriety, before she turned twenty-six.) Joey’s divorced parents shared the cost of the prescription, visits, and lab work, and uninsured Joey applied to the hospital-run clinic for charity care.

But Joey bumped into treatment barriers in March 2017, just as Tess had with waiting lists and funding hurdles: The only inpatient facility willing to accept her at the moment was a free, faith-based program in Charlotte that did not permit the use of Suboxone or any other drugs.

To get into the rehab, Joey decided to wean herself off MAT, even though she knew the dangers. And while Jamie tried to be encouraging, privately both she and Cheri worried. “She was so motivated and wanted to do it, and we all felt like it would really be a good fit,” Cheri said, even though the MAT tapering presented a catch-22.

“Her addiction was so severe, I don’t think she was fighting withdrawal symptoms as much as she was fighting her mental illness demons,” including bipolar depression and probably PTSD, Cheri said. In her experience, those who have serious psychiatric problems on top of their

addictions and who also use multiple drugs (not just opioids) are the very hardest cases to treat, even with MAT. In an ideal world, Joey would have gone from Vivitrol, which lasts about a month, directly to rehab, with the shot providing a bridge to fight her cravings, Cheri said.

Jamie worried, too, telling Joey's dad, "I don't know what makes her think she can do it now when she couldn't do it before. We're just doing the same old thing here." Her dad pointed out that Joey had never had much tolerance for pain. "She felt she couldn't get off anything unless she was on something else, but that's what a lot of drug addicts do; it's the addictive personality," Danny Gilbert said. "I think it's asinine to tell a drug addict you've got to be clean before you can come to my facility." (In the treatment center's defense, it couldn't afford to have medical staff on hand to supervise detox and/or medications, Jamie said.)

Joey had two halves of a Suboxone pill left. She was trying to stretch them out, self-weaning in preparation for rehab. The next day, Danny Gilbert was traveling in northern Virginia with his wife when he took a frantic call from Joey. She and her boyfriend had had another fight, and she felt her resolve slipping.

"Daddy, I don't want to die!" she told him. They argued on the phone.

A few hours later, she texted her father:

I just left goodwill, can you please transfer $4 so I can get a pack of cigarettes please?

Eight minutes later he texted Joey back:

Say what you want but everyone loves you…we want you back!!!! Get Cigarettes but get your life back, not more BS.

The next morning, Cheri phoned Jamie but had a hard time choking out the news: Joey had lain inside a Roanoke County house for *almost eight hours* before 911 was called. Police were investigating, but the so-called friends she was using with had cleaned up the scene, fearing prosecution, after Joey passed out. She died of an overdose of illicit methadone on March 26, 2017, the nineteenth lethal overdose in the Roanoke County

suburbs so far that year. She was twenty-seven years old.

"She fought hard against the demon of addiction and God has delivered her to a place of unconditional love, laughter and no more pain," her mother wrote in her obituary. "Watch over us, Jo, and smile down on us until we can hold you in our arms again."

Two days later, the moms of the Hidden Valley fraternity of users—only a few of their sons and daughters now among the living—took their seats among the memorial service pews. Patricia wept, marveling at how much the Gilbert family loved their troubled daughter. Even with all the sorrow she'd caused them, they had tried so hard to keep her safe.

"I was thinking to myself, 'If this was Tess, how would you feel right now, family?'" She firmly believed that Tess still had the potential to recover, to become a loving mother to her son. Patricia was still showing her grandson family pictures, coaching him to say "Mama" when she pointed to Tess. But new custody issues were emerging that Patricia kept secret from Tess—and she knew that Tess could die before they were resolved. She had already chosen the spot where she would sprinkle her daughter's ashes if it came to that: at a confluence of the Cape Fear River and the ocean where they had loved walking the dogs and searching for sand dollars, not far from the family's old beach house.

Six weeks later, Patricia intercepted a Facebook message between a Las Vegas drug dealer and Tess, now communicating through her rehab roommate's phone.

She was still at the facility the next day, when Patricia fired off a letter expressing her disappointment to her daughter. "If she fails, she is on her own," she told me.

It was Mother's Day 2017. Tess wished Patricia a happy one, via text. "I love you," Tess wrote. "But this [is] bullshit all of it," especially being away from her son.

"I'm going to [find] a way home," she said.

She signed the text to her mother ominously, using her street name:

Sweet T.

United States Penitentiary, Hazelton, Bruceton Mills, West Virginia

Chapter Twelve

"Brother, Wrong or Right"

In *The Odyssey,* Homer described a drug that would "lull all pain and anger and bring forgetfulness of every sorrow." A Victorian poet said taking

opium felt as if his soul was “being rubbed down with silk.”

In Virginia’s coalfields, a long-addicted OxyContin user spoke in hyperbolic terms about the first time she crossed paths with the molecule, back in 1998. “I thought, that’s all I need from here on out. I will *live life* like this,” Rosemary Hopkins, in recovery and on MAT under the care of Van Zee since 2009, told me in a counseling room at Sister Beth Davies’s office.

Rosemary had a theory about the way corporations had been allowed to unleash a flood of painkillers, a notion I heard more than once as I traversed Appalachia’s former factory and mining towns: “For that strong of a drug, for it to be everywhere you looked, it was like the government was controlling it, trying to get rid of the lowlifes.”

She laughed when she said it, but I could see what she was getting at. Although her hypothesis was somewhat different, it was a version of what federal prosecutor Andrew Bassford meant when, quoting President Garfield, he proposed that governments fail their citizens “not because of stupidity or faulty doctrines, but because of internal decay and rigidification.”

“I used to do eighty cases in a good year, but in recent years it’s been twenty-six, forty, whatever,” Bassford said in April 2017. “So the amount of cases being done does not match the problem, and we have found ways to make it more difficult to do cases—more boxes that have to be checked, more things to do in the service of perfection.”

When I offered that I was leaving his office after our third interview depressed—again—he said, “Well, you should be. Rehab is a lie. It’s a multibillion-dollar lie.”

An annual $35 billion lie—according to a *New York Times* exposé of a recovery industry it found to be unevenly regulated, rapacious, and largely abstinence-focused when multiple studies show outpatient MAT is the best way to prevent overdose deaths. “I’m afraid we don’t have good data on outcomes from residential programs,” said John Kelly, the Harvard researcher. While research supports users remaining in their home environments on outpatient MAT, desperate families continue to grasp for “cures” offered by companies marketing abstinence-only rehabs. “Part of it is, when you spend that much money, you think it’s going to work,” Cheri Hartman said. “But it is killing people for that myth to be out there—that

the only true cure is abstinence.”

I hoped the stories of Ronnie Jones and his victims would illuminate the ruts in both a criminal justice system that pursues a punishment-fits-all plan when the truth is much more complicated and a strained medical system that overtreats people with painkillers until the moment addiction sets in—and health care scarcity becomes the rule.

I hoped, too, that my interview with Jones would help answer Kristi Fernandez’s questions about what led to her son Jesse’s premature death. Was Ronnie Jones really the monster that law enforcement officials made him out to be? Had the statewide corrections behemoth that returns two thousand ex-offenders a year to Virginia’s cities, counties, and towns played a role in his revolving door of failures?

I had come to interview Ronnie Jones expecting I would have two hours, no recording devices allowed. On the day of our meeting, though, the visit stretched from morning into late afternoon, with the prison handler monitoring our visit from the other side of a glass wall and inexplicably allowing us to talk for more than six hours.

I had the better part of a day to try to discern how a sleepy agricultural county nestled in the Blue Ridge Mountains, with covered bridges and lovingly preserved two-hundred-year-old log homes, had gone from having a handful of heroin users to hundreds in a few short months, and how much Ronnie Jones was to blame for it.

Understandably guarded at first, Ronnie, thirty-nine, was gentlemanly and polite throughout the visit. During the two years he’d spent there, he said, he spent his time working out, studying Arabic and Swahili, and reading the works of Guy Johnson, Eric Jerome Dickey, and Maya Angelou. On my way to the prison, I’d been listening to the audiobook of Michelle Alexander’s *New Jim Crow*, I told him, the seminal book on mass incarceration that likens the War on Drugs to a system of racial control comparable to slavery and Jim Crow.

“I’ve read *The New Jim Crow* twice,” Ronnie said. He’d also read

lawyer Bryan Stevenson's majestic *Just Mercy*, a memoir about his work against the racial bias and economic inequities inherent in the criminal justice system, which included efforts on behalf of falsely accused death row inmates. "It had me crying when I read it," he said. These books we had both read challenged the tough-on-crime government narrative of the past forty years, one that fostered the shift in public spending from health and welfare programs to a massive system of incarceration, with a fivefold increase in imprisonment and corrections spending that soared from $6.9 billion in 1980 to $80 billion today.

Whereas Bill Metcalf, the ATF agent largely responsible for Jones's twenty-three-year prison sentence, took inspiration for his life's work from the image of the brain frying like an egg and Nancy Reagan's "Just Say No" slogan, Alexander and Stevenson saw fearmongering and institutional racism in mandatory minimum sentences, three-strikes sentencing laws, the abolishment of parole, and "stop and frisk" policing.

This was Ronnie's third time in prison. He already knew that one in three black men was destined to end up incarcerated, only to find himself branded as a felon and second-class citizen the moment he got out, blocked from the mainstream economy and propelled into a dystopian loop of jail, joblessness, and back to jail. He knew that drug-involved offenders, who represent half the incarcerated population, had a recidivism rate of 75 percent. His own story was a case in point.

"We can't arrest our way out of this problem," I'd heard again and again, from everyone from police chiefs to public health providers. But that sentiment seemed to apply only to the mostly white group of opioid users who were dealing or committing property crimes to stave off dopesickness —not to people like Ronnie, in prison for armed heroin distribution, or to the majority of other black and brown people arrested for selling the drugs, even though they were statistically less likely to use or to deal. (Three-quarters of federal drug offenders are black or Hispanic while 57 percent of state-imprisoned drug offenders are people of color.)

Why had blacks failed to become ensnared in opioid addiction? That question was addressed in 2014 data issued by the Centers for Disease Control and Prevention: Doctors didn't trust people of color not to abuse opioids, so they prescribed them painkillers at far lower rates than they did whites. "It's a case where racial stereotyping actually seems to be having a

protective effect," marveled researcher Dr. Andrew Kolodny of Brandeis University. Put another way: By 2014, while young whites were dying of overdose at a rate three times higher than they did in 2002, the death rate for people of color was relatively unchanged.

If, as Shannon Monnat had proposed, the hollowing out of the predominantly white working class was the kindling in the heroin epidemic, and the mounds of opioid pills in America's communal medicine chest was the spark, I was beginning to wonder whether the fragile transition of ten thousand prisoners a week from state and federal prisons into U.S. communities fanned the flames of the fire.

At the same time that Ronnie and I were speaking, the city of Winchester was launching the region's first drug court just a half hour north of the heart of Ronnie's Woodstock heroin ring. It was designed not only to connect offenders to treatment, including MAT, but also to help them access free housing and taxi vouchers to get to work (a serious barrier in rural areas), the latter paid for by grants from the local Rotary Club.

While the government's response to the opioid crisis had been molasses-slow, mired in bureaucracy, funding woes, and slow-to-close treatment gaps, here was an example of volunteers stepping in to patch up the holes. Winchester was becoming a magnet for people in recovery across the state, including ex-offenders who came for treatment and ended up staying because of its multitude of halfway houses—fourteen in a city of just twenty-seven thousand people—and of newly announced jobs.

Amazon was soon to open a warehouse and distribution center in the county, and Procter and Gamble was building a Bounce fabric-softener factory twenty minutes north. The fastest-growing church in town was led by an ex-offender and opioid addict, a charismatic pastor who held Sunday services at the downtown mall—in a bar.

What if Winchester's Rotarians and drug-court champions had been around to assist Ronnie Jones when he got out of prison, instead of one probation officer responsible for keeping up with 104 ex-offenders on her rolls?

"Right away they run into issues of having a paycheck that doesn't cover rent, utilities, and food, not to mention their court fines and child-support arrears—and that's when the issues really start," said Ronnie's probation officer, who asked not to be named because she wasn't authorized to speak.

“That’s usually when they commit new crimes.” In 2016, the Woodstock office had two probation officers tasked with doing monthly check-ins, field visits, and drug screening for 204 people, though an additional officer was scheduled to join the team.

Many ex-offenders have no driver’s license and no way to get one until they pay back the thousands they owe in court fines and child-support arrears. In some states, people with drug charges are permanently barred from getting food stamps, a holdover from a 1996 federal ban. (Virginia is one of twenty-six states that have eased some restrictions on the ban.)

“Think about it: You can do without a roof, but you can’t do without food,” said Mark Schroeder, a repeat drug-dealing offender and recovering crack addict who successfully opened his own garage-door-hanging business in the Shenandoah Valley in 2016 after a ten-year federal prison stint. He and hundreds like him were given reduced sentences following the 2015 decision *Johnson v. United States*, a U.S. Supreme Court ruling that redefined the status of “armed career criminals.”

“To feed yourself, you’re either going to rob somebody, or you’re going to go back to dealing or prostitution,” Schroeder said. “I’ve been there and done it myself.

“The whole thing is designed for you to come back.”

What if Ronnie’s reentry had been managed not by an overburdened and apathetic system but instead by workers from Bryan Stevenson’s Equal Justice Initiative, which sends clients to felon-friendlier cities like Seattle? There, jobs and harm-reduction measures are more plentiful, and police divert low-level drug and prostitution offenders who are addicted from prosecution before they’re booked, assisting with housing, case management, and employment services. Such a two-pronged approach not only addresses the need of former drug dealers to find legitimate work but also works to dry up the demand for drug dealing.

“It makes a huge difference,” Stevenson told me. “If we reduced our prison population by twenty-five percent, that’s twenty billion dollars we could save. And if we invested half of that in treatment, we could really increase people’s likelihood of success.”

In the 1970s, America decided to deal with drug addiction and dependence as a crime problem rather than a health problem, “because it was popular to find a new community of people to criminalize,” Stevenson explained. “And everybody was preaching the politics of fear and anger.”

As that narrative of addicts as criminals further embedded itself into the national psyche, the public became indifferent to an alternative response that could have eased treatment barriers, he said. As an example he cited Portugal, which decriminalized all drugs, including cocaine and heroin, in 2001, adding housing, food, and job assistance—and now has the lowest drug-use rate in the European Union, along with significantly lowered rates of drug-related HIV and overdose deaths. In Portugal, the resources that were once devoted to prosecuting and imprisoning drug addicts were funneled into treatment instead.

Ronnie Jones’s story was tough to fit into a neat arc of redemption, but it seemed to turn on poor decision making fueled by family instability and quick-fix desires. His rap sheet began with a felony grand larceny charge the summer before his senior year of high school. He’d borrowed a car from a girlfriend, then used that car to meet up with another girl, resulting in a catfight and, ultimately, his arrest and conviction for theft. While he was on probation for that offense, he nabbed another felony for driving another car, sans license, that contained stolen goods.

Growing up, he told me, he wanted Nikes instead of Reeboks, steak instead of hot dogs and fish sticks. He wished for a closer relationship with his single mother, a hospital nursing assistant and, later, nurse. But she got along better with his easier-going little brother, Thomas, who was into music and sports and was promoted to his school’s gifted program. “I’d get jealous of my brother, of his attention from my mom. I’d get mad at her and threaten all the time, ‘I’ll go live with my dad.’”

Ronnie was obstinate to a fault, recalled Thomas Jones III, and would talk back to teachers and to their mom. “The weird thing is, he wasn’t a very bad kid; it was more of his total disregard, at times, for authority. I learned that it was best just to try to stay out of his warpath.”

Now a music promoter based in Charlotte, Thomas Jones said his brother

had a brilliant business mind and had helped him, when he was younger, with his advanced math homework even as he refused to do his own.

Their family was not without connections. His uncle Petey Jones was a linebacker on the 1971 state-champion team memorialized in the movie *Remember the Titans*, which was set against a backdrop of racial tensions brought on by the integration of Alexandria's high schools. In 1990, his maternal grandfather, Thomas "Pete" Jones Sr., was such a fierce fighter for equal housing that then–president George H. W. Bush met with him and other residents to discuss ways to rid Alexandria's public housing units of drugs.

Ronnie and his brother grew up in Section 8 housing in northern Virginia, moving every few years as their mom worked her way up to better jobs. A no-holds-barred fight between the brothers when Ronnie was fifteen taxed his mother's nerves to the breaking point. She sent him to live in Alexandria with his father, dropping his belongings on the curb in trash bags and telling his dad, as Ronnie recalled it: "He your responsibility now. I'm done."

Ronnie's father and uncle were regular drug users. He remembered them going down into the basement regularly to freebase powder cocaine. Six months after moving in with his dad, Ronnie moved in with his maternal grandmother, Rosie, his favorite relative. Her husband was an Air Force mechanic who took Ronnie to air shows at Andrews Air Force Base, in Maryland, and let him sit in the pilot's seat. He was fascinated with airplanes and wanted to be an Air Force pilot. It was a short but happy time in a tumultuous upbringing: His grandmother helped him get a dishwashing job at a nearby retirement home, and he sold cookie dough for a door-to-door nonprofit organization on the side, developing an acumen for sales.

His grandmother gave him anything he wanted—as long as he stayed in school. But he had already switched schools ten times before his sixteenth birthday, often butting heads with his teachers. One memorable clash with authority came during a class discussion that spiraled into a debate about who had been persecuted most: African Americans, native Americans, or Jews. The exchange grew so heated that Ronnie was asked to leave the classroom, which he did, forcefully pushing the door on his way out in a way the teacher perceived as threatening. The incident culminated in a fine and his first juvenile probation stint.

“I play those incidents over and over in my head,” he said of his first few legal charges. “If I had never drove that girl’s car and then [the car with the stolen goods], I could’ve been probably in the military now and having a regular life.”

Jobs were hard to get. Because of Ronnie’s felony record, his applications were turned down by Burger King, McDonald’s, Walmart, and Lowe’s. For a time, he worked at Food Lion in Maryland, driving an hour each way to get there. A cousin introduced him to cocaine dealing, he said, whereupon Ronnie realized that he could stock shelves for two weeks and not come close to making what he could dealing drugs in a single day. The math was irresistible.

Ronnie said he hated hard drugs and didn’t want to end up like his dad. So he drank only on his birthday and New Year’s Eve, and eschewed marijuana entirely. But dealing drugs gave him the two things he craved most: money and respect. He says he was profiled in early 2000 when he and a black friend were pulled over on Interstate 66 near Herndon, Virginia, and naïvely consented to being searched, ostensibly for not having a county sticker on their car. (They were driving a car with Maryland plates, he said.) Police found 3 grams of crack cocaine tucked into his sock. “I was guilty. I did have the drugs.”

Bonded out of jail by his grandmother, he was arrested a short time later for selling drugs to an undercover cop, and the two state charges plus a probation violation combined for a state-prison sentence of eight and a half years. His court-appointed attorney was overworked and “just wanted to get me over with,” Jones said; he didn’t answer the letters Jones wrote about his case from jail. He was encouraged to accept the prosecutor’s first plea deal, and to remain mum in court. This was 2001, a time when prosecutors across the country were doubling the number of felonies they filed in state courts despite declining crime rates. In his 2017 book, *Locked In*, Fordham Law School professor John F. Pfaff argues that it’s politically safer and economically cheaper to charge a person with a felony, which sends them to prison—on the state’s dime—than it is to incarcerate someone locally or put them on probation, paid for by local budgets.

“No matter where you turn in this epidemic,” East Tennessee State University public health professor Robert Pack told me, “there are systems in place to address the problems, but none of them are working together.”

The biggest barrier to collaboration is the fact that everyone involved views the problem too rigidly—through the lens of how they get paid, according to Pack.

Ronnie finished high school in jail, then took computer-repair classes in the state prison system, earning a GPA of 3.6. He tutored other inmates working toward their GEDs and earned a certificate in computer-repair tech. His goal was to get a job as a certified network administrator, maybe land a government job.

His brother's career was on a high when Ronnie got out of prison in 2008. Thomas, also known by the stage name "Big Pooh," had been traveling in Asia on a contract with Atlantic Records, recording with the rap band Little Brother.

"I gave him five thousand dollars for a laptop and helped him get on his feet," Thomas told me. Ronnie was working for T-Mobile, selling cellphones for a time, but grew frustrated that he wasn't advancing in the company, a failure that he attributed to his record. He was too impatient, too clever by half. "I kept telling him, 'Man, the system is set up for you to fail. Just be happy you found some employment because most people who are felons can't,'" Thomas recalled. "Ronnie has a knack for quickly reading people and knowing how to talk to 'em and reel 'em in. I said, 'You just got to work that opportunity till you get another one.' But it wasn't fast enough for him."

Thomas was on the road in 2010 when he took another collect call from Ronnie. His brother had been locked up again, this time for credit-card fraud.

"I was like, 'Come on, we just did all this stuff trying to help you get on your feet?'" Thomas remembered, exasperated.

Thomas rapped about devotion and disappointment in a song called "Real Love," from an acclaimed solo album released in 2011:

> Brother, wrong or right
> The fact that you were incarcerated
> After being free let me know you never made it
> To that point where the old you is not outdated…
> No matter how this picture looks

I’m still putting money on your books.
I told you…we family.

It was the credit-card fraud charge that landed Ronnie in the diversion program at George’s Chicken, and for a time following his release from it, his family believed he had turned a corner. He told his brother and mom he’d launched a computer-repair startup, which was certainly within his abilities, given the skills he’d picked up in prison programs. Thomas’s own business was in a lull at the moment, so Ronnie floated the idea of starting a joint venture. He wanted Thomas’s help opening a Caribbean jerk-chicken restaurant in Winchester. He didn’t turn to his brother because he needed the money; Ronnie needed Thomas’s help securing a liquor license, which wasn’t possible for a felon.

“I didn’t understand the urgency for him wanting to buy something legitimate,” Thomas said. “I just kept saying, ‘I don’t live in Virginia, and I’m not going to have my name on nobody’s liquor license and I can’t be there. And anyway, who’s going to come to a restaurant in this dead little small town?’”

Thomas began doubting his brother during their final visit, when Ronnie and a girlfriend drove to Charlotte to see him and his wife. “I’m like, I don’t know if the computer business is this good? He had a Mercedes-Benz truck. And he had a motorcycle that he couldn’t really ride, and another car back at home.”

Thomas said he wondered if the girlfriend, who worked at a federal agency, owned some of the vehicles but admits that he didn’t really want to know. Thomas now believes his brother was trying to phase out of drug dealing so that if and when he got arrested, there would be a legitimate revenue stream already established to help support his daughters.

Ronnie Jones has frustrated his younger brother his entire life—and that pattern of behavior included his initial refusal to cooperate with Bill Metcalf and Don Wolthuis, the ATF agent and prosecutor responsible for his conviction. Ronnie thought he deserved a ten-year sentence, so he fired his first court-appointed attorney, Sherwin Jacobs, who’d negotiated a plea deal of fifteen years with Wolthuis—a decision Ronnie regretted the moment it backfired.

Thomas was on a month-long European touring stint when a relative texted him the stomach-sinking news that Ronnie's federal sentence was in: twenty-three years. "I told him, the last to talk is always the last to walk," Thomas said.

Though he's never been in legal trouble, Thomas said he is regularly profiled, pulled over ostensibly for speeding—presumably because he's a thirtysomething black man with tattoos driving a Lexus through his middle-class Charlotte neighborhood. Though the experience is frightening, he always looks forward to the moment in the exchange when the officer runs his license, and it comes back crystal clean, with the vehicle registered to his wife, a third-generation operator of a successful bail-bonding company. "I don't have the leverage to get smart or act crazy when I get pulled over," he said. "My goal every day is to make it back to my wife in one piece so I can live to fight another day, so I'm just 'yes, sir, no, sir,' and all that."

He feels for Ronnie and other ex-offenders getting out of prison. "They don't rehabilitate you in prison, and they don't make it easy for you to get a job. I truly believe they don't make it easy because they want you back, and they want you back because that's the new factory work in so many places now—the prison.

"You have to be very strong mentally when you get out to not make those same mistakes."

Ronnie Jones said he initially felt welcomed in Woodstock. When he first landed there to work, in 2012, he found it charming that drivers waved to one another on the country roads, and his minimum-wage paycheck from George's Chicken went further than it had in the city. "It was almost a culture shocker for me. I could count on one hand the number of black people. I loved it. I actually thought I couldn't get into anything there," he told me.

He didn't even mind the early shift, he said, even though "you're standing in chicken shit, and you be dealing with 'em while they're live, and they be scared." He kept working at George's after his twenty-one-week diversion sentence was complete but lost the job several months later when he got sick and had to be hospitalized for a week. At the time, he

hoped to open a small diner with ten chairs—he'd learned to cook from his mother, and his first job at the diversion center, where he worked before going to George's, had been as a cook—but no one would rent to him. He said the same thing happened when he contacted a landlord about renting space for a computer-repair shop and was told the space was already leased. ("I got a white girl to call, and he was willing to rent to her, and I was like, 'This is bullshit.'")

At the time, he owed $5,000 in medical bills and $20,000 in court fines and restitution. Jurisdictions across the country increasingly inhibit ex-offenders' ability to reenter society by assessing hefty court fines and fees, requiring them to pay thousands or face more jail time.

Jones was hired at another chicken plant but netted only $300 to $400 a week. "I was at the second chicken plant for less than thirty days before I decided, 'I'm making too much money; let me concentrate on this,'" he said, deciding to deal drugs full-time—temporarily, he told himself—until he could pay off his fines and go legit.

In a convoluted feat of logic twisting, Ronnie justified his heroin enterprise by declaring himself the ring's wholesaler, far removed from the moment the needle touched the vein. He clings to the narrative that he was providing an actual service—offering the drug cheaper and in a much safer environment than Baltimore. Like Purdue Pharma announcing it had created the perfect time-release painkiller that was addictive in "less than 1 percent" of cases and then reproaching the hordes of addicted people who misused its drug, Ronnie had an easy time shifting the blame, with responsibility often lost in the cloudy penumbra of bureaucratic disconnects and cops-and-dealers Whac-A-Mole.

If you were a user-dealer, you would, employing Ronnie's model, buy your heroin from his subdealers for $100 a gram, which was substantially cheaper than driving to Baltimore and paying $150, plus it saved you the driving time and the risk of dealing with armed inner-city dealers (though Ronnie and some of his lieutenants were also armed).

"Herr-on was already there," he insisted, a truth confirmed in interviews with survivors of people who died of heroin overdose before Ronnie arrived in Woodstock. "I never introduced herr-on to the area. The only thing I did: I gave it to 'em at a cheaper price."

Ronnie believes he was made out to be a monster in the federal

government's case against him, vehemently denying that he had sex with underage females and dopesick users—an accusation that Wolthuis said fueled him and the task force in their quest to put him behind bars for many years and possibly even for life. "I would pay for sex before I'd have sex with someone doing drugs," Ronnie said.

Jacobs, the fired first attorney, believes Ronnie on this point, even as he called him a "con man" and "a pain in the ass." Jacobs saw Ronnie as someone who dealt drugs because it "was easier than working, and you can be a big guy in your own eyes, and people follow you, and it's like you're the head of a business, which you are—until it all comes crashing down."

Female user-dealers are incentivized to lie in their quest for what the government calls substantial assistance, and they exaggerate their addictions so they'll be given less time, according to Jones and Jacobs. Keith Marshall, the dealer whose expletive "Fuck. You. Bring it." gave the case its informal name, said the women not only cooperated for less time but also played up their addictions to their advantage. When Kareem Shaw's girlfriend was arrested, "she batted her eyes and talked about how she was just an addict forced into this and used up by everybody when the reality was quite the opposite. She was selling and setting up new people to move [drugs] just like myself," Marshall told me in an email, mad that she'd gotten a lighter sentence than him and was due to be released from prison in late 2018.

Ronnie turns the case over in his mind, including his own complicity. "I promised myself I'd never grow up to be like my father, and while I may not have an addiction to an actual drug, I do feel my addiction," he said. "I'm addicted to that lifestyle. It wasn't my intention. I didn't want to do it. But no one would give me a job in the field I'd trained for, and no one would let me create my own."

He was disappointed in himself and felt bad about hurting his relatives, especially his daughters. He no longer has relationships with their mothers, one of whom told me, "Ronnie was just not mentally mature enough to be a father. His biggest thing was, he felt entitled."

Ronnie ended the interview with a version of the same old saw I'd heard

at so many of my stops along the heroin highway: He predicted that “ten more dealers would pop up to take my place,” which was accurate. It was hard to envision a future where shit in fact stopped.

It was a long drive back to Roanoke. I was too tired to stop in Woodstock, where I’d arranged to meet with Kristi. She was eager to learn what light Ronnie had shed on Jesse’s death, but I dreaded telling her just how little he seemed to think or care about the victims of his crimes. Since our last meeting, she had arranged to view the pictures police took of Jesse lying dead on the floor. He looked surprisingly peaceful. “What I’d been imagining was actually much worse,” she said. When Sergeant Lutz called them up for her on his computer screen, the task force had noted a lull in overdose deaths in the wake of the prosecution of Ronnie Jones and others in the FUBI ring. But that was also before fentanyl and other synthetic analogs came roaring onto the scene.

Kristi still went by her son’s grave overlooking the football field several times a month, less often since her family moved to the other side of the county. But she still decorated it for every holiday. “I feel bad every day that I don’t go,” she said.

She had recently met Dennis Painter’s son, the curly-haired toddler named for Jesse. His mother, Courtney, had awakened him in his car seat after she and Kristi ran into each other at the Dollar Store. “He woke up reaching for me,” Kristi said, as if it were Jesse reaching out from beyond the grave. “I got in my car and cried for ten minutes.”

It was almost three years since Jesse’s death. His grave was now decorated with red-white-and-blue pinwheels, an American flag, and a brand-new 55 metal sculpture painted in school colors. Over the next year, Kristi would hatch plans for a memorial five-kilometer race for opioid awareness that she envisioned meandering past Jesse’s old football field and the Shenandoah River. Photos of overdose victims, including another friend of Jesse’s who had recently died, would be placed along the runners’ path; the money raised would benefit the area’s substance abuse coalition.

In one week in October 2016, nineteen people in the northern Shenandoah Valley region would overdose, seventeen of them brought back

with Narcan. Baltimore dealers continued to hot-pack their heroin with fentanyl, an area naloxone trainer told me, because when someone dies, customers flock to his or her dealer, chasing a better high. “It’s like, ‘I might lose three of my customers, but in the long run I’ll gain ten of yours,’” theorized the trainer, a mom who’d lost a son to fentanyl-laced heroin. The fentanyl-packing strategy is also sometimes employed with known snitches or suspected confidential informants, the goal being to kill them.

After a day passed, I tried to break the news gently to Kristi over the phone that Ronnie hadn’t even recognized Jesse’s name.

In that respect, Ronnie Jones was no different than the drug reps in their tailored suits and SUVs: He had failed to see the harm his drugs had caused.

And why should he be any different?

A few months before I sat down with Ronnie, Purdue Pharma executive J. David Haddox gave a speech urging members of the Richmond Academy of Medicine not to be swayed by the narrative taking shape around the opioid epidemic. His company was working to create new and “safer” painkillers, he said. The assembled doctors were unimpressed. What can we do, they wanted to know, when our patients need pain relief but we don’t want them to become addicts? Haddox could only suggest using local pain specialists—including the friend of his who’d invited him down to deliver the speech. But there weren’t enough pain specialists, and the doctors were increasingly aware of studies showing that long-term opioids in fact created more pain in many patients, a condition known as opioid-induced hyperalgesia.

Eight years after the 2007 sentencing of the company and three top executives for criminal misbranding, more lawsuits were being filed against Purdue and/or other opioid makers and distributors by the month, and they would grow to include such plaintiffs as the city of Everett, Washington; the state of Ohio; Cabell County, West Virginia; and Virginia’s tiny Dickenson County, not far from Lee. Purdue had followed Big Tobacco’s playbook when it downplayed the risks of its drug, and now some of America’s best legal minds were trying to make it and other pharmaceutical companies pay

for the “public nuisance” burdening their communities. The states of West Virginia and Kentucky had already garnered modest settlement payments from Purdue, to the tune of $10 million and $24 million, respectively, victories that brought to mind the civil litigation brought by forty-six states and six other jurisdictions against the tobacco industry in 1998. Cigarette companies then agreed to pay billions to the states, in perpetuity, for the funding of prevention and public health programs.

But painkillers aren’t tobacco, and the cases differ partly because opioids have legitimate medical benefits when prescribed and used correctly, and the companies who make them use as fall guys the out-of-work coal miners and furniture makers and underchallenged youth who have illegally abused and diverted their drugs. “The cigarette companies finally caved, but only because the litigation costs were eating them alive,” said legal scholar Richard Ausness at the University of Kentucky. He foresaw the possibility of such a settlement being forged with opioid makers, but to a much smaller degree. “It’s a tough call because you want to punish them, but you may not want to put them out of business, because then you’re largely forgoing the right to any future claims,” he said. Tightening new opioid prescriptions through physician monitoring programs, then shifting the government’s focus to treatment and prevention, were more effective strategies than litigation, Ausness believed.

Haddox punctuated his talk with slides touting the work Purdue was undertaking to create new, “safer” painkillers. When his thirty-minute speech was over, the general practitioners in the audience grumbled a bit. Despite Haddox’s great slides and optimistic plans for new and improved opioids, the doctors were still slogging it out in the trenches. They knew they’d be the ones left holding the prescription pads when it came time to juggle their patients’ pleas for pain relief and addiction treatment with their patient satisfaction ratings, still used by many insurers to gauge reimbursements.

But Haddox remained firmly on point. “What’s getting lost here is the prevalence of chronic pain in this country,” he said. The optics of the opioid epidemic had clearly been bad for business. While Ronnie turned gray in

prison and Kristi prepared the next seasonal decorations for Jesse's grave, the Sacklers' rank among "America's Richest Families" slid from sixteenth to nineteenth on the *Forbes* list.

Powell Valley Overlook, Wise County, Virginia

Chapter Thirteen

Outcasts and Inroads

"If you want to treat an illness that has no easy cure, first of all treat it with hope."

—Psychiatrist George Vaillant, Harvard Medical School

In 1925, the psychiatrist Lawrence Kolb Sr. published a set of groundbreaking articles arguing that addiction afflicted only people who were born with personality defects. He distinguished between “normal” users, who had been prescribed opiates by their doctors, and users who were “vicious” (a word deriving from “vice”), who had become addicted via illicit channels. The latter were much worse than the former, he initially believed, and this notion led him to categorize the addicted person as a criminal rather than a patient deserving of treatment and care.

In the mid to late 1930s, Kolb oversaw the opening of two U.S. Narcotics Farms, in Lexington, Kentucky, and Fort Worth, Texas, part of the federal government’s so-called New Deal for the Drug Addict. In bucolic rural settings, the government provided treatment both to the addicted who had arrived by court mandate and those who had volunteered, along with job training and medical care. Meanwhile, the government scientists were allowed to conduct research on the farms’ captive populations.

Kolb changed his beliefs about addiction after his colleagues proved to him that “normal” people, including the 10 to 15 percent of patients who were health care professionals, could become addicted, too, if they were opioid-exposed.

The work at the Narcotics Farm labs led to the field of addiction medicine. Both farms closed in the mid-1970s—due to an ethics scandal over experimentation on the addicted who were improperly exploited as research subjects. But their legacy includes the establishment of the National Institute on Drug Abuse and the scientific notion that addiction is a chronic, relapse-ridden disease.

Today, courts largely continue to send the addicted to prisons when reliable treatment is difficult to secure, and many drug courts controlled by elected prosecutors still refuse to allow MAT, even though every significant scientific study supports its use.

Not every patient wants or needs maintenance drugs, because every human experiences addiction differently, and what works for one might not work for another. Still, it is crucial to preserve treatments for people with addiction and help them obtain the means needed to get off drugs, rather than simply treat them as criminals who have no right to health care.

If my own child were turning tricks on the streets, enslaved not only by the drug but also criminal dealers and pimps, I would want her to have the benefit of maintenance drugs, even if she sometimes misused them or otherwise figured out how to glean a subtle high from the experience. If my child's fear of dopesickness was so outsized that she refused even MAT, I would want her to have access to clean needles that prevented her from getting HIV and/or hepatitis C and potentially spreading them to others.

As the science historian Nancy D. Campbell, who documented Kolb's work, has written: "Perhaps the day will come when more sensible views prevail—that relapse is the norm; that drug addiction should be treated as a chronic, relapsing problem that affects the public health; and that meeting people's basic needs will dampen their enthusiasm for drugs."

But there is so much more work to be done.

Why, in less than two decades, had the epidemic been allowed to fester and to gain such force? Why would it take until 2016 for the CDC to announce voluntary prescribing guidelines, strongly suggesting that doctors severely limit the use of opioids for chronic pain—recommendations that echoed, almost to the word, what Barbara Van Rooyan begged the FDA to enact a decade before? Why did the American Medical Association wait two decades before endorsing the removal of "pain as the fifth vital sign" from its standards of care? If three-fourths of all opioid prescriptions still go unused, becoming targets for medicine-chest thievery, why do surgeons still prescribe so many of the things?

While it is true that doctor junkets funded by Big Pharma are no longer the norm, and physicians no longer ask reps to sponsor their kids' birthday parties, more than half of all patients taking OxyContin are still on dosages higher than the CDC suggests—and many patients in legitimate pain stabilized by the drugs believe the pendulum has swung too far the other way.

A journalist and former colleague of mine was so worried about the epidemic's chilling effect on painkillers that she emailed me an X-ray of her back, showing a sixty-four-degree curve in her lumbar spine—from the front, it resembled a question mark—and slipped disks that caused severe

arthritis pain. Painkillers had allowed her to work and actively pursue gardening, cooking, and beekeeping, and they precluded risky and potentially debilitating surgery.

And yet her scoliosis specialist had recently discontinued her pain management "without any notice and with no discussion during appointments to come up with a pain management strategy" because the new CDC guideline "frightened him into abandoning his patients," she said. (For her arthritis, she takes the synthetic opioid Tramadol; for neuropathy, she takes the seizure medication gabapentin, which is increasingly sought on the black market for its sedative effects.) "My life is not less important than that of an addict," my friend wrote, in bold letters, explaining that her new practitioner requires her to submit to pill counts, lower-dose prescriptions, and more frequent visits for refills, which increase her out-of-pocket expense.

"The system taking shape treats me like an addict, like a morally dubious person who must be treated with the utmost suspicion," she said.

The CDC guideline had become so controversial among pain patients that the two employees charged with drafting it received death threats.

To follow the physician's imperative of "Do no harm" in a landscape dominated by Big Pharma and its marketing priorities, the medical community only recently organized behind renewed efforts to limit opioid prescribing, teach new doctors about the nuances of managing pain, and treat the addicted left in the epidemic's wake. The number of residency programs in the field of addiction medicine has grown in recent years from a dozen to eighteen.

"We live in an era where for a century now the pharmaceutical industry has invested enormous capital investments in new drugs, and there's no turning back that clock," said Caroline Jean Acker, an addiction historian. "So, as a society, we're going to have to learn to live with possibly dangerous or at least risky new drugs—because Big Pharma's going to keep churning them out."

The birthplace of the modern opioid epidemic—central Appalachia—deserves the final word in this story. It is, after all, the place where I

witnessed the holiest jumble of unmet needs, where I shadowed yet more angels, in the form of worn-out EMTs and preachers, probation officers and nurse-practitioners. Whether they were attending fiery public hearings to advocate for more public spending, serving suppers to the addicted in church basements, or driving creaky RVs-turned-mobile-clinics around hairpin curves, they were acting in accordance with the scripture that nurse-practitioner Teresa Gardner Tyson had embroidered on the back of her white coat:

> Verily I say unto you, inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me. (Matthew 25:40)

One three-day weekend every summer in far southwest Virginia, Tyson plays host to the nation's largest free medical outreach event. Held at the Wise County Fairgrounds, Remote Area Medical serves the uninsured, from children with undiagnosed diabetes to adults on walkers with infected teeth, some caused by lack of dental coverage and others by years of meth use. It's where I crossed paths with people like Craig Adams, a construction worker and recovering opioid addict, who brought his wife, Crystal, to RAM so they could both get their teeth fixed: They'd used so many tubes of temporary dental repair glue, he told me, they'd lost count. Craig had spent eight years in the state prison system for breaking into Randy's Gateway Pharmacy in nearby Richlands, trying to steal OxyContin. But he was taking Suboxone now—"responsibly," he told me, "because my wife wouldn't have it any other way." Having lost scores of people to opioid overdose, including his mom and grandmother, he hadn't used illicit drugs in more than three years. "I had put off going to RAM for years because I figured they'd make you feel like shit about yourself, like ninety percent of the social service people do," he said. "But everyone was just…so…kind."

If there's an argument to be made for a single-payer health care system with mental health and substance abuse coverage, this is the lumpy ground on which to make it, a gravel lot in which upward of three thousand Appalachians camp out for days in 100-degree heat to be treated in exam rooms cobbled together from bedsheets and clothespins. Behind a banner for the VIRGINIA-KENTUCKY DISTRICT FAIR & HORSE SHOW, patients wait in

bleachers while volunteers pass out bottles of water as they triage them to pop-up clinics for medical, dental, and eye care.

I interviewed Tyson several times in the spring and summer of 2017, before and after the July RAM event that her organization helps plan and host. In the weeks leading up to it, she liaised with media from as far away as Holland and made frantic phone calls, once when her assistant struck out trying to secure enough bottled water for the RAM crowds. A nonprofit they usually counted on said this year's pallets were already reserved for natural-disaster relief. "If this isn't a disaster, I don't know what is!" Tyson said, managing to sound both desperate and upbeat.

In rural America, where overdose rates are still 50 percent higher than in urban areas, the Third World disaster imagery is apt, although the state of health of RAM patients was actually far worse. "In Central America, they're eating beans and rice and walking everywhere," a volunteer doctor told the *New York Times* reporter sent to cover the event. "They're not drinking Mountain Dew and eating candy. They're not having an epidemic of obesity and diabetes and lung cancer."

I had made a similar comparison two years before, when Art Van Zee drove me through the coal camps on my first visit to Lee County, just west of Wise. Though I'd covered immigration in rural Mexico and the cholera epidemic in northern Haiti, I told him, never before had I witnessed desolation at this scale, less than four hours from my house. Most of America would be shocked by the caved-in structures, with their cracked windows and Confederate flags, and burned-out houses that nobody bothered to board up or tear down. It felt completely out of scale with the rest of the nation I knew. But these conditions were hardly limited to St. Charles or Wise County, Van Zee pointed out. "On the other side of the cities [many Americans] live in, there's poverty and poor health probably just as bad," he said.

In Appalachia, he conceded, poverty and poor health were not only harder to camouflage; they were increasingly harder to recover from. For decades, black poverty had been concentrated in urban zones, a by-product of earlier inner-city deindustrialization, racial segregation, and urban renewal projects of the 1950s and 1960s that decimated black neighborhoods and made them natural markets for heroin and cocaine.

Whites had historically been more likely to live in spread-out settings

that were less marred by social problems, but in much of rural America that was clearly no longer the case. These were the same counties where Donald Trump performed best in the 2016 election—the places with the most economic distress and the highest rates of drug, alcohol, and suicide mortality.

The national media's collective jaw-dropping at the enormity of needs displayed at the RAM event underscored the fact that the outside world had zero clue. As the Appalachian writer and health care administrator Wendy Welch noted: "We're not victims here, except for when it comes to Purdue Pharma. But when one of us makes a mistake, it tends to be a fatal one."

I found hope in the stories of Tyson's staff and patients as I set out, in multiple visits, to discern what happened after the volunteer doctors departed for their urban enclaves, and the politicians and pundits went home. I felt hope as I witnessed Tyson, a bubbly, every-curl-in-place blonde, manage her workaday free clinic as she seamlessly steered her rattling 2001 Winnebago through southwest Virginia's serpentine roads, juggling phone calls from nurses, patients, and the media alike—in high-heeled, rhinestone-studded sandals. With her sorghum-thick accent, Tyson was camera-ready and thoroughly put together each time we met, except once, when mascara smudged her doctor's coat.

I would find out soon enough why she'd been crying for days, and it wasn't because the battery on her Winnebago had just conked out. (The nonprofit's marketing manager was dispatched with the battery booster to give us a jump, while Tyson's husband offered real-time jump-starting counsel via FaceTime.)

It was a fitting state of affairs for what happens after the out-of-state RAM do-gooders depart and Tyson's grant-funded Health Wagon staff of twenty is left to tend to the health needs of the region's uninsured. The program is called the Health Wagon because it was founded in 1980 by a Catholic nun and medical missionary named Sister Bernie Kenny, now retired, who first provided care out of the back of her red Volkswagen Beetle.

At our first stop, Tyson treated the swollen wrist of a substitute teacher

whose pay had just been reduced from $70 to $56 a day. She was a casualty of school district depopulation and austerity, measures that included closing two schools in the town of Appalachia, one of which was now a food bank. In St. Paul, where our RV was presently stalled, the middle-school roof had become so tattered that buzzards had descended on it a few months earlier to eat the rotting tiles. With no money for repairs, school administrators resorted to temporary measures to divert the vultures, erecting giant inflatable tube men, the silly beacons you see waving from car dealerships.

The fifty-four-year-old teacher hadn't had insurance in decades, not since she was pregnant and qualified for Medicaid; her husband, a former Walmart worker disabled by a series of strokes, was on Medicare. Because Virginia hadn't approved the Affordable Care Act Medicaid expansion, she patched together free coverage at RAM events and occasional visits to Tyson's mobile unit when it came to town. She had to be practically dying before she went to see her family doctor, who accepted cash at a discount rate of $63 per visit.

In a state with an increasingly flimsy safety net, people like Tyson had been left to clean up the politicians' mess. As the health care debate over repeated attempts to repeal the ACA raged in Washington and opioid activists waited for President Trump to declare the epidemic an official national emergency—to free up immediate federal disaster relief funds for cities and states—between patients Tyson followed the machinations on her phone, fuming as she scrolled.

A devoutly religious wife and mother from nearby Coeburn, she was finding it hard to remain optimistic. In our first interview, she'd been distraught over the recent death of a forty-two-year-old patient caused by untreated hepatitis C. Though he hadn't used or injected drugs for eight years, he could not afford to see a specialist. And by the time treatment could be arranged, "the damage was already done, and he couldn't overcome it," said his father, who owns a twenty-seven-acre cemetery.

The man buried his son near his office so he could visit him daily, he said. He invited me to tour the Wise County graveyard, where he offered to point out the scores of people he'd personally buried thanks to

“OxyCoffin,” as the pills are now known here.

Months later, Tyson found herself crushed by a repeat in the continuing tragedy: In spite of 24/7 news cycles and a dense web of interconnectedness, here was one more death that gained no media traction and inspired zero public action. She could give all the interviews she wanted during the month of RAM, but the truth was that the extent of the suffering here garnered very little attention outside the spectacle of the annual health care event.

Unremarked on were the slow-simmering and increasingly common stories of people for whom no treatment could be secured. This time Tyson was crying about Reggie Stanley, forty-five, who died in a Charlottesville hospital while awaiting a liver transplant, after twelve years of untreated hepatitis C. “This patient was such a good person. He did make the wrong decisions initially,” Tyson said of Stanley’s IV drug use, but he’d been sober for several years. She’d tried desperately to get him into treatment, but like 90 percent of her patients, he was uninsured, and Tyson could not persuade a gastroenterologist to take him on as charity care. (She has since had success dispensing free medication provided by the company that makes Harvoni, the expensive hepatitis-curing drug.) By the time Stanley made it to a liver-transplant list, his disease was too advanced.

“You can fix it upstream, when it’s affordable, or you can wait till they present back in the ER with stage-four cancer or cirrhosis, and they still need extended hospital stays,” Tyson said. “It’s a drain on the system no matter what, so why can’t we fix it upstream?”

Tyson kept looking at Stanley’s obituary on her phone, which included a photo of him beaming in his Clintwood High graduation gown. “He was a great guitar player, great singer, and a good soul who was loved by many,” one of the guest-book mourners wrote.

The region’s health-department director, Dr. Sue Cantrell—the same one who’d warned state supervisors about the epidemic two decades before, only to have her pleas dismissed as “a regional problem”—was slowly making inroads. With the Scott County, Indiana, HIV epidemic still in mind, Cantrell had been holding town-hall meetings in the coalfield

counties throughout the summer of 2017 to sound the alarm. Though Virginia had recently passed legislation paving the way for syringe exchange programs, every legislator in the coalfields had voted against the bill, citing widespread local law enforcement concerns, even though crime historically has not risen in communities with access to clean needles. Across the border in West Virginia, a 2015 syringe exchange had resulted in lowered overdose deaths and five-times-greater access to treatment and disease prevention services. Cantrell was hoping to arrange a visit from a West Virginia police chief to talk to local authorities, and her staff was already teaching users to clean their syringes between injections, giving out Clorox packets and plastic cups. She sometimes offered free food to entice patients both to be tested and to return for their results.

The RAM clinic offered free hepatitis C testing for the first time—a pharmacy professor estimated that 75 percent of IV drug users in the region have contracted it "and have no idea"—and handed out take-home naloxone kits with training to almost four hundred people. "In a rural area like this, just trying to get people to their appointments is huge," Cantrell told me. Two patients in the MAT clinic she runs in nearby Lee County, Virginia, either hitchhike or walk to their appointments, some from a distance of more than five miles.

She'd floated the idea of turning some of the area's subsidized housing units into "clean living facilities," with wraparound services and support group offerings, not unlike substance-free college dorms. "We need to support this as a chronic disease the same as we support cancer and other diseases," Cantrell said. "Not just evidence-based treatment and drug prevention programs but broadening it to meaningful education that leads to jobs with a living wage so there are options to stay in the area—or to leave."

At the Narcotics Farm in Lexington, Kentucky, researchers had once referred to the latter as "the geographic cure."

The idea of moving away from the site of addiction's onset appealed to younger people who grew up among addicted family members as well as to the recovering addicts themselves, and it had worked for some, like many of the returning Vietnam soldiers. But opioids are much more available today than they were then—summonable by text or via online cryptomarkets, aka the dark web—and vastly more potent.

“The biggest lesson of the science behind drug addiction is that alternate reinforcers are essential,” Nancy D. Campbell, the Narcotics Farm historian, told me. “If you want to keep people away from drugs and drug-related crime, you have to have rewarding activities. It’s work. It’s play. It’s an emphasis on the kinds of activities and relationships that people build their lives around. If we don’t do something to rebuild these communities, I don’t see this current drug configuration ebbing in the way that drug waves of the past historically have.”

The question echoed louder by the day in rural America: How do you inspire hope in a middle-school boy whose goal in life is to become a “draw-er,” like his parents before him and their parents before them? Did a president who bragged about winning a swing state—telling the president of Mexico, “I won New Hampshire because New Hampshire is a drug-infested den”—win because voters genuinely thought he could fix it, or because too many people were too numbed out to vote?

Voters should judge politicians at all levels on the literal health of their communities, lawyer Bryan Stevenson explained. And while most Americans support federal financing of health care and even a slim majority approves of single-payer, those reforms will likely remain political nonstarters until more voters begin defining themselves in contrast to the billionaire class holding sway in Washington. Also needed are more efforts to court nonwhite voters, including Hispanics (of whom 74 percent are currently registered to vote), African Americans (69 percent), and Asian Americans (57 percent).

“You’ve got too many leaders just not responding to problems,” Stevenson said. “Think about with HIV, with smoking, with Zika, you had this energetic leadership from people who were saying, ‘We’re going to win this.’ The mind-set of ‘This is unacceptable’ has to be brought into the way we think about addiction and the opioid epidemic. But part of the problem now is, we’re so hopeless…that we don’t try very hard.”

America’s approach to its opioid problem is to rely on Battle of Dunkirk strategies—leaving the fight to well-meaning citizens, in their fishing vessels and private boats—when what’s really needed to win the war is a full-on Normandy Invasion.

Rather than puritanical platitudes, we need a *new* New Deal for the Drug Addicted. But the recent response has been led not by visionaries but by

campaigners spewing rally-style bunk about border walls and “Just Say No,” and the appointment of an attorney general who believes the failed War on Drugs should be amped up, not scaled back. Asked in August 2017 why he hadn’t taken his own commission’s recommendation to label the epidemic a national emergency, President Trump dodged the question. He said he believed the best way to keep people from getting addicted or overdosing was by “talking to youth and telling them: No good, really bad for you in every way.” A few days later, he seemed to change his mind, saying he *would* make the emergency official, even as he remained tethered to a law-and-order approach.

But months later, he still had not followed through. When the so-called emergency was retrumpeted in an October 2017 press conference, Trump sounded bold and even hopeful, but his ballyhoo fell short of an official declaration, and included no additional treatment funding. At the time, seven Americans were dying of overdose every hour.

To be fair, the crisis had been cruelly ignored by both sides of the political aisle. The Obama administration had also been slow to address the crisis and tepid when it did. Caroline Jean Acker, the historian who is also a harm-reduction activist, told me she was scolded during a 2014 NIDA meeting for championing needle exchange and naloxone distribution after a speaker attempted to separate “good” addicts, or people who became medically addicted, from the illicit, or “bad,” users—as if there were no fluidity between the two. “The worst thing for politicians, I was told, was for them to appear they were being soft on drugs. Even under Obama, federal [Substance Abuse and Mental Health Services Administration] employees were told not to use the term ‘harm reduction,’” she said, sighing.

No matter where I turned in central Appalachia, the biggest barriers to treatment remained cultural. Stigma pervaded the hills and hollows, repeating itself like an old-time ballad, each chorus featuring a slightly different riff.

At the RAM event in Wise, a kerfuffle erupted when a local judge volunteering at the event accused a pharmacist of giving Narcan training to

a local Boy Scout troop without their parents' permission; she claimed the kids would party harder knowing they had Narcan to revive them. "Just ridiculous," one trainer told me.

But across the region, where it seemed every family had at least one soul crusher of a story, it would take more than one fairground debate to convince people that harm reduction was necessary to save lives, even as the region had the worst hepatitis C rate in the state. One-third of children in central Appalachia now lived with a nonparent adult, and 96 percent of the adopted kids weren't orphaned—they'd been removed from their drug-addicted parents by social service workers.

At another Health Wagon event, a man overdosed on meth in the parking lot while his friends took off, running up the mountain, according to the responding EMT, who recognized a familiar unconscious face. "Repeats," as Giles Sartin refers to many of his overdose calls, saying: "It's rare you'll get somebody who's just now getting hold of it." Sartin, twenty-one, has been an EMT since the tenth grade. He made the decision to train the day he was sitting in a freshman English class and heard the double thump of two classmates seated behind him hitting the floor.

They'd overdosed on OxyContin during a lesson on grammar and punctuation.

"Last week I Narcanned the same person for the fourth time," Sartin said. When the man woke up, he punched Sartin's EMT partner and broke his nose. He'd been speedballing painkillers with meth, which makes users paranoid and gives them "ridiculous strength." It was such a problem that Sartin's rescue squad had to adopt a new protocol: Even though people could die, they waited now for police to arrive before they went inside the patients' homes.

"There's communities where we're like an ice cream truck," Sartin said of the ambulance. "They'll try to steal our needles, our gloves, everything," especially in the Lee County hamlets of Keokee and St. Charles.

When I explained that my book began with OxyContin abuse in Lee County in the late nineties, Sartin cut me off with a warning: "Ma'am, there are spots in St. Charles where I would advise you not to be there at night. If they catch ya and don't know ya, well…I don't know."

Tyson had revised the Health Wagon's safety procedures, too. Whereas in Lebanon she tends to set her RV up outside a Food City grocery, or near

the town square in St. Paul, she has learned to avoid residential neighborhoods in smaller communities. In the former coal camp of Clinchco, a close call had persuaded her to switch locales from a neighborhood to the police station parking lot.

Some neighbors had rushed to her RV, screaming and banging on the door for help. “We get to their trailer, and in the living room we get ready to work on the first person we see on the floor, but that wasn’t even who they were talking about,” Tyson recalled. The real patient was in the rear room, they were told, but her body was already growing cold. Meanwhile, others in the trailer were screaming at Health Wagon staffers “to get the f—outta here!”

“I still stand by what we did, trying to revive her, but the dynamics here are changing, and you can no longer just go blindly in,” said Tyson, who was genuinely afraid during the exchange.

Even law enforcement tightened up procedures. In June 2017, the DEA recommended that first responders wear safety goggles, masks, and even hazmat suits to avoid skin contact with fentanyl and other powerful synthetics after reports of officers having to be Narcanned when they inadvertently brushed up against them on calls.

But these guidelines came way too late for caregivers in the coalfields: Tyson’s life-and-death scare in Clincho took place more than a decade earlier—in 2006.

As a Lebanon prevention leader put it in a recent town-hall meeting called Taking Our Communities Back: “We are pioneers when it comes to this drug epidemic. We can tell people what will happen in their other communities in twenty years because it’s already happened here to us. We are the canaries in the coalfields.”

If it sounds like alarmist antidrug hyperbole—a version of Nixon’s speech identifying drug abuse as “public enemy number one”—it’s not. University of Pittsburgh public health dean Don Burke recently published a study forecasting the epidemic’s spread. Charting drug-overdose deaths going back to 1979, he added a new wrinkle to the work of Anne Case and Angus Deaton, the economists who pointed out the soaring “deaths of

despair” among midlife white Americans.

Drug-overdose deaths had doubled every eight years over that time: Three hundred thousand Americans had died of overdose in the past fifteen years, and lacking dramatic interventions, the same number would die *in just the next five*.

“The numbers by themselves are disturbing, but more disturbing is the pattern—a continuous, exponential, upward-sloping graph,” Burke told me in 2017. A year before, more than a hundred Americans a day were dying from opioid overdose. Some epidemiologists were predicting the toll would spike to 250 a day as synthetic opioids became more pervasive.

Opioids are now on pace to kill as many Americans in a decade as HIV/AIDS has since it began, with leveling-off projections tenuously predicted in a nebulous, far-off future: sometime after 2020. In past epidemics, as the public perception of risk increased, experimentation declined, and awareness worked its way into the psyche of young people, who came to understand: “Don’t mess with this shit, not even a little bit,” as another public health professor put it. But that message has not yet infiltrated the public conscience.

What about the more than 2.6 million Americans who are already addicted? Will the nation simply write them off as expendable “lowlifes,” as Van Zee’s patient still believed?

“My hope is that there is an end in sight,” Burke told me. “Some natural limit, or some policy where we deflect the curve downward.” But even in states where downturns have intermittently appeared—such as in Florida, following the crackdown on pill mills—“eventually those places snapped back to that curve, and we don’t know why,” he said.

In the carefully couched words of an academic, Burke suggested that the War on Drugs should be overhauled, with input gathered from other countries, including Portugal, that have decriminalized drugs and diverted public monies from incarceration to treatment and job creation.

He wondered whether drug cartels were the economy’s new invisible hand—a modern-day Adam Smith creeping around America’s suburbs, cities, and small towns, proffering stamped bags of dope. The economist had assumed the free-market economy would operate efficiently as long as everyone was able to work for his or her own self-interest, but he had not foreseen the elevation of rent-seeking behavior: the outsized greed of

pharmaceutical companies and factory-closing CEOs, and the creation of a class of people who were unable to work.

In 2017, two decades after OxyContin erupted in Lee County, Virginia's Board of Medicine ordered that, to prevent doctor-shopping, all doctors were to check the drug-monitoring system every time they issued a prescription. This mandate arrived at the same time new CDC figures showed that residents of two rural Virginia towns had been prescribed more opioids per person than any other place in the country. (The top locality was Martinsville, and the fourth was Galax, the small cities where my book *Factory Man* was largely set.)

As far behind as Virginia had been in its initial response, state health-department officials were now working hard to expand MAT as well as to crack down on its abuse. The expansion was mostly modeled after a Suboxone clinic in rural Lebanon, called Highpower, where a younger version of Art Van Zee, Dr. Hughes Melton, set up practice in 2000 because he wanted to treat the underserved. Melton was helping direct the state's response to the opioid crisis; among his initiatives was a new statewide push for syringe exchange and some tighter controls on MAT prescribing. His wife, Sarah Melton, a pharmacy professor and naloxone trainer, hadn't just given training sessions to more than four thousand doctors about the perils of opioids; she'd turned in a fair number for overprescribing them, too.

The Meltons were so busy that often the only times I could interview them were at night or when they were in their cars. It was in their Highpower clinic that several patients had first explained the diversion and abuse of buprenorphine to me—a practice harm-reduction proponents elsewhere in the country dismissed every time I brought it up.

Finding a balance between treating and perpetuating addiction had been pursued in the United States since the 1800s, when doctors used morphine to wean patients from laudanum, then later used heroin to get patients off morphine. Soldier's disease had sparked a period of stern prohibition in the Harrison Act and, eventually, the War on Drugs. "Our wacky culture can't seem to do anything in a nuanced way," explained Dr. Marc Fishman, a

Johns Hopkins researcher and MAT provider.

While Fishman believed buprenorphine, methadone, and naltrexone were all imperfect solutions, they remain, scientifically speaking, the best death-prevention tools in the box. “I apologize for my white-coated, nerdy scientist colleagues who have not invented better yet, I get it!” he said. The naysayers would be more open to MAT if its proponents would more openly acknowledge the drawbacks of maintenance drugs—significant relapse rates when patients stop treatment, for instance—instead of portraying them as a kind of perfect chemical fix, Fishman argued.

The explosive costs of addiction-related illness will eventually force health systems to integrate addiction treatment into general health care, he predicted, including a smoother transition of overdose patients from hospital ERs to outpatient MAT. “Too often, we’re still giving them Narcan, then sending them along with a tired old Xerox of AA meeting phone numbers, and telling them, ‘Have a nice life.’”

In a treatment landscape long dominated by twelve-step philosophy, only a slim minority of opioid addicts achieve long-term sobriety without the help of MAT, Fishman reminded me. “AA is not a scalable solution in an epidemic like this, and most opioid addicts just can’t do it” without MAT, he said.

In the Appalachian Bible Belt, a blend of MAT and twelve-step programs seemed to work best, which is why Art Van Zee and Sister Beth Davies still communicate daily about their patients, the nun letting the doctor know, for instance, when a shared patient suffers a personal setback, like a death in the family or a job loss. It had happened in the spring of 2017 with one of their longtime patients, Susan (not her real name), whose brother died of overdose. Then, a few months later, Sister Beth emailed me that it had happened again: Another of Susan’s brothers died of overdose, the youngest, whom she’d “practically raised. The loss is tremendous.”

Among Susan’s ten siblings, only three had managed not to become opioid-addicted, although one of the three was a pill dealer who didn’t himself use, Susan had told me. She’d been in Van Zee’s Suboxone program for six years and was now transitioning off disability via a program

called Ticket to Work. She was putting in twelve-hour shifts as a nursing-home licensed practical nurse and going to the local community college to earn her registered-nurse degree.

"Some of my family's like, 'Why don't you just keep your [disability] check and stay home?'

"And I'm like, 'I've always wanted to go to school to be a nurse, and I can't make it on seven hundred and forty dollars a month, and besides, you just feel so much better about yourself when you work.'"

Asked how the epidemic had changed her community, Susan sighed and told me it was now just an ingrained part of the culture. Her fifteen-year-old son believes the only way to avoid its perils is to move away. "I can't live here, Mom," he told her. "There's nothing here but drugs and nursing homes."

The first time Susan saw Van Zee, he spent two hours with her, learning her medical history, including the details of her addiction and childhood abuse. She'd recently had surgery for lung cancer, and he did not make her feel like crap for continuing to smoke (though he suggested she stop).

The members of her twelve-step support group—the one led by Sister Beth—like to joke: "When you go to Van Zee's office, you might as well take a pillow and a blanket and a book, because you're going to wait there a long time." They worry, though, about what they will do if something happens to the seventy-year-old doctor and the eighty-three-year-old nun. "There's so many of us who would just be—lost," Susan said.

Van Zee was still working sixteen-hour days, much to Sue Ella's chagrin. He was still conferring daily with Sister Beth over their growing roster of opioid-use-disorder patients (now the preferred term)—not counting the 150 people on his waiting list—either on the phone or via email multiple times a day.

Van Zee told me his greatest fear now was of being hit by an intoxicated driver while he jogged the winding roads—not because he feared his own death but because where, then, would his patients go?

Nationwide, attitudes about the drug-addicted were shifting, faster in urban settings than rural. At the edge of Boston's South End, in a neighborhood

some derisively called Methadone Mile, I stood in the low light of a homeless shelter clinic where users converged on a former conference room to be medically monitored as they rode out their heroin highs, often staggering in, propped between friends. In the facility's public restrooms, a clever maintenance worker had rigged reverse-motion detectors that sounded visual and audible alarms to summon help if a person hadn't moved for four minutes. The initiatives were the brainchild of the shelter's medical director, who had sometimes tripped over bodies on her way to work, some of them having been fatally struck by cars. Dr. Jessie Gaeta's goal in opening Supportive Place for Observation and Treatment inside the shelter was to keep users alive until they were ready to be funneled into treatment, as well as to separate them from those in the homeless community already in recovery (almost a third of the shelter's clients have opioid-use disorder).

But the brownstone-filled neighborhood was rapidly gentrifying, and the cultural obstacles, even in liberal Boston, were significant. Neighbors were worried that SPOT would just attract more heroin users, dirty needles, and crime. Many accused Gaeta and her staff of enabling continued drug use.

The project got the neighbors' reluctant blessing, but only after Gaeta invited community leaders and officials to the shelter and showed them what would happen in the small, ten-recliner room.

Over the course of more than fifty neighborhood meetings, "I got my ass kicked, basically," she said.

But many skeptics were won over when they realized she was treating the problems that were already happening outside *indoors.* In a program that didn't even keep patients' names on file (a strategy called low threshold, to build trust), staffers monitored those who stumbled in on heroin combined with an increasing multiplicity of other drugs.

The SPOT room was the first place where skittish rape victims would let Gaeta administer proactive treatments for sexually transmitted illness as they tentatively told her their stories in an adjoining kitchenette. Only then would they allow her to stanch the bleeding brought on by forced sodomy with a gun or by duct tape ripped from their mouths.

"Even in a mission-based organization, there's still so much stigma around how we should treat addiction," Gaeta said. "You have to constantly fight this notion that we shouldn't wrap our arms around people who don't

want treatment.”

Everywhere in America, it was painstaking to walk skeptics through the social, criminal, and medical benefits of helping the least of their brethren, but worth it—even if you had to get your ass kicked.

In Appalachia, harm reduction was very slowly making inroads. In Lebanon, Virginia, where anti-MAT drug-court workers had once been castigated by harm-reduction proponents, Judge Michael Moore’s hair had turned from salt-and-pepper to white in the year since I’d first interviewed him.

But the top Russell County prosecutor had recently signed off on allowing the drug court’s first Vivitrol participant, a thirty-year pill addict who admitted she could not stop abusing buprenorphine. Moore praised the prosecutor’s decision and viewed it as a harbinger of greater sensitivity in the criminal justice system to the realities of addiction. Half the probationers from his regular circuit-court docket were now on Suboxone, and “we do see good things with it,” he said. If his own kids were addicted, he told me, he, too, would want the option of MAT.

“Last fall the governor declared opioids an epidemic and I was like, ‘Are you kidding me? We’ve had the epidemic since 2002!’” Moore said. One of his present drug-court participants, in fact, was born dependent on the drugs.

“It’s really discouraging and scary because what kid, sixteen or seventeen, doesn’t know that opiates are addictive? They can see it in their family, so how can they not know, and yet they take them anyway. And there are parents out here just like me, or better, who have drug-addicted kids.”

The local schools had recently adopted new prevention models, after studies showed kids were more likely to use drugs after DARE. (One advocate told me she remembered her classmates sharpening the DON’T off their DARE pencils so they actually read DO DRUGS.) A new school policy diverted first-time juvenile offenders into treatment instead of expulsion or jail.

On Thursday nights, Judge Moore helps serve dinners to participants in a

twelve-step program at a local church. He also persuades his friends in the community—from fast-food managers to local contractors—to hire his drug-court participants.

At a recent jury orientation, Moore's bailiff was approached by two boys, ages four and five. Neil Smith thought they were the grandchildren of a potential juror, but it turned out they were only temporarily with him as foster children, and they were looking for a permanent parent—a fact that became clear when the boys took one look at his bailiff's uniform and asked him, "Will you be our daddy?"

Smith is on the far end of middle-aged, a kindly-looking sort. Both his parents worked in the mines, and they grew a twelve-acre plot of tobacco on the side near the hamlet of Cleveland. His first memory of the judge was from when they were both kids: He remembered an adolescent Michael Moore getting on the same Russell County school bus that he rode, his face obscured by an armload of books, his bright future laid out before him.

One of the truest things I heard in my reporting came from David Avruch, a Baltimore therapist who works with a largely homeless, heroin-addicted clientele. In his experience, the base problem wasn't a dearth of harm reduction but an economic structure that created more foster kids and fewer Michael Moores.

"The more we talk about the epidemic as an individual disease phenomenon or a moral failing, the easier it is to obfuscate and ignore the social and economic conditions that predispose certain individuals to addiction," Avruch said. The fix isn't more Suboxone or lectures on morality but rather a reinvigorated democracy that provides a pathway for meaningful work, with a living wage, for everybody.

Judge Moore asked me, three times in one sitting, what I had learned from my reporting that he could feel hopeful about. He chuckled as he said, "I can't wait to read your book, because then maybe we'll know what to do"—but he seemed closer to tears than laughter.

I told him what Sue Ella Kobak had said, more times than I could count: "The answer is always community." I told him about Teresa Tyson's Health Wagon and Sue Cantrell's commitment to stopping the spread of

hepatitis C. The elusive gap between law enforcement and health care seemed as if it were finally beginning to close, I explained, even in a few remote Appalachian towns.

I described a faith-based treatment center in nearby Bristol that had just turned a donated former nursing home into a rehab with 240 beds. Geared to housing addicted people, veterans, aging-out foster kids, and ex-offenders getting out of jail, it had been brought to fruition by Bristol Recovery Center director Bob Garrett, who had spent three years forging collaborations with local courts, police, churches, and social service agencies. Participants would eventually pay to live in the center, nestled in a peaceful wooded compound, after they found jobs with the center's help.

At first, Garrett told me, he wasn't going to allow participants to be on MAT, but he changed his mind after serving on a community coalition spearheaded by East Tennessee State University public health professor Robert Pack. Since then, he's preached the benefits of "evidence-based treatment" to churches across the state at dinners and presentations on addiction. "We want to show [the addicted] that they're loved and cared about," he told me. "And we're trying to teach the lay folk, 'They're not really bad people,' and 'That's a sin' doesn't really work."

I told Judge Moore, finally, that Pack's coalition—an alliance of mental health and substance abuse administrators who call themselves the working group—had just scored another coup. Of all the upstart recovery programs I had surveyed in my reporting, this collaboration represented the strongest model for thwarting governmental rigidity and bureaucratic indifference to the crisis, and it had the potential to be replicated elsewhere.

In a rural town between Johnson City and Kingsport, Tennessee, the alliance was about to open a treatment clinic called Overmountain Recovery. It was deliberately named: Overmountain, for the disparate group of local farmers and frontiersmen, called the Overmountain Men, who beat back the British in the Battle of Kings Mountain, turning the tide in the Revolutionary War; and Recovery, because the treatment is meant to go beyond MAT to include group and individual counseling, yoga, and other alternative therapies, plus job-training support. Though the outpatient clinic would eventually offer Suboxone, it would predominantly be a methadone clinic, because methadone is cheaper and harder to divert (participants drink the liquid daily in front of a nurse), and the nearest methadone facility in the

region was over a mountain some sixty miles away.

“We would not have pulled this off without the working group,” said Pack, who began his addiction research after losing a dear friend to opioid-related suicide in 2006. With the backing of his university, the region’s nonprofit hospital corporation, and the state’s mental health agency, Overmountain was the latest project of Pack’s working group, which had secured $2.5 million in grants, eight funded projects, twenty-five research proposals, and the opening of a Center for Prescription Drug Abuse geared toward research. And, maybe even more important, it was co-led by Dr. Steve Loyd, a charismatic physician with local roots who had been opioid-addicted himself.

Located in Gray, Tennessee, a solidly middle-class community of farmers and suburbanites, with Daniel Boone High School just a mile and a half away, Overmountain fought a mighty resistance on its march to opening its doors, in September 2017. Headed by a respected area farmer, Citizens to Maintain Gray worried that patients taking methadone would be too high to drive safely. And, while the members of the group weren’t exactly against the idea of the center, they didn’t want it anywhere near them, even as some admittedly privately to Loyd and Pack, “My son is dealing with this.” But the working group showed up and heard them out. They brought in outside police chiefs and methadone providers, giving decision makers examples and studies from other communities that overrode their safety concerns. To win near-unanimous approval from the city zoning board and the state, they willingly endured more than a year of public ass kicking. In a community of just 1,222 residents, more than 300 people had spoken out publicly against the project, some referring to Pack and Loyd as drug lords.

In recovery for more than a decade, Loyd knew exactly how to explain himself to people in his hometown, to make them see the struggle anew: Before seeking treatment, he had doctor-shopped his own colleagues, stolen from relatives’ medicine cabinets, and even faked an ankle injury so he could have orthopedic surgery and get discharged with painkillers. His father called him out on his addiction in 2004 and forced him to get help, funneling him into ninety days of inpatient rehab, followed by five years of random drug screens, support services, and intensive monitoring.

A key component of Loyd’s success was the threat of punishment; his

medical license could be yanked if he relapsed and/or made a critical medical error while treating a patient. He still checks in daily for the possibility of a random drug screen, via an app on his cellphone, even though he's now Tennessee's assistant commissioner for Substance Abuse Services. The daily routines of his life as a recovering addict and physician keep him committed to recovery, just as the scar on his left ankle reminds him how desperately low the drug-addicted can go.

Though Loyd's treatment was too expensive to be replicated to scale—he paid $40,000 cash up front (limited coverage is now available to those with insurance, but it would cost almost twice that today)—he believes the five-year treatment model, common for addicted doctors and airline pilots, is ideal. It's why they tend to have opioid-recovery rates as high as 70 to 90 percent.

"There's nothing scientific at all about twenty-eight days of [residential] treatment," Loyd said of the kind heralded in movies and on reality TV. "It takes the frontal lobe, the insight and judgment part that's been shut down by continued drug use, at least ninety days just to start to come back online and sometimes two years to be fully functioning."

But most users don't have access to ninety days of treatment, much less two years. Only one in ten addicted Americans gets any treatment at all for his or her substance use disorder—which is why there's such a push for outpatient MAT and, increasingly, programs that divert the addicted from jail to treatment.

While drug courts rightly provide not only intensive monitoring but also the threat of a swift jail sentence, Loyd believes that all people in recovery, especially those who relapse, should be allowed MAT, even if they have to sue to get it. "The judges who don't allow it are in violation of the Americans with Disabilities Act. They just are!" he said. Denying opioid-addicted participants medicine they have legitimately been prescribed is akin to denying diabetics their insulin on the grounds that they're fat.

If 90 percent of people with diabetes were unable to access medical treatment, there would be rioting in the streets.

Loyd made his MAT argument repeatedly as he tried to sell the idea of

Overmountain to the doubters in Gray, ten minutes down the road from his Boones Creek hometown. The crowd was tougher than he anticipated.

To intimidate him, they filmed him as he spoke. They yelled, “Put it in *your* neighborhood!” and placed condemning signs in the hands of their ten-year-old children as they marched.

At one meeting, Loyd tried to explain the science behind addiction—that it was a chronic brain disease, and relapses were to be expected—when a woman in the audience interrupted to ask, “Just how many chances are we supposed to give somebody?”

He tried to appeal to the group’s humanity, as Gaeta had done in Boston, pointing out that addiction *already was* in their neighborhood. Simply turning their heads away out of fear or sanctimonious denial was equivalent to enabling the spread of overdose deaths—quite possibly, even, in their own families.

From the community center where he stood, in the heart of the Bible Belt, Steve Loyd could make out four church steeples. He had played ball and gone to Sunday school with many of the people in the room.

There were leaders here and elsewhere who agreed with the woman, he knew, including an Ohio sheriff who’d recently proposed taking naloxone away from his deputies, claiming that repeated overdose reversals were “sucking the taxpayers dry.”

Loyd thought immediately of the answer Jesus gave when his disciple asked him to enumerate the concept of forgiveness. Should it be granted seven times, Peter wanted to know, or should a sinner be forgiven as many as seventy times?

In the shadow of the church steeples, Loyd let Jesus answer the woman’s question: “Seventy times seven,” he said.

If the federal government wouldn’t step in to save Appalachia, if it steadfastly refused to elevate methods of treatment, research, and harm reduction over punishment and jail, Appalachia would have to save itself.

Epilogue

Soldier’s Disease

Back in my adopted hometown of Roanoke, where I’d been following

families for going on six years, the addicted people I came to know were in widely ranging states of wellness, some far more fragile than others. Their relatives were worn out. Many seemed to age before my eyes, like a video on fast-forward.

The day his mother arrived to pick him up from the Petersburg, Virginia, penitentiary in February 2017, Spencer Mumpower was exuberant when he spotted her walking toward him. “I want to run to you, but I still have these prison clothes on, and I’m afraid they’ll shoot me!” he shouted, only half joking.

“That’s OK,” Ginger hollered back. “I’ll run to you.” There was almost no weekend since Spencer began his prison sentence, in 2012, when she hadn’t visited him in federal prison and/or put money on his commissary account, almost no month in which she had not tried to coax prosecutors, lawyers, politicians, probation officers, and even judges to grant her only son an early release.

That August, exactly a year after my prison interview with Ronnie Jones, Ginger left her Roanoke jewelry store, located on the fringes of Hidden Valley, and drove to a North Carolina halfway house to pick up Spencer, who had been living there for six months since his prison release. He was free to finally leave his confinement, all exquisitely toned 165 pounds of him, with a body that could deadlift five hundred pounds, in sets of five reps.

Sober for seven years, Spencer had replaced his heroin and methamphetamine addiction with martial arts even before he’d left for federal prison. The jujitsu practice had sustained him throughout his incarceration—even when his girlfriend dumped him and when his former martial-arts teacher and onetime father figure was arrested and jailed for taking indecent liberties with a teenage female student.

Spencer stuck to his recovery and to his prison workouts, ignoring the copious drugs that had been smuggled inside, and he read voraciously about mixed martial arts. Using the Bureau of Prisons’ limited email system, he had Ginger copy articles about various MMA fighters—laboriously pasting in one block of text at a time—so he could memorize pro tips and workout strategies and, eventually, through her, reach out directly to fighters and studio owners for advice.

If all goes well, Spencer will be taking the geographic cure when he

moves to another Virginia city, which he doesn't care to name, to work for one such studio—once his probation officer signs off. While he was enjoying his new freedom, the reality of life after prison was also settling in. Prison had given him post-traumatic stress disorder, he told me, and his transition to the outside world was proving to be far harder than he'd imagined. Sleeping in a room without the lights on or anyone else nearby made him nervous, as did driving a car. Ginger drove him to the gym most days, or he took an Uber, which didn't exist in Roanoke when he left for prison in 2012. To help with his PTSD, he planned to get a service dog.

Scott Roth's mom, Robin, still texted me regularly with pictures of sunflowers, along with images of Vanilla Rice pretending to cook with a sword, and another jokey one of him donning her fur coat the Christmas before he died. She texted a picture of an eighth-grade Scott, blond and bespectacled and wearing a classy black tux to his Catholic-school dance. He'd insisted she buy him a dozen roses for the dance, not just for his date but also for the girls who didn't have one, she wrote; a trail of sunflower emojis decorated her note.

Still engulfed in her grief, Robin Roth had been mourning her son's death now for eight years, and she was occasionally asked by his old friends for help getting into treatment, which she happily extended. She wanted me to convey both the depth of her grief and the ways in which she believed she had failed her son: "I wish I would have built him a stronger support system. I thought I could do it all as a single mom. I made a mistake. Find at least four adults your young adult can trust and turn to. Know their names and let them know that you are counting on them to help you assist your child to make good choices.

"Whatever rules you make, you better stick to them. Your son or daughter depends on it. They will call your bluff on everything. Don't you budge. Changing the rules only confuses a young, developing mind."

Two years earlier, Robin had moved into an apartment, downsizing from the suburban split-level where she'd raised her only child. It had been hard to leave the Hidden Valley home: the place where she'd removed all the bathroom doors, thinking that might keep Scott from shooting up; the yard

where she'd grown the massive sunflower field after his death.

Occasionally, stray sunflowers still sprout up in the yard of her former home—eight feet tall, some of them, with a dozen or more blooms. They are not just memorials to Scott Roth but also to the epidemic's intractability. The young woman who bought Robin's house had not only been addicted to heroin herself (she's been sober now for more than four years), but her sister, twenty-seven-year-old Joey Gilbert, is the one who relapsed and died in March 2017, despite the Hope Initiative angels' herculean efforts to help her. Had Joey had access to Medicaid health insurance and a clear path forward for continuing her MAT, her family firmly believes, she'd be alive today.

In the early fall of 2017, I sat down again with the Hope Initiative director, Janine Underwood, Bobby's mom, who grew more despairing by the day. All the overdoses and all the deaths—none of it seemed to inspire more awareness of the tragedy or its toll on families, many of whom were still cowering in shame.

Bobby's old friends continued showing up to Hope every week. Some had been using for almost a decade, and "they are so, so very tired of the way they're living," Janine said, and yet they were so equally afraid to give it up.

One friend, a thirty-year-old man, had broken down when he realized Janine was Bobby's mom. Though his mother had driven him to the Hope clinic from the suburban ranch-house-turned-meth-lab where he now lived, she was so ashamed that she waited outside in her car.

Betsy (not her real name), a young woman who had once babysat for Bobby's sister, showed up recently at Hope, too, determined to get sober. But by the time Janine and Hope volunteer Nancy Hans went to her home to help arrange a transfer to detox, Betsy was nodding out. During a brief coherent moment, she pulled out her Hidden Valley High yearbook, pointing to a homecoming-dance picture of herself and her friends: Three of the five were now active heroin users, she said, her voice slurring as she spoke.

Then, abruptly, she pointed to the window. "Look, it's raining," she said.

“That’s Bobby looking down on us.”

Nancy and Janine made dozens of phone calls to get Betsy into the community services board-run detox. Janine even drove her to the facility, but it wasn’t yet providing buprenorphine for detox, and Betsy left after just twelve hours, saying she couldn’t take the pain of being dopesick.

By the time the women lined up a facility that would allow her to be on MAT, Betsy had fled to New York, partly to avoid an upcoming court date for drug charges. A few days later, she overdosed on fentanyl-laced heroin in Central Park, where EMS workers revived her and let her go. The last Janine heard from Betsy, she had taken off for New Jersey, where she was now presumably trading sex for drugs.

Unlike the Tennessee Tri-Cities collaboration that had birthed Overmountain, Roanoke had not created a working group to transcend bureaucratic logjams, but perhaps in time it would. Nonfatal overdoses in 2017 had more than doubled the previous year’s count, and fatal overdoses had nearly tripled (and those figures were likely an undercount).

At a sparsely attended public forum at Tess’s alma mater, police recounted the August 2017 seizure of 4.4 pounds of fentanyl along I-81—enough for 1 million fatal overdoses. They’d also recently arrested a Cave Spring High graduate attempting to sell 700 “Xanax bars” at the local community college that contained fentanyl he’d mail-ordered via the dark web from Hong Kong.

Ronnie Jones was right again: Shit had not stopped at all, but with continued regional-media cutbacks—the *Roanoke Times* was down to just a single Roanoke Valley police reporter, and there were now sprawling heroin-ring prosecutions that received zero media attention—the public was left to believe that it had.

Warren Bickel, the world-class addiction researcher, had just nabbed a $1 million grant for his Virginia Tech Carilion Research Institute to pilot new MAT protocols for the streamlining of ER-to-outpatient transfers: Patients who overdosed would be directly connected to outpatient buprenorphine via a newly FDA-approved once-monthly injection called Sublocade. Bickel had recently lost a family friend to overdose. The young

man had been taking Suboxone, but when he tested positive for additional opioids during a follow-up visit, his doctor cut his Suboxone dosage back as punishment. “What he needed was an increased dose, not less,” Bickel said. When I told Bickel that Tess was still living homeless on the streets of Las Vegas, paying for illicit drugs with sex work, he called up a study he’d coauthored in 1988, showing that buprenorphine definitively protects the addicted from overdose death and leads to reduced crime and better health. “Holy mackerel, this is such an old study, but people still aren’t aware,” he said.

The community services board in Roanoke had recently added MAT treatment for twenty-one patients, but only if they first engaged in counseling. Carilion still had a three-week wait for its outpatient MAT. When I floated the idea at a Carilion-sponsored forum that every doctor who’d accepted a Purdue Pharma freebie should feel morally compelled to become waivered to prescribe Suboxone as a way to beef up treatment capacity, the response among the doctors in the room was…crickets.

As Philadelphia edged closer to launching the nation’s first supervised safe-injection facility, efforts to start a syringe-exchange program in Roanoke remained sluggish and mired in politics—even as the rural health department director Dr. Sue Cantrell finally won permission to open one in Wise, in the most conservative part of the state. The Virginia General Assembly seemed on the verge of passing a Medicaid expansion, finally, but with a provision that the “able-bodied” be required to work.

The changes weren’t trickling down fast enough for Tess. When I told her mom about the limited MAT expansions in the fall of 2017, paid for via state and federal grants, she called the community services board office and was told that only pregnant women were being accepted at the time. Soon after, Tess messaged me at 4 a.m. from someone else’s phone, saying she planned to enter another Nevada rehab and asking if I’d send her more books when she got there.

I texted back that I already had the new David Sedaris book ready to send.

“Oh, awesome!” she said, thanking me for my “positivity” and support.

She didn’t have an address where she could receive the book, but she would let me know when she checked herself into a rehab. Her elderly grandfather had agreed to fund another round of treatment, even though Tess had recently talked him into wiring her $500, allegedly to pay a friend to drive her back to Roanoke. “He knew he was being played, but he loves her so much, and he was probably thinking, ‘What if she’s hungry?’” said Patricia, who learned about her dad’s cash transfer after the fact. Though the ploy was likely another con for drug money, Patricia was buoyed by Tess’s having reached out to her family and me, and updating her Facebook page with pictures of her son. Unknown to us at the time, Tess had applied for Medicaid in Nevada, which expanded access in 2014 under the ACA—another indication that she was actively seeking treatment and MAT.

“The problem is, we don’t even know where she is” or, worse, what pimp and/or drug dealer she was now beholden to. In a November 2017 phone call, Tess was hopped up on crystal meth, Patricia believed, and paranoid that “gang stalkers” were trying to kill her. As she walked down the streets of Las Vegas, she thought people in passing cars were flashing their lights at her. She thought strangers were shouting her son’s name.

“All Tess has to do is tell us where she is, and the treatment people will come and pick her up.”

Of the 132 addicted users who had come to the Hope Initiative in its first year, fewer than ten had gone to residential treatment and stayed sober.

But Patricia still slept with her cellphone every night, waiting and praying that Tess would one day be among them.

In early December, Tess seemed better, judging from sporadic text messages and calls to her mom. She’d decided to make her way home to Roanoke, though her plans for the journey were vague. Patricia lined up a bed at an abstinence-only treatment center fifteen minutes from her home, Tess’s grandfather agreed to cover the flight and rehab, and Patricia spent a week navigating the Department of Motor Vehicles bureaucracy to get Tess a temporary ID that would allow her to board an airplane.

But where to send the ID? Tess was still homeless, and another week passed before she called Patricia with an address via a borrowed phone,

possibly belonging to a current or former pimp. “Are you in danger?” her mom asked, and Tess claimed she was not, repeating a line she often said: “I’m a soldier, Mom. I’ll be fine.”

“Yes, love,” Patricia responded. “But sometimes even soldiers fall.”

On December 9, Tess may have used that same borrowed phone to respond to one of my Facebook posts, about an early reading I’d given in a Richmond bookstore from the prologue of this book. “Yay,” she wrote. “I helped make it!”

I told her, via instant messenger, that her mother and I were eager to see her. She asked if she could read an advance copy of this book, I said she could, and later she texted that she really wanted to “work on it.” It was unclear whether she was referring generally to her recovery or to the trip back to Roanoke for her fourth rehab attempt.

Tess was walking the Las Vegas streets at night, I would later learn, often picking up johns, sometimes sleeping in corners of a casino. Her last known residence was an abandoned minivan in a parking lot. During one winter freeze, she turned up at a friend’s house wrapped in a blanket. “Some nights I’ve talked to her, and she’d just be up walking all night,” said Mark Sharp, who befriended Tess in rehab in the spring. “She missed her son a lot. She wanted her mom. She said she was all right, but I was like, ‘No, you’re not.’”

A construction laborer and former heroin user now working in Portsmouth, Virginia, Sharp said he offered to fly out and drive her back in a rental car, but Tess told him not to worry; her mother was making arrangements to fly her home.

“For a drug addict trying to be clean, Vegas is really no place to be,” Sharp said. Tess was aware of Las Vegas gangs, but she wasn’t mixed up in them, to Sharp’s knowledge. “She wasn’t afraid to go into the wrong part of town, though,” he added. “She really weren’t scared of nothing.”

Tess gave Sharp the same line she gave her mother: She was a soldier, not to worry, she would make it home.

In the days leading up to Christmas, Tess sent her mother scattered texts with mixed messages, telling her she loved her, thanking her for looking

after her son and her beloved dog, Koda. She'd be home soon, she insisted, though she had yet to pick up her ID.

"Our poet has been begging for money, saying she is sick but no trip to ER," Patricia texted me on December 22.

The next day, Tess wrote to say she'd just gotten on Suboxone, to prevent her from becoming dopesick during her trip. But she still hadn't picked up her ID.

"I am thankful for my dad and have peace of mind knowing that when she is ready I can make something happen quickly," Patricia said, the day before Christmas Eve. "It is for the angels to watch over her."

The morning after Christmas, Patricia got the call. Las Vegas police had traced Tess's identity through her fingerprints and her tattoos—the Tree of Life on her shoulder and another on her side that said "God forgive me my sins."

On Christmas Eve, in the Dumpster of a central Las Vegas apartment complex, a homeless man foraging for cans discovered Tess. She was naked, inside a plastic bag, and there were partial burns on her body and the bag, as if whoever murdered her had tried to erase the evidence of her death. The cause of death was blunt head trauma.

The story made national news, and Patricia, determined that people should understand both the disease of addiction and her daughter's incredible strength, spoke to every reporter who contacted her. The attention made some family members uncomfortable.

I saw a family riven by Tess's death as it had been throughout the last five years of her life, some members second-guessing each other's actions and still debating enabling versus helping and the meaning of tough love. "As my son is fond of saying, 'Whenever Tessy was presented with choices, she was expert at making the very worst choice,'" said her father, Alan, enumerating the many times that he and Tess's siblings had tried to help, paying for rent, rehab, or food. But those efforts were primarily in the earlier years of Tess's addiction.

By the time Tess left for Nevada, as she wrote in her journal around that time, "I was stealing, robbing, selling my body, and anything else I could do

to make money for drugs. I was beaten, raped, robbed, and malnourished. I ended up in the hospital with my mom's help where I detoxed and got on medication and where I am writing this now. I am going to die if I keep living the way I am."

She was dead now, her grieving family a perfect microcosm of the nation's response to the opioid epidemic: well-meaning but as divided as it was helpless, and utterly worn out.

Police were investigating, but Alan Henry theorized that Tess "had gotten crosswise with somebody she owed something to," possibly a drug dealer or a pimp—an argument Patricia rejected outright as blaming and unjust "when we have no idea of what happened to her."

A former counselor of Tess's who works with addicted and sex-trafficked women in Las Vegas said it was entirely possible that Tess had in fact been a victim of gang stalking. Addicted women who do sex work are sometimes threatened with rape or murder if they refuse to join a gang trying to "turn them out," or coerce them into prostituting themselves on the gang's behalf.

Another rehab worker who knew Tess and had herself been a heroin-addicted sex worker from 2003 to 2010 told me that four of her prostitute friends had been murdered by gangs and left in Dumpsters and, in one case, the air-conditioning ducts of a motel. "These gangs will stalk you and hurt you and block you from making money," said Kathleen Quirk, who does street-level counseling with addicted prostitutes in Las Vegas, offering cookies she bakes in her home as a way to forge an initial bond. "They make your life miserable until you do what they say—or you end up dead."

The scenarios were almost beyond comprehension for those at home closest to Tess.

Her grandfather, a retired auditor for IBM, was struggling to grasp the violent nature of Tess's death. As Patricia relayed the details in the booth of a steakhouse chain, where they stopped after making arrangements for Tess's cremation, his eyes welled with tears and he said, "Oh…That means somebody hit her."

Tess finally made her flight home the night of December 30. It was

unseasonably cold in Virginia, the winds howling and furious. The snow flurries reminded Patricia of all the cold nights she'd spent worrying about Tess. She was still sleeping with her cellphone, awaiting Tess's transport to Roanoke. Just after midnight, she texted me:

Her body has arrived.

It took funeral-home technicians two days to make Tess presentable enough for Patricia to view her body. Her head had been shaved in Las Vegas, for the collection of evidence, and Tess's older sister had picked out an outfit from one of Tess's favorite shops, including an embroidered vest, leggings, and a bright silk-cashmere headscarf with a boisterous, smiling Frida Kahlo.

In a windowless nook of a downtown Roanoke funeral parlor, not far from where Tess once roamed the streets, Patricia caressed the back of the scarf, as if cupping a baby's head, and told her poet goodbye.

It was January 2, Tess's birthday. She would have been twenty-nine.

Patricia tucked the treasures of her daughter's life inside the vest—a picture of her boy and one of his cotton onesies that was Tess's favorite, some strands of Koda's hair, and a sand dollar.

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Prologue

Interviews: Ronnie Jones, Don Burke, Kristi Fernandez

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Chapter One. The United States of Amnesia

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Chapter Two. Swag ’n’ Dash

Interviews: Dr. Steve Huff, Rosemary Hopkins, Ray Kohl, Dr. Sue Cantrell, Dr. Art Van Zee, Sue Ella Kobak, Dr. Vince Stravino, Jan Mosley, Greg Stewart, Dr. Molly O’Dell, Debbie Honaker, Jennifer Ball, Crystal Street, Sister Beth Davies, John Kelly, Doug Clark, Dennis Lee, Emmitt Yeary, Sheriff Gary Parsons, Rev. Clyde Hester, Tony Lawson

detailed television ads touting specific medical claims: Dylan Scott, “The Untold Story of TV’s First Prescription Drug Ad,” *STAT,* Dec. 11, 2015, https://www.statnews.com/2015/12/11/untold-story-tvs-first-prescription-drug-ad/.

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there were scant industry or federal guidelines: U.S. General Accountability Office report, “OxyContin Abuse and Diversion and Efforts to Address the Problem,” December 2003, 15–17, https://www.gao.gov/new.items/d04110.pdf. Voluntary guidelines regarding drug company marketing and promotion were issued by July 2002 by the Pharmaceutical Research and Manufacturers of America. In April 2003, voluntary guidelines were issued by the Office of Inspector General, U.S. Department of Health and Human Services.

Purdue handpicked the physicians: Barry Meier, *Pain Killer: A “Wonder” Drug’s Trail of Addiction and Death* (New York: Rodale Press, 2003), 99–101.

If a doctor was already prescribing lots of Percocet: Ibid., 103. High-prescriber target was also outlined in Purdue Pharma’s 1996 Budget Plan for OxyContin, 56.

a term reps use as a predictor: Deciles are based on volume, past prescribing history, managed care mix, and adopter status, and are used as a way of getting reps to prioritize time and resources; author interview, longtime pharmaceutical sales rep, Dec. 18, 2017.

the more visits that doctor received: Purdue Pharma’s 1999 Budget Plan, 65. Meier, 99–103. GAO report, “OxyContin Abuse and Diversion,” 15–20: “Purdue directed its sales representatives to focus on the physicians in their sales territories who were high opioid prescribers.”

who often brought along “reminders”: Purdue Pharma’s 1999 Budget Plan, 65.

the higher the milligrams a doctor prescribed: Author interview, former Purdue Pharma OxyContin sales rep, Jan. 26, 2017.

family doctors now the largest single group: Paul Tough, “The Alchemy of OxyContin,” *New York Times Magazine,* July 29, 2001.

Reps began coming by before holidays: Author interview, pharmaceutical sales rep, July 28, 2016.

Purdue reps were heavily incentivized: David Armstrong, “Secret Trove Reveals Bold ‘Crusade’ to Make OxyContin a Blockbuster,” *STAT,* Sept. 22, 2016.

“We were impressionable young doctors”: Author interview, Dr. Steve Huff, Aug. 7, 2016.

When he set about trying to coax: Ibid., Sept. 26, 2017.

“Cadillac high”: Author interview, Rosemary Hopkins, Sept. 23, 2016.

in nearby Galax, a factory town: Author interview, Ray Kohl, director of tourism for Galax, Aug.

8, 2016.

Cantrell remembered setting up: Author interview, Dr. Sue Cantrell, March 23, 2016.

Jobs in coal mining: Brad Plumer, "Here's Why Central Appalachia's Coal Industry Is Dying," *Washington Post*, Nov. 4, 2013; Nathan Bomey, "Coal's Demise Threatens Appalachian Miners, Firms as Production Moves West," *USA Today,* April 19, 2016.

That's where he met his wife: Author interview, Dr. Art Van Zee, Sept. 3, 2017.

"'The best doctor in America'": Author interview, Dr. Vince Stravino, March 13, 2017.

Locals often compared Van Zee… to Abraham Lincoln: Author interview, Jan Mosley, June 30, 2016.

"When his patients are admitted to the ER": Ibid.

accompany a patient in cardiac arrest: Author interview, Greg Stewart, Sept. 23, 2016.

The time when he cracked three ribs: Author interviews, Van Zee and Sue Ella Kobak, March 3 and 4, 2017.

a physician colleague treated a septuagenarian: Author interview, Stravino.

"Nobody would listen to her": Author interview, Dr. Molly O'Dell, March 22, 2016.

In 1997, the Roanoke-based medical examiner: Rex Bowman, "28 Deaths Linked to Drug—OxyContin Plagues Southwest Virginia," *Richmond Times-Dispatch*, Feb. 9, 2001.

"a little bit unique": Bowman, "Drug Sparks Crime Surge—Southwest Virginia Hit Hard by Opiate Abuse," *Richmond Times-Dispatch,* Oct. 21, 2000. The overdose deaths weren't reported until Bowman's report the following February.

So it happened that in the early 2000s: Author interview, Debbie Honaker, March 16, 2016; follow-up interview, Aug. 8, 2016.

The Board of Medicine suspended Dr. Dwight Bailey's: Lindsey Price, "Doctor's License Suspended Amid Prescription Drug Allegations," WCYB, Aug. 6, 2014, and confirmed in the Board of Medicine's License Lookup: https://dhp.virginiainteractive.org/Lookup/Detail/0101031921. "Had he not given her that junk, my sister would still be here," said Jennifer Ball, who said her sister sought help from Bailey after injuring her back while lifting her handicapped son. She died at forty-one from a heart attack brought on by a combination of blood-pressure medicine, Xanax, and opioids; author interview, Ball, Aug. 5, 2016.

"It's our culture now": Author interview, Crystal Street, March 16, 2016.

24 percent of Lee High School juniors: Author interview, Van Zee, Sept. 23, 2016.

Machias, Maine, was a remote town: The population of Washington County in Maine has been in decline for the last three census periods; the median household income is $38,083, according to U.S. Census data from 2010 and 2016. Nearly one in three children in the county lives in poverty, according to Tom Walsh, *Bangor Daily News*, Feb. 7, 2012.

The plainspoken sheriff: Donna Gold, "A Prescription for Crime," *Boston Globe*, May 21, 2000.

"That's us!": Author interview, Sister Beth Davies, Sept. 23, 2016.

"The extent and prevalence": Letter from Van Zee to Dr. J. David Haddox, Aug. 20, 2000. Van Zee's medical partner, Dr. Vince Stravino, had already filed official complaints about children in the area "crushing, snorting and injecting Oxycontin" and "come to the hospital with overdoses and abscesses because of injections," according to a Purdue response written by Mayra Ballina, the company's associate medical director, on May 8, 2000.

"My fear is that these are sentinel areas": Letter from Van Zee to Dr. Daniel Spyker, Purdue's senior medical director, Nov. 23, 2000.

Forty to 60 percent of addicted opioid users: George E. Woody, "Advances in the Treatment of Opioid Use Disorders," National Institutes of Health, Jan. 27, 2017: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5288680/#ref-1; M. J. Fleury et al.,

"Remission from Substance Use Disorders: A Systematic Review and Meta-Analysis," *Drug and Alcohol Dependence*, Nov. 1, 2016; studies interpreted by Harvard Medical School's John Kelly, author interview, Aug. 31, 2017.

"Among the remedies which it has pleased": Meier, *Pain Killer*, 42.

makers of the painkiller Talwin: C. Baum, J. P. Hsu, and R. C. Nelson, "The Impact of the Addition of Naloxone on the Use and Abuse of Pentazocine," *Public Health*, July-August 1987: 426–29.

Unemployed Tazewell miners: Author interview, Doug Clark, Aug. 9, 2016.

and he seemed intimidating: Author interview, then–Tazewell County prosecutor Dennis Lee, now in private practice, May 2, 2016.

"There's just no comparison": Tom Angleberger, "Panel Discusses OxyContin Problem," *Roanoke Times*, Sept. 25, 2000.

Sales-rep bonuses were growing exponentially: In 2001, the average salary for a Purdue sales rep was $55,000, and the average bonus was $71,500, according to U.S. General Accountability Office report, "OxyContin Abuse and Diversion and Efforts to Address the Problem," December 2003, https://www.gao.gov/new.items/d04110.pdf.

"starter coupons": Ibid., 23. "In 1998 and 1999, each sales representative had 25 coupons that were redeemable for a free 30-day supply.…Approximately 34,000 coupons had been redeemed nationally when the program was terminated in July 2001."

The trips were free: Ibid., 22.

"The doctors started prostituting themselves": Author interview, Emmitt Yeary, Jan. 24, 2017.

Purdue had passed out fifteen thousand copies: GAO report, "OxyContin Abuse and Diversion," 27.

"pseudo addiction": Explained in the Purdue Pharma "I Got My Life Back: Patients in Pain Tell Their Story" video, narrated by Dr. Alan Spanos, 1997.

"go to sleep" before they stopped breathing: Thomas Catan and Evan Perez, "A Pain-Drug Champion Has Second Thoughts," *Wall Street Journal*, Dec. 17, 2012.

The region had now buried forty-three: Laurence Hammack, "Deaths from OxyContin Overdoses on the Rise," *Roanoke Times*, Feb. 10, 2001, and author interviews, Van Zee.

At the Lee County jail: Hammack, "Lee County Is the Epicenter of Abuse," *Roanoke Times*, June 10, 2001.

"stacking 'em on the floor": Author interview, Lee County sheriff Gary Parsons, March 3, 2017.

one of the prisoners had bought four OxyContin tablets: Rex Bowman, "Prescription for Crime," *Time*, March 21, 2005.

While attempting to make a night deposit: Harless Rose was sentenced to life in prison for murdering the thirty-five-year-old store manager, Timothy Hughes; author interview, Richard Stallard, March 3, 2017; and "Life Term Imposed in Wise Slaying," *Richmond Times-Dispatch*, March 31, 2003 (wire reports).

a man made the bold move: Billy Gene Lawson fired a shot at two young men trying to get his wife's pills, shooting twenty-six-year-old Shannon Fleenor in the back of the head. Lawson was charged with second-degree murder, but a jury of twelve county residents voted to acquit; author interview, Stallard.

"'spot and steal'": Author interview, Rev. Clyde Hester, March 3, 2017.

petition drive asking the FDA: Originally at recalloxycontinnow.org, but the website is no longer live.

"In a place where people barely have money": Author interview, Stravino.

"the crack of Southwest Virginia": Hammack, "Deaths from OxyContin Overdoses on the Rise."

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Laurence Hammack, "OxyContin," *Roanoke Times*, June 10, 2001.

ten-point plan to curb abuse: Ibid.

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black-box warning on the drug: Reuters Health, "Purdue Pharma's OxyContin to Get Black Box Warning," July 25, 2001.

It was now possible for a rep: Author interviews, former Purdue sales reps, Jan. 26 and Nov. 1, 2017.

"The issue is drug abuse, not the drug": Laurence Hammack, "Seeing OxyContin Abuse Firsthand Pushes St. Charles Doctor's Petition," *Roanoke Times*, Nov. 25, 2001.

"We are an average family": Meier, *Pain Killer,* 138; author interview with banker, name withheld by request, Jan. 12, 2017.

"'tremendous insult'": Author interview, Kobak, March 3, 2017.

the newspaper ad never ran: Meier, *Pain Killer,* 140.

The next day Friedman gathered with: Author interview, Stewart, Sept. 23, 2016; banker interview (name withheld by request), Jan. 12, 2017; and Meier, *Pain Killer,* 140–42 .

"except broken bodies": Author interview, Kobak.

executives might be able to intimidate the people: Author interview, Sister Beth Davies, Aug. 10, 2016. "Beth, my hands are tied," she remembered her former student telling her, apologetically.

Sister Beth had stood up to a crowd: Greg Edwards, "Plant Moves to Clean Up Spill," *Roanoke Times*, Oct. 31, 1996.

That event pitted company miners: Author interview via email, Sister Beth Davies, Feb. 3, 2017.

"She was absolutely the most fearless": Author interview, Tony Lawson, Jan. 30, 2017.

"Greed makes people violent": "A Connecticut Yankee Meets Ol' King Coal," excerpted from John G. Deedy, *The New Nuns: Serving Where the Spirit Leads* (Chicago: Fides/Claretian, 1982), in *Salt*, September 1982.

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Chapter Three. Message Board Memorial

Interviews: Dr. Steve Huff, Ed Bisch, David Courtwright, Eric Wish, Nancy D. Campbell, Lee Nuss, Barbara Van Rooyan, Dr. Art Van Zee, Dr. Steve Gelfand, Richard Ausness, Laurence Hammack, Barry Meier, Lisa Nina McCauley Green, Lt. Richard Stallard, Randy Ramseyer, John Brownlee

***New York Times* reporter Barry Meier and a colleague:** Francis X. Clines with Barry Meier, "Cancer Painkillers Pose New Abuse Threat," *New York Times*, Feb. 9, 2001.

The news was disseminating, finally: Paul Tough, "The Alchemy of OxyContin," *New York Times Magazine*, July 29, 2001. The extent of the spread of the drug was also chronicled early on by Seamus McGraw, "The Most Dangerous Drug to Hit Small-Town America Since Crack Cocaine?," *Spin*, July 2001.

"pharming": Author interview, Dr. Steve Huff, Sept. 27, 2017.

his son was dead from it: Author interview, Ed Bisch, Jan. 26, 2017.

"After the old-time addicts died out": Author interview, David Courtwright, July 21, 2016.

hipster counterculture: Courtwright, *Dark Paradise: A History of Opiate Addiction in America* (Cambridge, MA: Harvard University Press, 2001), 148–52.

Progressive doctors championed the carefully restricted use: Courtwright, "Preventing and Treating Narcotic Addiction—A Century of Federal Drug Control," *New England Journal of Medicine*, Nov. 26, 2015.

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they returned to spread-out social networks: Lee N. Robins et al., "Vietnam Veterans Three Years After Vietnam: How Our Study Changed Our View of Heroin," *American Journal on Addictions*, May 2010: 203–211; author interview, Eric Wish, April 22, 2016.

the veterans who continued to struggle with addiction: Author interview, historian Nancy D. Campbell, Aug. 9, 2017.

"In the early 1990s, probably ninety percent": Author interview, Courtwright.

bluntest moniker he could think of: After some heated exchanges with Purdue that ended with the company giving him a $10,000 "grant" for equipment to facilitate drug-awareness presentations, Bisch was persuaded to change the name to OxyAbuseKills.com, a decision he later regretted. "I was duped," Bisch told me.

the drug's sales in 2001 hit $1 billion: Barry Meier and Melody Petersen, "Sales of Painkiller Grew Rapidly, But Success Brought a High Cost," *New York Times*, March 5, 2001.

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Purdue's marketing of OxyContin had been "appropriate": Bloodsworth, "Group to Target

OxyContin Maker in Orlando Rally," *Orlando Sentinel*, Nov. 17, 2003.

"At the time, I knew very little about the drug": Author interview, Barbara Van Rooyan, Jan. 16, 2017. The right-wing radio host made national headlines in 2003 after checking himself into rehab for an addiction to OxyContin, publicly admitting that he had tried to kick his painkiller habit twice before: Jerry Adler, "In the Grip of a Deeper Pain," *Newsweek*, Oct. 20, 2003.

Sue Ella admired the way her mild-mannered husband was stifling: Author interview, Sue Ella Kobak, March 4, 2017.

Wright had signed off on a 1995-filed NDA review and **"Care should be taken":** "Medical Officer Review," NDA #20-553, 14, written by Curtis Wright, Team Medical Review Officer. The 68 percent figure, also included in the NDA, comes from the Center for Drug Evaluation and Research Pilot Drug Evaluation Staff, "Pharmacology Review," submitted Dec. 28, 1994, NDA #20-553, 6.

"the biggest form of drug abuse today": Chris Mullikin testimony, outlined in transcript of FDA's "Anesthetic and Life Support Drugs" Advisory Committee hearing, Jan. 30, 2002, Gaithersburg, MD. Online at http://www.fda.gov/ohrms/dockets/ac/02/transcripts/3820t1.htm.

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Van Zee pressed on, raising similar concerns: Barry Meier, *Pain Killer: A "Wonder" Drug's Trail of Addiction and Death* (New York: Rodale Press, 2003), 185–91; author interviews, Dr. Art Van Zee, Sept. 23, 2016, and Feb. 11, 2017.

an ethical quandary a *Milwaukee Journal Sentinel* reporter: John Fauber, "E-mails Point to 'Troubling' Relationship Between Drug Firms, Regulators," *Milwaukee Journal Sentinel*, Oct. 6, 2013.

The same *Journal Sentinel* reporter, John Fauber: Fauber and Ellen Gabler, "Doctors with Links to Drug Companies Influence Treatment Guidelines," *Milwaukee Journal Sentinel*, Dec. 18, 2012.

results of that investigation would end up: Paul D. Thacker, "Senators Hatch and Wyden: Do Your Jobs and Release the Sealed Opioids Report," *STAT*, June 27, 2016.

"nothing's come of it": Author interview, Dr. Steve Gelfand, Feb. 9, 2017.

(That initial application would be rejected): John O'Brien, "Blumenthal Calls Out FDA Over OxyContin Petition," Legal NewsLine, July 31, 2007. Rejection of it: Harriet Ryan, "Purdue Pharma Issues Statement on OxyContin Report; L.A. Times Responds," *Los Angeles Times*, May 6, 2016.

"I'm a stubborn Dutchwoman": Author interview, Van Rooyan.

Among RAPP's first courtroom targets: Karen White v. Purdue Pharma, Circuit Court for the Tenth Judicial Circuit Court, Polk County, FL, Civil Division, 2003.

White claimed in her legal filing: Ibid.

the company bragged in a press release: Laurence Hammack, "OxyContin Settlement a Reversal of Fortune," *Roanoke Times*, May 12, 2007.

"Personal injury lawyers" and **the firm's legal bills:** Meier, *Pain Killer*, 232–33.

Purdue still had 285 lawsuits pending: "Former Drug Firm Worker Says He Was Fired for Being a Whistle-Blower," *Record-Journal* (Meriden, CT), Aug. 25, 2003, quoting spokesman Timothy Bannon; Julie Fishman-Lapin, "Fired Former Employee Withdraws Lawsuit Against OxyContin Manufacturer," *Stamford Advocate*, March 9, 2004.

His bosses banned him from undertaking: Described in Marek Zakrzewski v. Purdue Pharma, Superior Court of Danbury, CT, 2003. Case dismissed: Fishman-Lapin, "Fired Former

Employee Withdraws Lawsuit."

calling the allegations "baseless": Fishman-Lapin, "Fired Former Employee Withdraws Lawsuit."

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2001 arrest of two Purdue employees: Ashanti Alvarez, "Arrests Heighten Battle Over Painkiller," *Bergen Record* (NJ), July 6, 2001.

Giuliani brokered a behind-the-scenes negotiation: John Solomon and Matthew Mosk, "The Importance of Being Rudy—Close Up," *Washington Post*, May 15, 2007. Giuliani role in DEA settlement: Meier and Lipton, "Under Attack, Drug Marker Turned to Giuliani."

Purdue Pharma heaped praise on its American hero: Meier and Lipton, "Under Attack, Drug Marker Turned to Giuliani."

***Time* magazine's Person of the Year 2001:** http://content.time.com/time/specials/packages/article/0,28804,2020227_2020306,00.html.

Purdue spent $500,000 defending the case: Elaine Silvestrini, "OxyContin's Maker Cleared in Suit Over Sales Tactics," *Tampa Tribune*, Feb. 9, 2005.

She'd been a champion of the drug's painkilling properties: Ibid.; Silvestrini, "Firing Was Retaliation for Ethics Fight, Suit Says," *Tampa Tribune*, Feb. 1, 2005.

one opioid-addicted Orange County veterinarian: Doris Bloodsworth, "Legal Drugs May Be Tracked—Jeb Bush Is Pushing for a Databank to Fight Abuse of Prescriptions," *Orlando Sentinel*, March 25, 2003.

her lawyer had not proved the illegality: Order, White v. Purdue Pharma, Inc., U.S. District Court, Middle District of Florida, Tampa Division, Jan. 26, 2005. From Richard Ausness, "The Role of Litigation in the Fight Against Prescription Drug Abuse," *West Virginia Law Review*, Spring 2014: 1165: "Suits against Purdue by individual consumers have almost always failed because the company has successfully argued lack of causation, misuse, wrongful conduct, and expiration of the statute of limitations."

"'Don't tell us what you believe'": Author interview, Richard Ausness, Jan. 27, 2017.

he had a boyish appearance that belied: Jen McCaffery, "Brownlee Voted into Attorney Post for Virginia," *Roanoke Times*, Oct. 13, 2001. The showboating earned Brownlee a reputation: Mike Gangloff, "Brownlee Resigns—May Run for Office," *Roanoke Times*, April 17, 2008. Brownlee retried Knox after the 2006 acquittal and hung jury, a trial that ultimately saw the doctor convicted of racketeering, health care fraud, and distribution of marijuana, and losing his medical license in 2006.

Brownlee needed a big legal win: Brownlee prosecuted National D-Day Memorial Foundation president Richard Burrow twice for fraud, after which Burrow filed a prosecutorial misconduct complaint with the Justice Department, but Brownlee was exonerated from wrongdoing, according to Gangloff, "Brownlee Resigns." Both of Burrow's cases ended in hung juries.

With plans to seek elected office: Author interview, Laurence Hammack, April 14, 2016; Brownlee himself announced he was running for Virginia attorney general in 2008, a year after the Purdue case was closed. He yielded the nomination to Ken Cuccinelli in 2009.

Udell wanted Meier taken off the beat: Daniel Okrent, "The Public Editor: You Can Stand on Principle and Still Stub a Toe," *New York Times*, Dec. 21, 2003. Okrent said that Meier's 2003 reporting on Rush Limbaugh's addiction was "probably a mistake," quoting Meier's editor at the *Times*. "Certainly, the paper's reputation could have been served by removing even the slightest hint of conflict," Okrent wrote.

"Their agenda was to shut me down": Author interview, Barry Meier, Jan. 24, 2017.

(Meier would not write about Purdue Pharma): Meier covered only two stories on the company between the publication of his book and the 2007 settlement, both of limited, technical scope:

"Court Says OxyContin Patent Is Invalid," *New York Times*, June 8, 2005; and, with Andrew Ross Sorkin, "Drug Maker May Buy Rival for $7.5 Billion," *New York Times*, July 25, 2005.

"Never assume I already know!": Van Zee loaned me a copy of the Wood Reports, compiled by Gregg Wood, from March 2004, which he'd saved on CD and which took up 361 pages of a Word document.

"elephant to a blind man": Author interview, Emmitt Yeary, Jan. 24, 2017.

"he worked": Author interview, Lisa Nina McCauley Green, Feb. 2, 2017.

"For a miner who avoids being crippled": John C. Tucker, *May God Have Mercy: A True Story of Crime and Punishment* (New York: Delta, 1998).

the country doctor was the perfect conduit: Yeary initially asked for $5.2 billion in damages in what he predicted would become a class-action lawsuit, but his quest for class-action certification was later dropped and folded into a civil case brought on behalf of McCauley and two similarly injured laborers from the region.

a patient Van Zee was by then treating: From an affidavit of Art Van Zee, filed in McCauley v. Purdue Pharma, Van Zee testified: "It was clear to me that he had developed profound opioid addiction during the course of his treatment with OxyContin. By opioid 'addiction,' I specifically mean…McCauley demonstrated tolerance to increased amounts of OxyContin; increased his dosage on his own; a characteristic withdrawal syndrome when he was attempting to come off OxyContin;…and continued use of OxyContin despite harm (physical, social, personal, and family harm) from his continued use of OxyContin." McCauley v. Purdue Pharma, U.S. District Court for the Western District of Virginia, Big Stone Gap Division, filed Oct. 31, 2004. McCauley initially went to Van Zee for help in weaning himself off methadone.

It didn't matter that the septuagenarian: Author interview with Green; McCauley deposition, Jan. 22, 2003, Abingdon, VA; filed in *McCauley.*

Norton was sentenced to five years: Associated Press, "Four Sentenced in Lee County Scam—Corruption Plot Led to Hospital's Bankruptcy," Nov. 17, 2000. Norton's treatment of McCauley in 1999 was outlined in McCauley's medical records, subpoenaed from Van Zee for the case.

federal prosecutors were also investigating Norton: Sales-rep notes written by Kimberly Keith explain that Norton "has been convicted of money laundering etc and last week was sentenced to 5 years in fed prison, pulled me into a room to tell me that the US attorney's office was going to get him with over prescribing of narcotics but got him with this one first, said we, as a company, should know that they are after us and making us enemy #1 with oxycontin"; written about a Nov. 20, 2000, visit to Norton's office.

"the Shadow Company": Author interview, Richard Stallard, March 3, 2017.

His family had sent him to rehab seven times: Author interview, Green.

Brownlee's belief that Purdue had knowingly concealed: Author interview, Van Zee, Sept. 24, 2016.

***New York Post* reporter broke the news in 2005:** Brad Hamilton, "Jury Eyes RX Bigs in OxyContin 'Coverup'; Allegedly Hid Painkiller Peril," *New York Post*, June 12, 2005.

"Sometimes people get intimidated by big companies": Author interview, Randy Ramseyer, March 17, 2016.

only to leave his post in 2001: Gregory D. Kesich, "Former Prosecutor Backs Drug Company—Maine's One-Time U.S. Attorney Tells Senators the Maker of Oxycontin Has Worked to Curb Abuse," *Portland Press Herald*, Aug. 2, 2007. "The drug diversion problem was not caused by OxyContin, and it will not be solved by going after OxyContin as a whipping boy," McCloskey said.

doling out prescriptions from the back seat: Author interview, Ramseyer; Dr. Denny Lambert,

who was also addicted to opioids, was sentenced to fifty-two months in prison for illegally distributing OxyContin, Ritalin, and Dilaudid: Laurence Hammack, "Doctors or Dealers?," *Roanoke Times*, June 11, 2001.

"Look, my view of the case was": Author interview, John Brownlee, Sept. 30, 2016.

"his star power alone": Author interview, U.S. assistant attorney, March 2, 2017.

a memo written by the federal prosecutors to Brownlee: From a memo draft written Sept. 28, 2006, from the assistant prosecutors to Brownlee.

"Brownlee, you are fine": "Evaluating the Propriety and Adequacy of the OxyContin Criminal Settlement," hearing before the Committee on the Judiciary, U.S. Senate, July 31, 2007, online at https://www.gpo.gov/fdsys/pkg/CHRG-110shrg40884/html/CHRG-110shrg40884.htm.

senior Justice Department officer phoned Brownlee: Ibid.

eleventh-largest fine paid by a pharmaceutical firm: David Armstrong, "Purdue Says Kentucky Suit Over OxyContin Could Be Painful," *Bloomberg News*, Oct. 20, 2014.

two thousand cardboard containers they'd filled: Hammack, "OxyContin Settlement a Reversal of Fortune."

falsified charts created by Purdue: "Agreed Statement of Facts," United States of America v. The Purdue Frederick Company, Inc., and Michael Friedman, Howard R. Udell, and Paul D. Goldenheim, filed in the U.S. District Court for the Western District of Virginia, Abingdon Division, May 7, 2007, 7–8.

("I would not write it up at this point"): Point No. 36 of Attachment B to Plea Agreement, *The Purdue Frederick Company, Inc.*, et al., 13.

68 percent of the drug: Point No. 20(a.), *The Purdue Frederick Company, Inc.*, et al., 6.

oxycodone was harder to extract: Ibid.

OxyContin caused less euphoria: Point No. 43, 14, *The Purdue Frederick Company, Inc.*, et al.

Chapter Four. “The Corporation Feels No Pain”

Interviews: Sister Beth Davies, Dr. Art Van Zee, Andrew Bassford, Randy Ramseyer, Dr. Sue Cantrell, Barry Meier, Judge James Jones, Andrew Bassford, Jeff Udell, Lee Nuss, Laurence Hammack

the Barter stage featured a homegrown comedy: *The Quiltmaker,* a comedy by Catherine Bush, Barter’s playwright in residence, premiered at the Barter in the spring of 2007.

even written a poem: “OxyContin,” by Dr. Art Van Zee, *Annals of Internal Medicine,* April 6, 2004: 527.

“Everything I’d written was now justified”: Author interview, Barry Meier, Jan. 24, 2017.

voices broke periodically as they choked out: From a host of names submitted in memorial to Ed Bisch’s memorial website (no longer active, but Bisch provided me with a document he had archived that contained hundreds of names).

two moms in matching rain scarves held each other: Barry Meier, “3 Executives Spared Prison in OxyContin Case,” *New York Times,* July 21, 2007. Don Petersen took the photograph.

“What if it was your son or daughter”: Testimony of Victor Del Regno, about his son, Andrew, from the transcript of United States of America v. The Purdue Frederick Company, Inc., and Michael Friedman, Howard R. Udell, and Paul D. Goldenheim, sentencing hearing, U.S. District Court for the Western District of Virginia, Abingdon Division, July 20, 2007: 10–12.

“Brian is here in the courtroom with me today” and **“I think jail is too good for you guys”:** From the transcript of *The Purdue Frederick Company, Inc., et al.,* sentencing hearing, 28–30.

“I think you should go spend some time in a rehab facility”: Ibid., 20–21.

“a personal tragedy for Mr. Udell”: Ibid., White testimony, 92–102.

“a criminal, and that is horrendously harsh punishment”: Ibid., Good testimony, 103–109. Goldenheim left the company in 2004.

to jail him would be virtually unprecedented: Ibid., Mark D. Pomerantz testimony, 83–91.

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Chapter Five. Suburban Sprawl

Interviews: Chief Chris Perkins, Dr. Steve Huff, Sgt. Chad Seeberg, Dr. Jennifer Wells, Don Wolthuis, Warren Bickel, Robin Roth, Kristi Fernandez, Lt. Chuck Mason, Spencer Mumpower, Ginger Mumpower, Tony Anderson, Vinnie Dabney

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Chapter Six. “Like Shooting Jesus”

Interviews: Sgt. Joe Crowder, Dr. Anna Lembke, Cheri Hartman, Tony Lawson, Judge Bob Bushnell, Andrew Nester, Shannon Monnat, Nikki King, Spencer Mumpower, Dr. William Massello, Dr. Martha Wunsch, Vinnie Dabney, Nancy Hans, Dr. Hughes Melton, Andrew Bassford, Dr. John Burton, Ron Salzbach, Jamie Waldrop, Drenna Banks, Christopher Waldrop

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Chapter Seven. FUBI

Interviews: Sgt. Brent Lutz, James Kendrick, Sheriff Tim Carter, Don Wolthuis, Shannon Monnat, Sgt. Kevin Coffman, Mark O'Brien, Dennis Painter, Courtney Fletcher, Kristi Fernandez, Agent Bill Metcalf, Lauren Cummings, Dana Cormier, Keith Marshall

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His lawyer told me he'd overdosed five times: Author interview, Dana Cormier, May 25, 2016.

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FUBI: Author interview, Wolthuis, Jan. 7, 2016, and with agents and task force officers who worked the case.

Chapter Eight. “Shit Don’t Stop”

Interviews: Agent Bill Metcalf, Don Wolthuis, Lauren Cummings, Thomas Jones III, Ronnie Jones, Kristi Fernandez, Dennis Painter, Courtney Fletcher, Dr. Nora Volkow, Tracey Helton Mitchell, Dr. John Kelly, Dr. Andrew Kolodny, Barbara Van Rooyan

former Marine who’d been kicked out: Author interview, Bill Metcalf, June 9, 2017, and Joshua Pettyjohn’s presentencing report.

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One of his first death cases: Author interview, Wolthuis, June 28, 2017.

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Jesse still owed $25,000 for that earlier rehab stint: Author interview, Fernandez, Sept. 10, 2017.

"The whole system needs revamped": Author interview, Tracey Helton Mitchell, May 8, 2017.

"in any given episode, they only see": Author interview, Dr. John Kelly, May 25, 2017.

He was forty-eight hours away from a do-over: Author interview, Fernandez, June 20, 2016.

"I'm not trying to do dope": Details from the last weekend of Jesse's life came from interviews with Fernandez, Painter, Fletcher, and Sgt. Brent Lutz.

"Arthur, I have been hearing a lot of foul shit lately": Ronnie Jones's letter to Arthur (no last name given), written by Jones on Jan. 13, 2015, and submitted by Wolthuis as evidence of continued harassment and drug dealing, even after Jones's arrest, in the government's case.

"Most agents would have written it off": Author interview, Wolthuis, June 2, 2016.

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Chapter Ten. Liminality

Interviews: Tess Henry, Patricia Mehrmann, Dr. Hughes Melton, Dr. Lisa Andruscavage, Kim Ramsey, Dr. Cheri Hartman, Kate Neuhausen, Missy Carter, Chief Mark Mitchell, Sarah Melton, Nancy D. Campbell, Dr. Steve Loyd, Judge Jack Hurley, Anne Giles, Don Flattery, Dr. Art Van Zee, Dr. Nora Volkow, Dr. Jennifer Wells, Jamie Waldrop

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Chapter Eleven. Hope on a Spreadsheet

Interviews: Janine Underwood, Dr. Karen Kuehl, Erin Casey, Cheri Hartman, Louise Vincent, Mark O'Brien, Tracey Helton Mitchell, Sgt. Kevin Coffman, Nancy Hans, Dr. John Burton, Dr. John Kelly, Jamie Waldrop, Emma Hurley, Danny Gilbert, Charles Cullen, Patricia Mehrmann, Wendy Gilbert, Britney Gilbert, Skyler Gilbert

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Chapter Twelve. “Brother, Wrong or Right”

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Epilogue. Soldier's Disease

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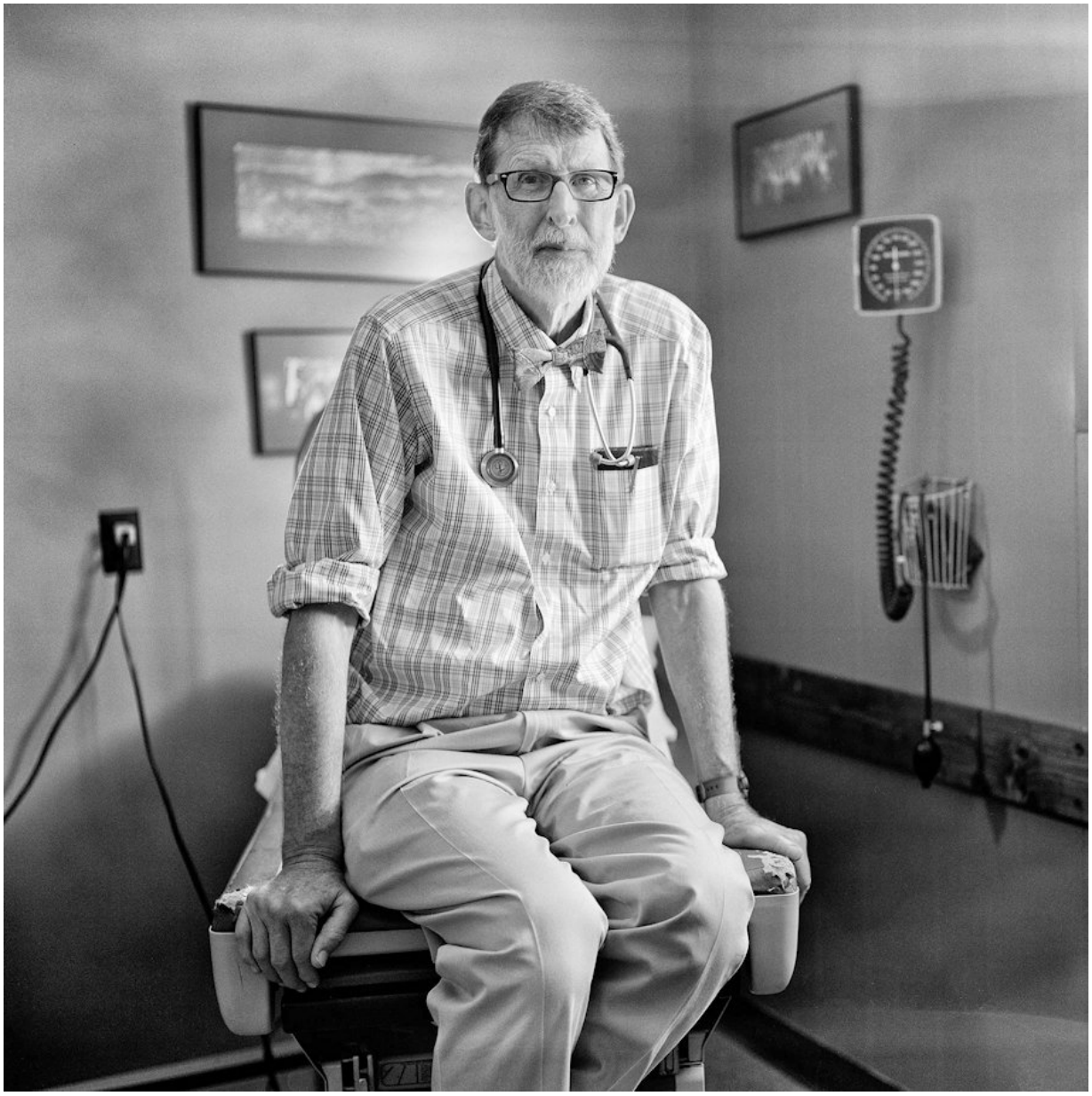
Photos

After the death of her nineteen-year-old son, Jesse Bolstridge, Kristi Fernandezbecame obsessed with the story of his swift descent into addiction, including finding any missing details that might explain how he went from high school hunk and burly construction worker to heroin-overdose statistic.



From the small sliding-scale clinic where he practices in Virginia's westernmost county, Dr. Art Van Zee was among the first U.S. physicians to warn people about the dangers of OxyContin. The overdose victims showing up in the ER in the late 1990s weren't simply his patients; they were also dear friends, many of them descendants of the coal miners whose pictures line his exam-room walls.

Sister Beth Davies was a plucky activist nun who had already spent decades standing up to coal-mining operators, and she refused to be swayed by Purdue Pharma's marketing or its offers of "blood money." Executives at the company might have been able to intimidate people up north, where their philanthropy held sway, but it didn't work with Sister Beth.

“Mark my words: This is the beginning of a disaster for us,” Pennington Gap, Virginia, pharmacist Greg Stewart told Sister Beth Davies in the late 1990s. He had already been the victim of two robbery attempts, including one by the OxyContin-addicted son of a hair-salon owner who crawled in through the ceil-ing vents connecting the salon to Stewart’s store.

The first time Big Stone Gap lieutenant Richard Stallard heard about the new painkiller, a confidential informant told him it was already available on the streets: "This feller up here's got this new stuff he's selling. It's called Oxy, and he says it's great."

“We enabled her,” said Ashlyn Kessler’s grandmother, Lee Miller, who is raising Ashlyn’s young son while Ashlyn finishes a federal prison sentence for heroin distribution. A paralegal with a degree from Jerry Falwell’s university, Ashlyn was one of the region’s top drug mules, making the trek from Roanoke to New Jersey three, sometimes four, times a week.

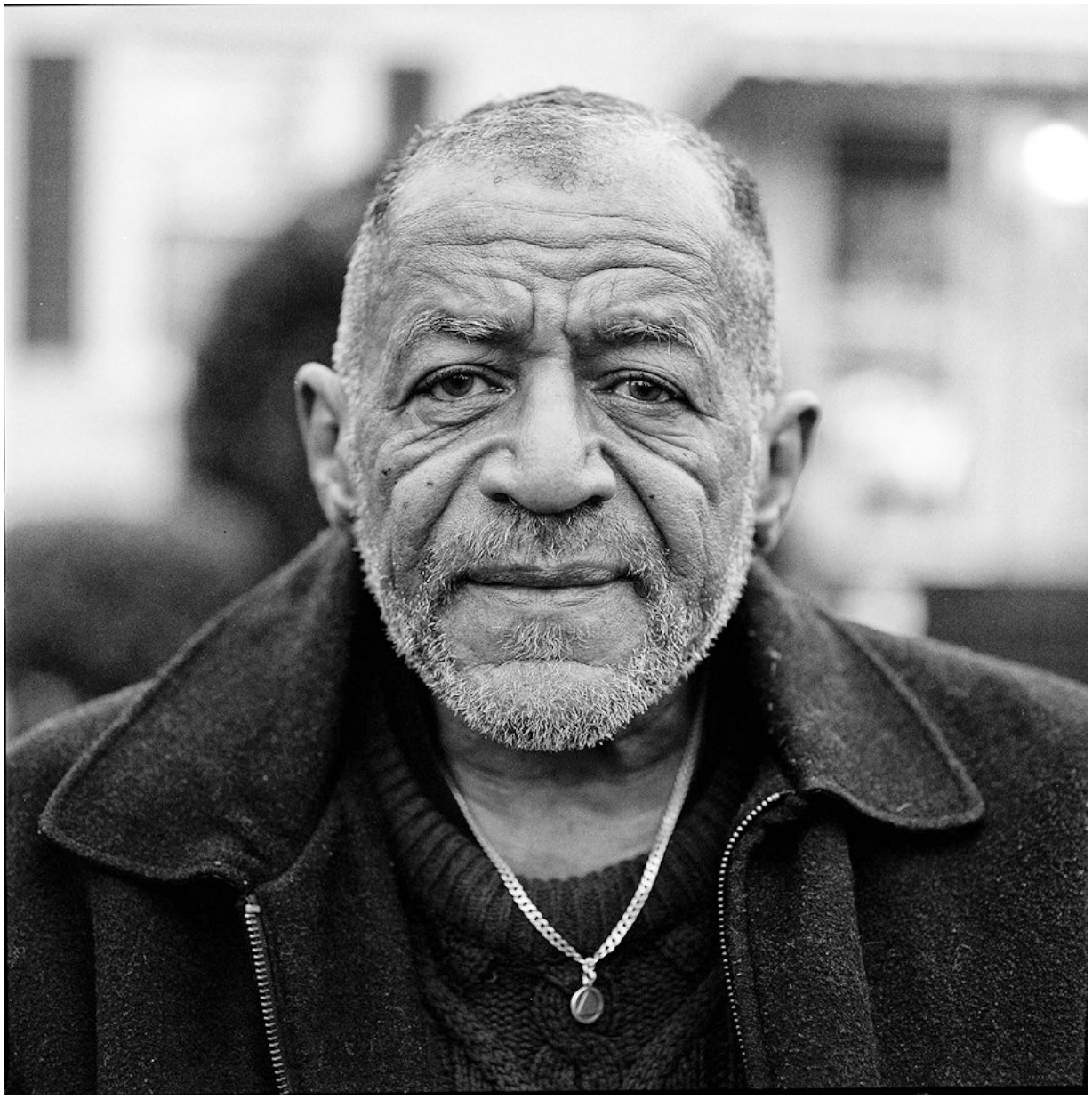
Jamie Waldrop, a surgeon's wife and a recovery coach, had two children who became addicted, first to pills, then to heroin. "Until they go off to rehab, you don't realize just how dysfunctional your life has become."

When her twenty-eight-year-old daughter, Tess, checked herself out of a Nevada treatment program, Roanoke nurse Patricia Mehrmann tried desperately to track her movements, including via Facebook Messenger, to prostitution websites featuring her daughter. "There is no love you can throw on them, no hug big enough that will change the power of that drug."

Still raw in her grief—her son Bobby had been dead only six months—Janine Underwood could draw a detailed mental map of the treatment landscape, from health care privacy hurdles to instructions on what to do the moment you realize your twenty-one-year-old is injecting heroin. "I'm in health care, and there were just so many things I didn't know," said Underwood, the administrator of a free clinic for the working poor.

In 2016, psychologist Cheri Hartman teamed up with Jamie Waldrop and Janine Underwood as well as local police officers to try to divert Roanoke users from jail into treat-ment. Hartman and her husband, psychiatrist Dr. David Hartman, battled bureaucratic logjams, political indifference, and stigma concerning the use of buprenorphine to treat opioid-use disorder.

After her son Spencer's conviction for heroin distribution made front-page news in 2012, prominent Roanoke jewelry store owner Ginger Mumpower became a de facto counselor to worried parents, some of whom drove two hours just to talk to someone about their children's addiction to heroin and pills. (Photograph by Josh Meltzer)



Substance-abuse counselor Vinnie Dabney had been a mostly functioning heroin user for three decades before court-ordered treatment in the late 1990s put him on the path to sobriety. "The moment [heroin] crossed those boundary lines from the inner city into the suburbs, it became an 'epidemic.' But nobody paid any attention to it until their cars were getting robbed, and their kids were stealing their credit cards."

Sergeant Brent Lutz spent nights, holidays, and weekends surveil-ling a heroin ring that was operating out of a poultry plant on the outskirts of Woodstock, Virginia. “How it transformed from a pill problem to a heroin problem here, it was like cutting off and on a light switch.”

ATF agent Bill Metcalf spent the bulk of 2013 relentlessly investigating members of what was then one of Virginia's largest heroin rings, a conspiracy that federal agents informally named "FUBI." "Man, this reminds me of The Wire," he told Lutz late one night during a surveillance operation.

Wise County, Virginia, EMT Giles Sartin made the deci-sion to train for emergency medicine the day he was sit-ting in a freshman English class and heard the double thump of two classmates seated behind him hitting the floor. “Last week I Narcanned the same person for the fourth time. There’s communities where we’re like the ice cream truck.”

In her mobile Health Wagon, nurse practitioner Teresa Gardner Tyson and her grant-funded staff of twenty are largely left to tend to the health needs of the uninsured in Virginia's coalfields. During repeated attempts to gut the Afford-able Care Act in 2017, Tyson grieved for her patients who were dying due to untreated hepatitis C caused by IV injection of opioids and Virginia's repeated failures to expand access to Medicaid.

Of his 1993 Lee County (Va.) High graduate class of two hundred students, A. J. McQueen said more than half were either in prison or battling addiction. “We have to wear rubber gloves now when we make arrests,” the drug detective said.

In 2017, public health professor Robert Pack and Dr. Steve Loyd led a coalition to open Overmountain Recovery, a center offering methadone and other treat-ments in the conservative rural community of Gray, Tennessee, where opposition was fierce. This collaboration among a university, a regional nonprofit hospital, and the state's mental health agency represented one of the strongest models I witnessed for thwarting governmental rigidity and indifference to turning back the crisis.

Also by Beth Macy

Truevine
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About the Author

Beth Macy is the author of the widely acclaimed and bestselling books *Truevine* and *Factory Man.* Based in Roanoke, Virginia, for three decades, she has won more than a dozen national awards for her reporting, including a Nieman Fellowship for Journalism at Harvard.

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