The New Heroin Epidemic

Ten years ago, prescription painkiller dependence swept rural America. As the government cracked down on doctors and drug companies, people went searching for a cheaper, more accessible high. Now, many areas are struggling with an unprecedented heroin crisis.

By Olga Khazan

Illustrations by Lauren Giordano

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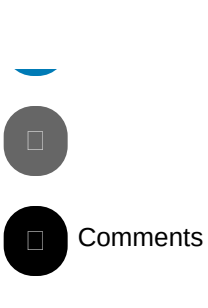
In a beige conference room in Morgantown, West Virginia, Katie Chiasson-Downs, a slight, blond woman with a dimpled smile, read out the good news first. “Sarah is getting married next month, so I expect her to be a little stressed,” she said to the room. “Rebecca is moving along with her pregnancy. This is Betty’s last group with us.”



“Felicia is having difficulties with doctors following up with her care for what she thinks is MRSA,” Chiasson-Downs continued. “Charlie wasn’t here last time, he cancelled. Hank ...”

“Hank needs a sponsor, bad,” said Carl Sullivan, a middle-aged doctor with auburn hair and a deep drawl. “It kind of bothers me that he never gets one.”

“This was Tom’s first time back in the group, he seemed happy to be there,” Chiasson-Downs went on, reading from her list.

“He had to work all the way back up,” Sullivan added.

Chiasson-Downs and the other therapists with the Chestnut Ridge Center’s opiate-addiction program had gathered to update each other on the status of their patients before launching into the day’s psychotherapy sessions. Here in West Virginia, where prescription painkillers have long “flowed like water,” as Sullivan said, the team works to keep recovering addicts sober through a combination of therapy and buprenorphine, a drug used to treat painkiller and heroin addiction.

Chiasson-Downs’ patients are in the “advanced” group—so called because they’re well into their recoveries. She relayed a few success stories—a new baby here, a relapse averted there—but even years after they’ve found sobriety, her charges’ lives are still precariously balanced.

What Tom (not his real name) was attempting to work his way back up from was the weekly “beginner” group, where advanced patients are sent if they relapse and cannot stay clean. It happens fairly frequently, Sullivan, the director of the treatment program, said.

For patients in the less advanced groups, the therapists’ updates are gloomier.

“Trent called in crisis last week, and he didn’t come,” said Laura Lander, another therapist. An acquaintance who was supposed to give Trent a ride to the clinic instead stole his money and medication and then left him by the side of the road.

“He went without his meds,” Doug Harvey, the case manager, added.

“He will have used this week,” Sullivan concluded.

“Jessica, she’s still living with her boyfriend, who is actively using.” Lander said.

“So she’s craving every day,” Sullivan noted.

"She's financially dependent on him," Lander said. "Three kids and nowhere to go. He's a jerk to her."

"She lives out in the middle of nowhere," Sullivan added. "She talked about her neighborhood being full of people who use. Her family all uses. I'd be surprised if she's clean today."

The therapists' stories go on, sketching a picture of a region that's understaffed and under-resourced, and that found itself unprepared for an epidemic it has disproportionately been affected by. One woman has been skipping meetings and "doing weird things with her meds." Another patient filled his prescription with a new doctor, raising the possibility he was "doctor-shopping," or getting multiple prescriptions from different physicians simultaneously. A woman who lives more than two hours away wasn't going to make it in—the Medicaid van that normally brings her fell through this week.

The meeting is brief and matter-of-fact. There's some lighthearted banter between updates—one patient, apparently trying to curry favor with Lander, repeatedly called her "sweetie" over the phone. When the final chart is read, the group breaks, and the therapists head into their separate sessions.

In the newest front in the war on drugs, people from all walks of life are battling addictions to pills that are perfectly legal and distributed by medical professionals. Since prescription painkillers became cheap and plentiful in the mid-90s, drug overdose death rates in the U.S. have more than tripled. West Virginia was slammed especially severely, and for the past several years it's had the highest drug overdose death rate in the nation.

More recently, heroin has taken root here after authorities cracked down on unscrupulous doctors who were overprescribing pain meds, sending addicts searching elsewhere for a similar high. In West Virginia, heroin-overdose deaths have tripled over the past five years, while prescription-painkiller deaths have dipped slightly. There were many contributing factors, not the least of which were personal decisions by the addicts themselves, but it's clear that pharmaceutical companies, negligent doctors, and even the law-enforcement backlash have all played a role.

Now, the state's few addiction treatment specialists—Sullivan is one—are drowning under their caseloads.

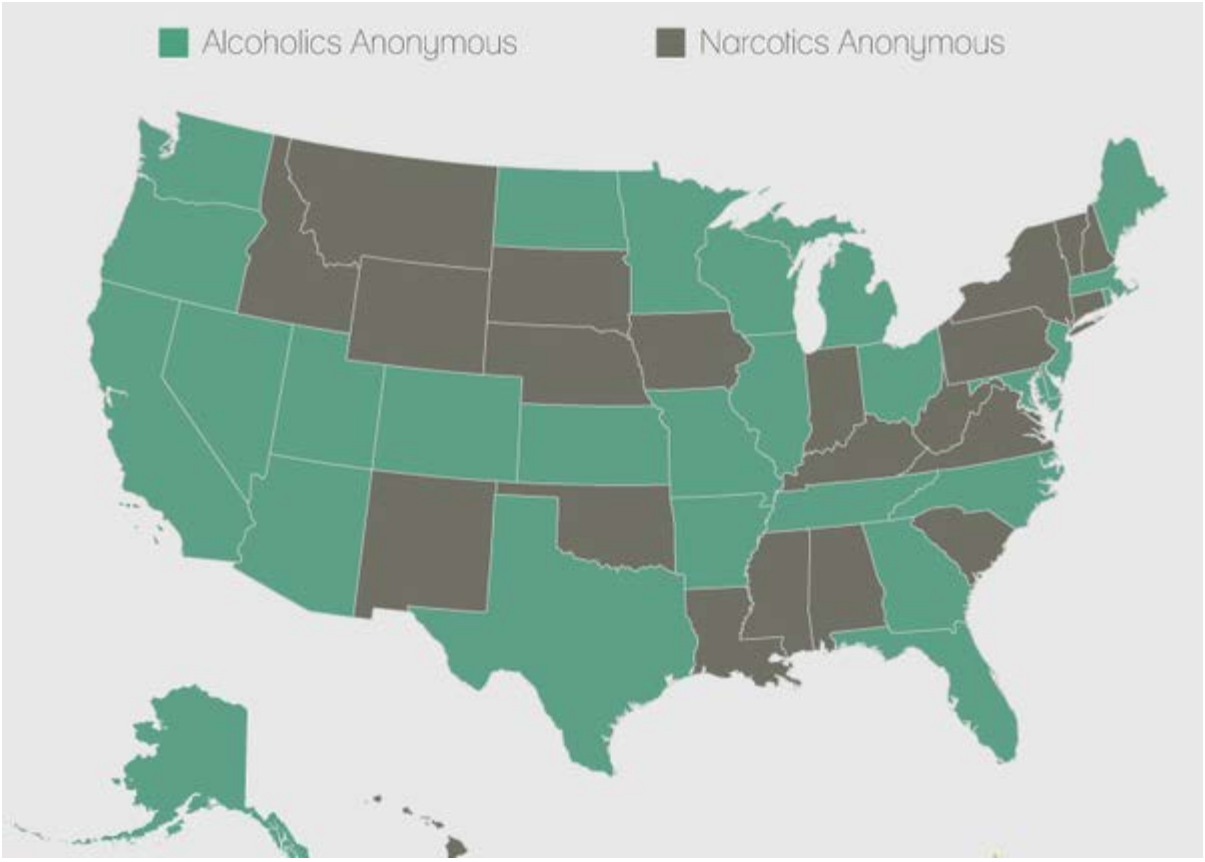
The goal at Chestnut Ridge, Sullivan explained, "is to treat effectively and treat as many we can. We're exhausted and overwhelmed with how many opioid addicts there are in this area."

(*The Atlantic* was granted access to Sullivan's clinic, but some patients preferred to remain anonymous. In this article, these patients are identified by pseudonymous first names only.)

There's a waiting list to get into the center's program, and the only applicants prioritized are pregnant women. Sullivan isn't above telling the sons of local tycoons to get in line. By the time they secure a spot, the average patient has been waiting for weeks or months.

Over the years, Sullivan has tried giving patients methadone, buprenorphine, and now naltrexone. He thinks buprenorphine—given out here in dissolving strips called Suboxone—is the best option, but he argues that the medicine isn't the most important part. Here, all patients receive talk therapy as part of their treatment, and they can't get their medication without attending psychoeducational group sessions. Those who are furthest into their recoveries attend once a month, but the others come weekly or biweekly. Moving from the weekly to the biweekly group takes 90 straight days of abstinence, a feat most patients can only accomplish within five or six months because of relapses. They're also required to attend four 12-step Alcoholics Anonymous or Narcotics Anonymous meetings each week in their home communities.

Most Popular 12-Step Meeting by State



Recovery.org

The clinic tries to strike at "all parts of their addiction," Sullivan explains. "The biological, legal, and psychological problems."

Jeff Kesner, a janitor at a chicken plant, makes a five-hour round trip to Sullivan's beginner group every Wednesday. This is the nearest addiction clinic to his home that accepts Medicaid, the health insurance program for the poor. He realized he needed help when he had what he describes as a nervous breakdown five months ago. He was using opiates, meth, "benzos"—anti-anxiety drugs—really anything he could find. One day he overdosed in public, and when the police arrived, he "flipped out," he said. First he ran, yelling at the cops that they'd have to shoot him if they wanted to arrest him, and then he hit one of the officers.

"I've destroyed my life," Kesner said. "I'm 41 years old, and I have nothing because of drugs."

After 28 days in jail, he checked himself into Sullivan's clinic. He and his sponsor have since started a Bible-based group, Celebrate Recovery, back in his hometown of Moorefield. He said he still knows lots of addicts, but he tries to avoid them.

"Back where I'm from, there is nothing for people to do," he said. "There are no jobs. No drive-ins. No youth centers. There is no economy. People are going to doctors, getting scripts, and selling them on the street to survive."

To explain why opioid addiction is such a hard condition to treat, Sullivan contrasts it with diabetes, which, while "a terrible disease," is treated basically the same way whether the patient is in Denver or Dubai. But there's no one way to cure a heroin or painkiller addict. With addicts, Sullivan said, "their whole lives are organized around them getting opioids."

An invisible affliction, pain is one of the hardest ailments for doctors to treat. There's no blood test, and there are no visible symptoms. It can be difficult to tell whether a patient is exaggerating, or whether their state of mind might be exacerbating their condition.

With the cause of their pain unclear, some chronic-pain patients have felt misunderstood and doubted as they're passed off from specialist to specialist.

"Is it too much to ask that we, the patients, no longer be bound to a system ... of unbelievable referrals with unscientific, unproven treatments (and hope) sold to the patient by each referring physician?" one such patient told his pain-management advocacy group. "In many cases, patients end up worse and more and more destitute, yet they grasp for hope with each referral."

Huge numbers of people suffer this way. A study out this month from Washington State University Spokane found that nearly one in five American adults report being in pain almost every day for spells of three months or longer.

Opioids are chemicals that change the way the brain perceives pain. Some chronic-pain patients, experiencing relief for the first time in years, describe them as "a miracle." A pulled tooth might be agonizing, but with a little Vicodin, the brain thinks the mouth is in tip-top shape.

Narcotics such as morphine, based on the chemical compounds found in poppies, have been available since the early 1800s, but soon after these substances' medicinal properties were

discovered, so too, were their addictive natures. In the early 20th century, scientists figured out how to synthesize new kinds of opioids—hydrocodone and oxycodone—with the hope that these new molecules would be less habit-forming. Percocet and Vicodin, which melded semi-synthetic opioids with acetaminophen (Tylenol), came along in the 1970s.

For decades, the medical establishment considered only the suffering of cancer and postoperative patients severe enough to be dosed with heavy-duty opioids. But in the 1980s, doctors began arguing in medical journals that all forms of chronic pain should be treated more aggressively. Congress declared the 2000s to be the "Decade of Pain Control and Research."

Makers of narcotic painkillers downplayed the risk of addiction and devised slick promotional campaigns for the drugs. Of this, the pain medication OxyContin was one of the most dramatic examples.

"The distribution to health care professionals of branded promotional items such as OxyContin fishing hats, stuffed plush toys, and music compact discs was unprecedented."

Shortly after Purdue Pharma introduced OxyContin, an oxycodone opioid, in 1996, the company sent thousands of physicians and pharmacists on all-expenses-paid junkets to resorts across the southwestern United States to learn about the drug. Purdue bolstered its sales force and compiled databases of doctors who were likely to prescribe OxyContin. Its sales representatives received millions in bonuses for persuading doctors to write scripts. The company argued that, because of its time-release formula, the drug was far less addictive than Percocet or Vicodin.

"The distribution to health care professionals of branded promotional items such as OxyContin fishing hats, stuffed plush toys, and music compact discs ... was unprecedented for a schedule II opioid," Virginia primary care doctor Art Van Zee wrote in an article in the *American Journal of Public Health*. Among the swag was a CD titled "Swing in the right direction with OxyContin"

and a pedometer that reads, “OxyContin ... A step in the right direction.” By 2002, doctors were prescribing 10 times more OxyContin than they had in 1997, and the drug’s sales made up 80 to 90 percent of Purdue’s revenues.

In 2007, Purdue pled guilty to misleading the public about the risk of addiction to the drug in a lawsuit brought by the U.S. Department of Justice, and it paid $634.5 million in fines. Three of its executives also pleaded guilty to criminal charges. In a statement to *The Atlantic*, a Purdue representative said the company “accepted full responsibility for the actions some of its colleagues took during a period that ended in 2001.”

One of the consequences of the marketing blitz was a fundamental change in the way pain was perceived, both by doctors and by patients. Pain was no longer understood as something that had to be endured—it could be easily and quickly treated with pills.

“By the 1990s, it became unacceptable for patients to be in pain,” Sullivan said.

Even for a conscientious doctor, it can be hard to tell the difference between a desperate patient who is genuinely suffering and a manipulative patient who’s seeking out drugs. In one study of 2,486 visits made to a hospital emergency room, 15 percent of patients asked for a specific pain

medication by name, and 30 percent said their pain level was a "10 out of 10."

Worse yet, some hospital doctors' pay and promotions are tied to "patient-satisfaction scores," which can be sunk by bitter patients who feel their providers don't dispense painkillers readily enough.

The delicate balance between over- and under-prescription is even trickier to strike in West Virginia, where some 20,000 people work in coal-mining jobs that gradually grind away at the body.

In the end, the doctors overshot. Painkillers were doled out for minor or nonexistent complaints. In the early 2000s, Vicodin was bought and sold through online pharmacies. Pain treatment centers would occasionally advertise like car dealerships: In 2006, one Florida clinic placed an ad reading "Need painkillers?" in a local newspaper alongside a discount coupon for new patients. Well-meaning general practitioners, who lacked the time or training to analyze their patients' vague symptoms of discomfort, blanketed the Ohio Valley with painkiller prescriptions instead.

Though painkillers are mostly safe if taken exactly as instructed, patients' chances of overdosing spike if they take a higher-than-recommended dose, if they combine the pills with other medications, or if they are predisposed to drug dependence. People without prescriptions would get their hands on the pills from family and friends—one 2006 study of people who died of painkiller overdoses in West Virginia found that 63 percent did not hold prescriptions in their own name. Some discovered that snorting or injecting a crushed OxyContin tablet could produce a powerful, heroin-like high. (In recent years, Purdue has developed new formulations of OxyContin that are encased in plastic, so that they can't be crushed or chewed.) By 2004, OxyContin was by some measures the most commonly abused prescription painkiller.

Several physicians in the area took advantage of the booming painkiller demand in order to get cash, sex, or both. One of Sullivan's patients had to stop seeing his physician when the doctor was charged for exchanging pills for sex. In 2012, a western Pennsylvania doctor named Michael Vogini was sentenced to six to 12 years in prison for prescribing Vicodin and Xanax to at least six female patients in exchange for sexual favors. One of the patients had died of an overdose in 2006, with the cause determined to be "acute combined drug toxicity of phentermine, diphenhydramine, dextromethorphan, carisoprodol, meprobamate, prochlorperazine, ropiramate, alprazolam, diazepam, hydrocodone, and hydromorphone."

Other cases devolved into inscrutable tangles in which the doctors were accused of sexual

impropriety and the patients of lurid scheming. In 2006, the Maryland Board of Physicians suspended the license of the Baltimore-area pain specialist Nelson H. Hendler, saying, among other things, that he had allegedly demanded oral sex from female patients before he would give them medication. Among other allegations, one patient accused him, in 2002, of "pressuring her for sexual favors, telling her that her health insurance was insufficient to compensate him for his services," according to the suspension order.

After a patient of his died of a painkiller overdose, Hendler was charged with possession with intent to distribute narcotics. His medical license was revoked after he pled an Alford plea, in which the defendant maintains innocence but admits that there was sufficient evidence to convict.

In an interview with *The Atlantic*, Hendler claimed the charge resulted from the fact that, whenever he suspected patients were asking him for too many prescriptions, he would demand they turn in their unfinished pill bottles before prescribing them more painkillers. When the DEA raided his office, he said it was these unfinished pill bottles that he was accused of intending to distribute.

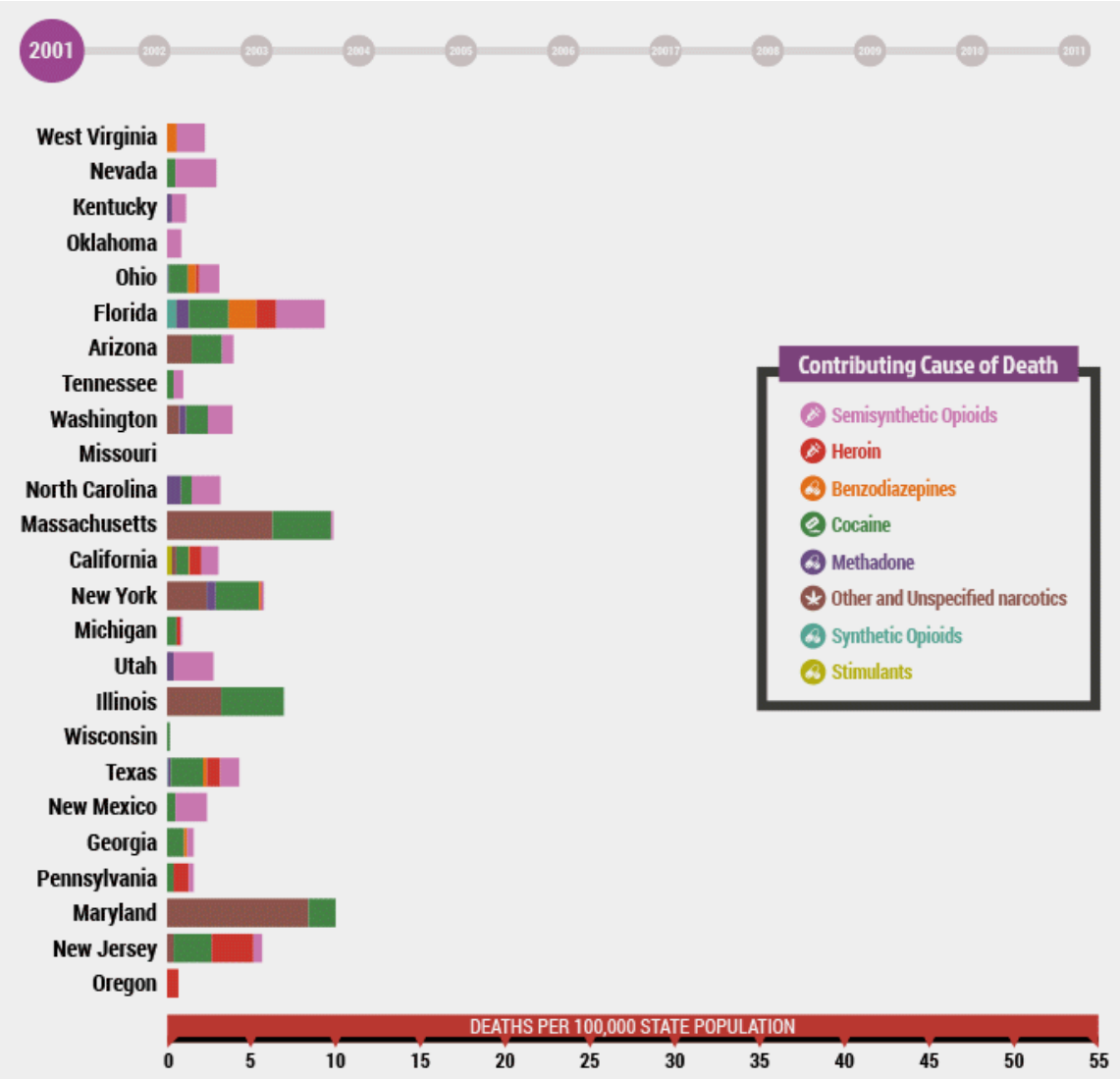
Later, several of Hendler's female patients sued him for allegedly forcing them to sexually pleasure him in exchange for painkillers. "Now, wasn't that worth it?" Hendler allegedly asked one such patient, according to the woman's attorney.

Hendler claims the women had substantial outstanding medical bills and, spurred by an angry ex-girlfriend, concocted a plot to get out of their debts by suing him. Two of the cases were dismissed, and two settled.

"Even if I could get my medical license reinstated, I wouldn't go back into the clinical practice of medicine," said Hendler, who now leads a quiet life in retirement. "While most of my patients were wonderful, decent people, the small percentage of them who are just out to get narcotics and money would still constitute a danger to me."

Sullivan said he knows of some doctors who continue to prescribe patients extra Suboxone, knowing that they'll sell it, in an attempt to "whet people's appetite" for the drug.

Drug Overdose Deaths Per 100,000 People



CDC Wonder Database/Drugabuse.com

West Virginia's first methadone clinic opened in 2000, and by 2003, six more had popped up to help treat the growing influx of painkiller addicts. According to an analysis by the *Charleston Gazette*, between 1999 and 2009, per capita consumption of oxycodone, hydrocodone, and fentanyl tripled in the state. By 2009, West Virginians were annually filling an average of 19 prescriptions per person, the highest rate in the nation.

Across the country, overdose deaths from prescription painkillers quadrupled between 1999 and 2011. That year, West Virginia led the nation in per-capita deaths attributed to semisynthetic opioids. Like heroin, the drugs slow breathing down, sometimes until it stops altogether. Mix them with alcohol or other pills, and the chances of accidental death soar. For those who live, one perverse side effect of long-term opioid abuse is hyperalgesia—an increased sensitivity to pain.

Over the past couple of years, though, the prescription frenzy seems to have subsided slightly,

partly thanks to a slow realization by physicians and lawmakers that the pills were ending up on the streets. Like that of many other states, West Virginia's pharmacy monitoring board now requires doctors to ensure patients aren't collecting painkiller prescriptions from multiple providers. West Virginia and several other states have linked their painkiller prescription databases in order to prevent out-of-state "painkiller tourism." In 2012, West Virginia officials sued 14 drug distributors for allegedly shipping painkillers to careless pharmacies.

Other doctors have been spooked away from handling chronic pain patients at all, fearing they could wind up in jail if a patient misuses the drugs. In 2004, a prominent Virginia pain doctor named William E. Hurwitz was sentenced to 25 years in prison for prescribing what prosecutors said was a dangerous amount of opioids to addicts, some of whom later re-sold their prescriptions. But at his trial, one patient who suffered from debilitating migraines said she was largely bedridden until Hurwitz began treating her. In 2007, Hurwitz' prison term was cut to five years, with the judge concluding that he helped more patients than he hurt.

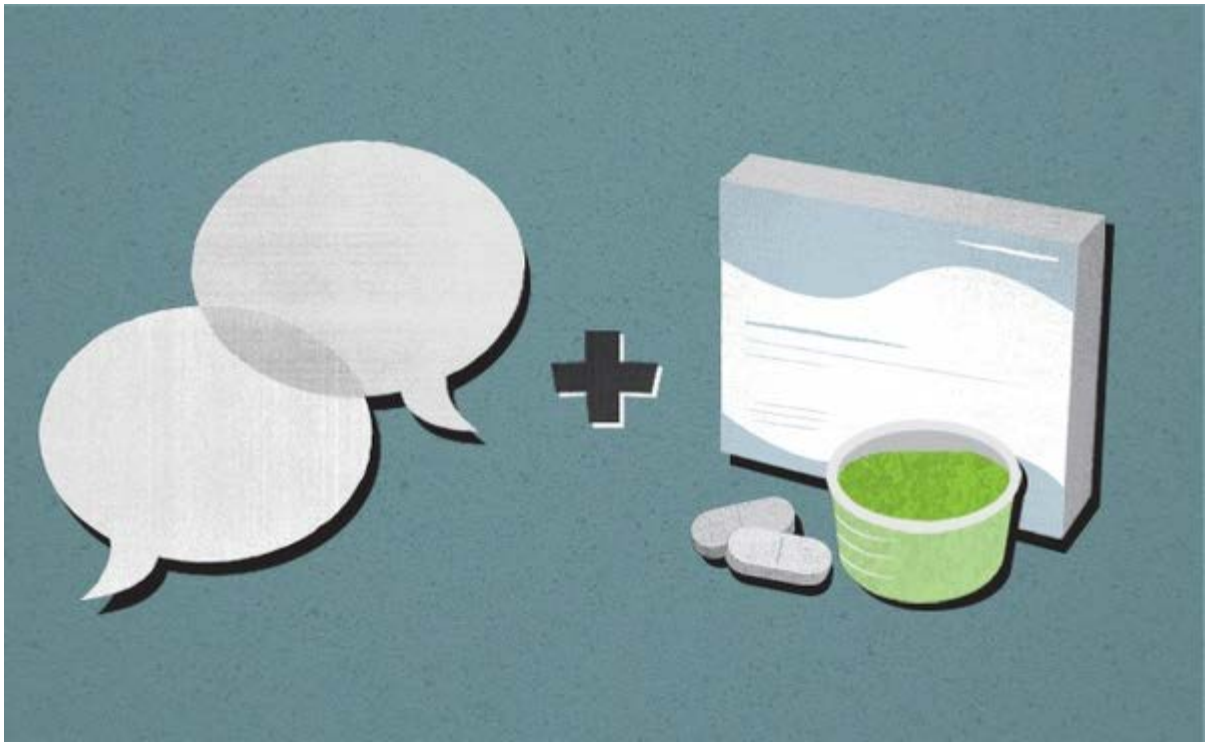
This month, the Drug Enforcement Administration reclassified hydrocodone-based drugs such as Vicodin as schedule II drugs, just one level below outlawed substances like ecstasy and LSD. (OxyContin was already a schedule II drug.) Under the stricter classification, doctors will now only be able to prescribe the medications for a month at a time, and for no longer than three months total for any given patient.

"I've destroyed my life. I'm 41 years old, and I have nothing because of drugs."

In West Virginia, law-enforcement officials have been busting unscrupulous doctors. William Ihlenfeld, the U.S. Attorney for the Northern District of West Virginia, said the state is currently prosecuting a number of doctors accused of flagrant abuse of the system. One allegedly signed blank prescriptions and left them with her office staff, who weren't trained physicians, to give out as they saw fit. The staff of another doctor, this one in Harrison County just south of Morgantown, were allegedly selling painkillers on the side. Douglas Broderick, a New Jersey gynecologist who federal prosecutors said was feeding the painkiller addiction in West Virginia, was indicted but died before his trial. Ihlenfeld said Broderick was making $200,000 in cash

each month from people who had no medical need for opioids. Fearful that he would be robbed, Broderick allegedly hired armed guards to protect him and his practice.

"We've come to realize the impact that even ... one corrupt medical professional can have on a community," Ihlenfeld said. "If we identify someone like that and they aren't playing by the rules, it has the same effect as taking out 10 street-level drug dealers."



West Virginia still has one of the highest painkiller prescription rates in the nation—as well as one of the highest painkiller-overdose death rates—but the death rate from pills here is slowly declining. Between 2011 and 2012, oxycodone-related deaths in the state decreased from 223 to 182, and those from hydrocodone declined from 171 to 142. Two years ago, the DEA set up a tactical diversion squad in Charleston, West Virginia to fight illegal pill distribution.

The crackdown on doctors might have stanched the flow of prescription pills, but it did so with a deadly externality: West Virginians have turned to heroin—a cheaper and, frequently, more accessible high. Law enforcement officials here told me that heroin is now their "number-one problem."

Suzan Williamson, the DEA resident agent for West Virginia, said that she used to arrest stereotypical "junkies" when she worked in Manhattan decades ago—largely impoverished, deprived inner-city residents. These days in Appalachia, she said, "you have a broad span of addicts. Here you have somebody who might have had legitimate pain, [but] could no longer

afford pills, so to keep the high they switched over to heroin."

Efforts to disrupt the heroin incursion are complicated by the fact that West Virginians seem to be equally susceptible to the drug, regardless of wealth or education level.

"It's affecting all segments of society," Ihlenfeld said. "All levels of income. All neighborhoods. It's [affecting] everybody."

What's more, West Virginia is in some ways the perfect market for heroin dealers—Morgantown is close to Pittsburgh, to the north, and Baltimore, to the east. Heroin costs just $20 per bag, about half the price of a single OxyContin pill, but the cost adds up. One patient of Sullivan's is now spending $100 a day on Pittsburgh dope.

For Kevin, a 38-year-old "beginner" patient of Sullivan's, the transition to heroin was precipitated by a decades-long relationship with Vicodin and Percocet. His ex-wife had a Percocet prescription for her back pain, but she hardly ever took the pills. Instead, Kevin would take five or six each day.

"The only time I touched heroin was whenever I couldn't find pills," he said. "There were times where I did it for a couple days at a time until I found pills, then I would just do the pills." Still, the harder stuff took over eventually.

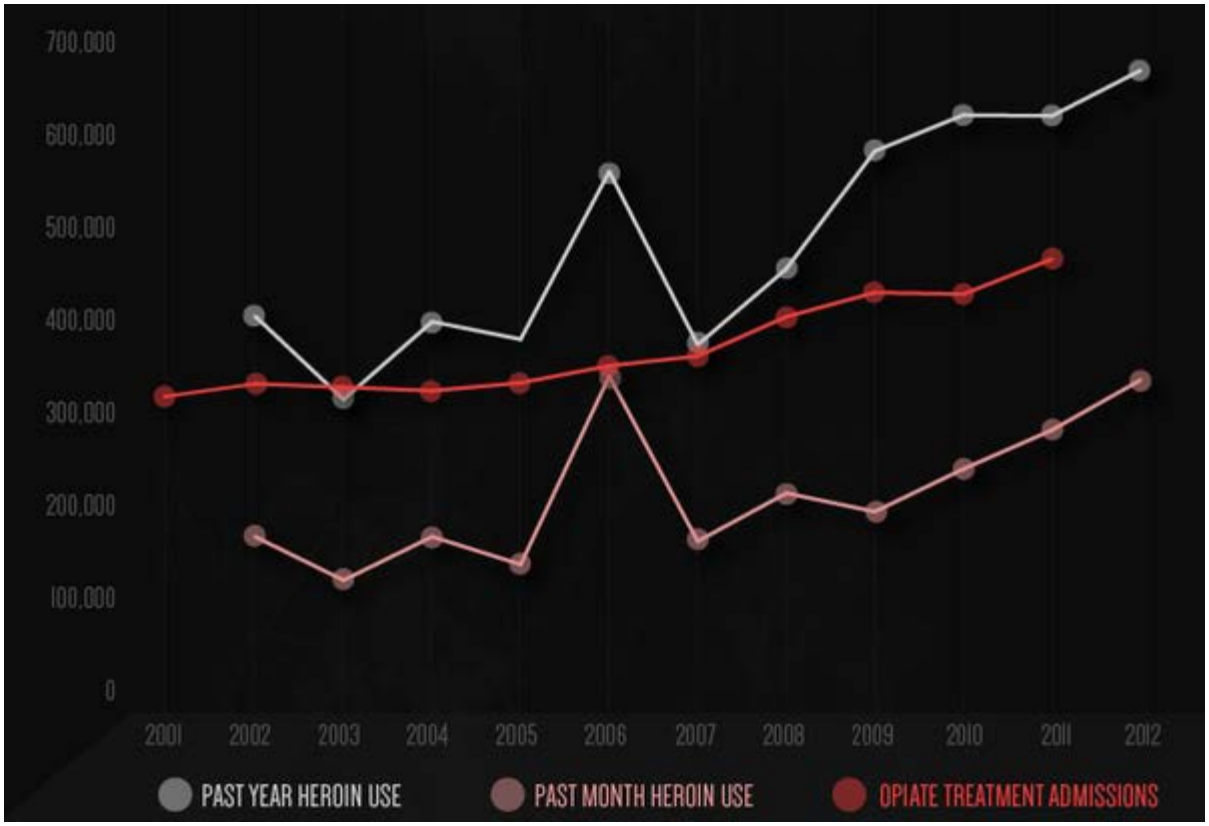
"If you were doing painkillers, you'd never be thinking, 'I'm going to be shoving a needle in my arm,'" he said.

Kevin moved to Morgantown from Florida, but within a few years he had broken up with his girlfriend and started living on the street. Eventually, he showed up at an emergency room.

"I just said, 'I'm depressed, I'm sick as a dog, I want to try to get into the clinic, I don't know what to do, I don't have a place to live, I don't have a job. I don't have any money, I don't have any insurance. If you send me out of here I'm going to go to a bridge and jump off.'"

West Virginia is a microcosm of the national drug-abuse picture. Recently, the prescription painkiller epidemic has finally begun to wane, but it's dragged heroin addiction along in its wake. In 2012, the most recent year for which data are available, nationwide deaths from prescription painkillers dropped 5 percent from 2011, but heroin overdose deaths surged by 35 percent.

Heroin Use and Opiate Treatment Admissions Over Time



National Survey on Drug Use and Health/Heroin.net

Heroin isn't necessarily more addictive than OxyContin, but it's more unpredictable, said Asokumar Buvanendran, an anesthesiology professor at Rush University Medical Center in Chicago. "Ten milligrams of Oxy is always 10 milligrams of Oxy," he said. With heroin, impurities and contamination can make an already dangerous drug even more deadly.

The CDC has found that three out of every four new heroin users report having abused prescription painkillers prior to taking up the drug. In a high-profile recent example, the actor Philip Seymour Hoffman died after his prescription painkiller addiction led him to heroin.

Sullivan, who has been working in addiction treatment in the region since 1985, said he rarely saw a heroin addict in his early years. "Even 10 years ago, we saw no heroin," he said.

Now, he sees it every day. One 19-year-old patient has been on heroin for four years. Of the four new patients Sullivan saw the morning we met, one heroin addict had Hepatitis C, Hepatitis B, and HIV. She came from a huge family, Sullivan said, most of whom are now dead from overdoses.

Alicia Frum, a patient in Sullivan's advanced group, had been smoking pot and dropping acid for about 10 years before she was introduced to heroin. It wasn't something she had set out to do, and yet, "the first time I did it, my brain and body said, *this is what you've been missing your*

whole life."

She had a daughter at 16 with a fellow addict, and for a time, she thought her life was simply fated to be that way. "I thought, I haven't died, and I haven't overdosed," she said. "Maybe this is what I'm supposed to be—some drug-addict mom."

Two years ago, she got pregnant with her son, Cain, and decided she was tired of blowing through money and spending her days searching for her next fix. She talked to the intake staff of Chestnut Ridge on a Friday, bought enough heroin to last through the weekend, and had her first appointment on Monday.

Heroin is one of the most addictive drugs, more habit-forming than cocaine, alcohol, and other common substances. Buprenorphine alleviates the withdrawal symptoms of heroin without giving patients the same euphoric high of heroin, and without slowing respiration. It works better than quitting cold turkey, but it's even more effective when it's monitored properly and paired with therapy.

Unlike some opioid-stricken areas of the country, West Virginia lacks many of the resources necessary to treat the epidemic. On Staten Island, police carry naloxone, a nasal spray that helps revive people who are in the middle of an opioid overdose. This spring the West Virginia legislature killed a bill that would have let its emergency personnel do the same.

Though Suboxone and similar drugs are readily available at clinics throughout the state, group therapy is harder to find. West Virginia has 83 mental-health shortage areas, and only about two-thirds of West Virginians are able to access mental-health treatment.

Melinda Campopiano, medical officer for the Substance Abuse Mental Health Services Administration, said that there are only a few places in the country with an adequate supply of providers who can offer buprenorphine alongside therapy.

"The people in more rural states that have fewer doctors to start with have even fewer people who can treat opiate addiction with buprenorphine," she said. "The hardship is magnified."

Doctors who want to offer group therapy alongside medication may need to spend hours on the phone with insurance companies in order to hash out the correct billing codes. "So many doctors are just busy running from patient to patient," Campopiano said.

Sarah, one of Sullivan's patients, said the clinic her husband, also a former addict, attends takes a far more lax approach. "They never drug test him there," she said. "He never sees the doctor. They say, 'You don't have to go to meetings.' They've offered him a higher dose.'" There's

another addiction clinic in Parkersburg, closer to her home, but she said the treatment process there feels like "cattle-moving": Patients wait in line for Suboxone, then leave.

Kesner, the man in the beginner group, said that when he was first calling around for help, all of the programs closer to his home had months-long waiting lists. The only reason he got into Chestnut Ridge, he said, is because he checked into the hospital's emergency room first.

One reason for the scarcity of good treatment is that Medicaid payment rates for psychologists are extremely low. Sullivan said he gets just $22 per patient for an hour of therapy from Medicaid. On top of that, federal restrictions limit opioid-addiction doctors to 100 patients each, and all of the Chestnut Ridge doctors are maxed out.

Even his privately insured patients struggle with reimbursement. One man in Sullivan's advanced group has been paying the $500 for his treatment out-of-pocket for the past few months because of an insurance mix-up.

"I'm always approached by someone who says, 'I've got a daughter or a brother, or a son or a sister, and we just can't find a place for them to get treatment,'" William Ihlenfeld said.

It took Kevin, the formerly homeless man, several weeks to get into Sullivan's clinic after his ER visit. He now takes Suboxone, works at Burger King, and lives in a shared house in Morgantown. He's relapsed several times, but he said his life is dramatically better overall.

"[Suboxone] kind of gives you a buzz when you first start taking it, but after it's been in your system for a while, that goes away, and, like, I feel good every day when I wake up," he said. "I don't crave for drugs and pills and stuff like that anymore. I just feel normal, and I've been on it for almost a year and a half now. And honestly I think if I hadn't come here, I probably would have been dead."

For the first part of their therapy sessions, Sullivan's patients see him *en masse* for a half-hour. Sitting in a quiet circle, the dozen or so people discuss their 12-step meetings, personal issues, and medication refills. The group therapy model is based on the effectiveness of AA, in which alcoholics gather to share stories and offer support to one another.

"I'm in the process of going through a divorce," said Jennifer Gayda.

"Is he going to fight you?" Sullivan said.

“Oh hell yeah,” she replied.

“Even losing a husband may not be the worst thing,” Sullivan offered.

“Actually, it’s pretty good. I’m doing the 10th step every night,” she said, referring to the portion of the AA sequence in which addicts “take personal inventory” and admit their wrongdoings.

“This is nobody’s first choice,” Sullivan told me later. “Everyone tries multiple times on their own to quit unsuccessfully. They finally come here because they don’t believe anything they do is going to work.”

“They’re in this kind of pain,” he added, pointing to his head.

Sarah, who has been sober for four years and comes from a middle-class family, started using Vicodin and Percocet when she was in college. Soon, heroin arrived from Detroit, and she switched drugs in order to save money.

“At first I wasn’t shooting it, but it progressed to being an IV drug user, and that is something that takes everything away rather quickly,” she said. “Within the first six months I was using it, I ended up losing just about everything.”

Today, seeing her sitting in Sullivan’s group in a neat brown blouse and makeup, you’d never guess she had ever been an addict.

The group’s confessional style erodes denial and builds camaraderie. It gives patients sober friends and a place to go during the day. Most importantly, it’s an accountability mechanism: The only way to get kicked out of the clinic is to lie about having used.

After Sullivan leaves the room, Chiasson-Downs leads a longer talk-therapy session.

That day, it was Betty Cumberledge’s last session—she had been sober for three years and was no longer required to attend group therapy. To commemorate the event, she composed a goodbye letter. “I don’t know if I can live without you guys,” she said, tearing up.

Chiasson-Downs pulled out a bucket of Play-Doh and asked each person to sculpt two figurines: One depicting their lives while they were addicted, and one representing what it’s like to be in recovery.

An older man in a backward baseball cap rolled some yellow dough into a long snake. He tangled it and held it up: “I was a twisted pretzel,” he said. He pulled on the ends. “Now my life’s an

untwisted pretzel."

Cumberledge made, first, a coffee table covered in drugs, and then, a shining sun. "I feel like my life has come together," she said.

Felicia Corley, a quiet blond in a gray sweatshirt, held up a purple jagged structure, saying her addiction had made her "rigid." "Now," she said, showing off a perfectly smooth ball, "I feel more solid."

One boyish-looking man depicted his addiction as a jackass, complete with tiny yellow droppings. A pale, melancholy woman next to me made a startling realistic marijuana pipe filled with Play-Doh pot, along with a handful of small blue pills.

Gayda, the woman going through the divorce, made a round "no" sign, to represent the fact that while she was addicted, she had no time for friends, family, or her kids. "They were bothering me, they interrupted me getting high," she said. Her "after" was a three-part triangle—the symbol for Alcoholics Anonymous.

Sarah made an orange tube—a bottomless pit.

"I was hating life, but it was never-ending," she said.

Then she laid four clay letters, H-O-P-E, on the chair next to her. "Because I have that today."

Olga Khazan is a staff writer at *The Atlantic*, where she covers health.
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