Illustration by Jan Diehm / The Huffington Post

Dying To Be Free

There's A Treatment For Heroin Addiction That Actually Works. Why Aren't We Using It?

By Jason Cherkis(http://www.huffingtonpost.com/jason-cherkis/)

JANUARY 28, 2015

The last image we have of Patrick Cagey is of his first moments as a free man. He has just walked out of a 30-day drug treatment center in Georgetown, Kentucky, dressed in gym clothes and carrying a Nike duffel bag. The moment reminds his father of Patrick's graduation from college, and he takes a picture of his son with his cell phone. Patrick is 25. His face bright, he sticks his tongue out in embarrassment. Four days later, he will be dead from a heroin overdose.

That day, in August 2013, Patrick got in the car and put the duffel bag on a seat. Inside was a talisman he'd been given by the treatment facility: a hardcover fourth edition of the Alcoholics Anonymous bible known as "The Big Book." Patrick had tagged some variation of his name or initials on the book's surfaces with a ballpoint pen, and its pages were full of highlighting and bristling with Post-its.

Back in the wood-paneled living room of their Lexington, Kentucky, home that afternoon, Patrick and his parents began an impromptu family meeting about what to do next. Patrick's father, Jim, took his usual seat in the big red chair, and Patrick's mother, Anne Roberts, sat on the couch. Patrick took the footrest between them, sitting with his hands on his knees. Was he ready to be home? Did he have a plan to get a sponsor? Maybe he should start looking for a job or apply to graduate school?

Before he entered Recovery Works, the Georgetown treatment center, Patrick had been living in a condo his parents owned. But they decided that he should be home now. He would attend Narcotics Anonymous meetings, he would obtain a sponsor – a fellow recovering addict to turn to during low moments – and life would go on. As they talked, though, a new reality quickly set in. Their son's addiction was worse than they had thought. It wasn't just pain pills, Patrick told them. It was heroin.

In her shock and heartbreak, Anne looked away. “I didn’t criticize him for it because I knew he felt so bad,” she explained later. “I knew he felt he had let us down.” Patrick stared at the floor, unable to look at his parents. He’d lost a year to the drug, along with a girlfriend he adored and a job caring for victims of traumatic brain injury – a job that made him feel that he was doing something worthwhile with his life. He didn’t want to be a heroin addict.

Jim had worked for decades as a public school English teacher and taught at aviation camps as an amateur pilot. Anne was in nursing and health care administration. Before Patrick was born, she had even helped run a methadone clinic treating heroin addicts and later had worked in substance abuse and psychiatric wards for the Department of Veterans Affairs. Jim and Anne knew how to be steady in a crisis.

Anne’s thoughts raced to her days at the methadone clinic. So many of her clients had done well: the smartly attired stockbroker who came in every day, the man who drove a Pepsi truck making deliveries all over the state, the schoolteacher who taught full time. She was also familiar with a newer maintenance medication on the market sold under the brand name Suboxone. Like methadone, Suboxone blocks both the effects of heroin withdrawal and an addict’s craving and, if used properly, does it without causing intoxication. Unlike methadone, it can be prescribed by a certified family physician and taken at home, meaning a recovering addict can lead a normal life, without a daily early-morning commute to a clinic. The medical establishment had come to view Suboxone as the best hope for addicts like Patrick.

Yet of the dozens of publicly funded treatment facilities throughout Kentucky, only a couple offer Suboxone, with most others driven instead by a philosophy of abstinence that condemns medical assistance as not true recovery. Even at clinics that offer the medication, the upfront costs and budget limitations render it out of reach for the vast majority who come through their doors. But Patrick had insurance, and Anne, with her treatment background, thought she could find a prescribing doctor.

“Patrick, we can get you the medication,” Anne told her son. “There are other options. We can put you on methadone or we can get you Suboxone. There are other things that you can do besides the 12-step program.”

Patrick knew firsthand about Suboxone’s potential. He had tried it on the black market to stave off sickness when he couldn’t get heroin – what law enforcement calls diversion. But Patrick had just left a facility that pushed other solutions. He had gotten a crash course on the tenets of 12-step, the kind of sped-up program that

some treatment advocates dismissively refer to as a "30-day wonder." Staff at the center expected addicts to reach a sort of divine moment but gave them few days and few tools to get there. And the role of the therapist he was assigned seemed limited to reminding him of the rules he was expected to follow. Still, by the second week, he appeared to take responsibility for his addiction. When they could reach the facility's staff, his parents were assured of their son's steady progress. Patrick was willing to try sobriety one meeting at a time.

"No," Patrick told his parents. "I think I can do it. I want to try this first."

Patrick made for a natural 12-step convert. The rituals of self-discipline were nothing new. He'd kept a journal since the 8th grade documenting his daily meals and workout routines. As a teenager, he'd woken up to the words of legendary coaches he'd copied from books and taped to his bedroom walls – John Wooden on preparation, Vince Lombardi on sacrifice and Dan Gable on goals. He had been a dominant wrestler in high school and a competitive bodybuilder in his early 20s. At his training peak, he measured and recorded his water intake down to the ounce.

Patrick (in red), 16, swiftly pins his opponent.
Courtesy of Jim Cagey and Anne Roberts

Patrick went undefeated in county high-school tournaments. He made stickers with the words "STATE CHAMP" written on them in black marker and put them all over the house. But multiple knee injuries – and knee surgeries – ended those dreams. Around the time he graduated from the University of Kentucky, the knee pain returned, and he developed an addiction to pain medications.

Patrick's habit built steadily and in secret. He needed a Percocet just to get out the door. After a statewide and federal crackdown on pain pills made them too expensive, he switched to heroin. He shot up alone in the privacy of his condo – neither his best

friend nor his girlfriend at the time ever saw him with a needle. His habit developed to the point at which he was shooting up a half-gram of heroin a day.

On his first night home from rehab, Patrick attended a Narcotics Anonymous meeting. He woke up the next morning and told his mother of the relief he felt at not having to worry about scoring drugs. “It’s like being normal,” he said. He sounded astonished and grateful. The next morning, he told her the same thing.

SHARE YOUR STORY

To share a story about your or a loved one’s experience with drug treatment, write to treatmentstories@huffingtonpost.com(mailto:treatmentstories@huffingtonpost.com) or leave a voice mail at 860-348-3376. Please include your phone number.

Anne had stocked the fridge with Patrick’s favorite mini cinnamon rolls and made up his bedroom before he came home. Although she had long ago taken down most of his “STATE CHAMP” stickers, she had left one up on the frame of his bedroom door. He was an only child and they were close. Now they had to be closer.

Patrick spent the next few days taking steps toward finding a normal routine. He looked for construction jobs, and he thought about enrolling in graduate school for physical therapy. He visited a troubled childhood friend who had become a shut-in, just to keep him company. He made plans to get back in the gym with his best friend, and he apologized to his former girlfriend, hoping for a second chance. “It was the most wonderful conversation we ever had,” Stacey Hawkins recalled. “I said, ‘Everything’s going to be OK. You keep talking this way, I’ll marry you tomorrow.’” Patrick, she added, “felt very victorious, almost.” Over meals, he quoted the Big Book from memory to his mother.

At one Narcotics Anonymous meeting, Patrick ran into two young women he knew from rehab. Those women could be bad news, he confessed to his mother one afternoon in their kitchen. Let’s get out the NA schedule and find a different meeting, Anne offered. Patrick told her he’d already found a later one to attend. He had it covered.

Anne and Jim kept working on a Plan B. Anne was worried that her son hadn’t found a sponsor yet, so she called a friend in AA; he promised to help get Patrick a sponsor after the weekend, when he’d be back in town. Jim called doctors to see if they

prescribed Suboxone. He had already put Patrick on a waiting list for a long-term 12-step facility in Lexington. He was told that a spot might open up in six months or so but there were no guarantees.

By Friday night, three days after leaving rehab, Patrick's willpower showed signs of strain. He came home late, hours after his meeting ended. The next morning, while Anne was out jogging, Patrick left the house, telling his father that he'd be back later. He hadn't returned by that evening. His parents' calls went straight to voicemail; their texts went unanswered.

9:17 p.m.: "Patrick, let us hear from you tonight. I hope all is well. Stay strong & take care."

10:49 p.m.: "We need to hear from you – it's getting late."

After attending Sunday church service the following morning, Jim drove to Patrick's condo. He spotted his son's car in the lot, knocked on the condo's door, and then let himself inside. He checked the bathroom. "I tried to open the door, you know, and something was blocking it," he recalled. "And it was Patrick. He had fallen back against the door." On the kitchen counter there was a spoon, a cotton ball, a lighter and the cap to a syringe.

In the days and weeks that followed, Patrick's parents grieved. They notified friends and relatives, wrote a eulogy for their newspaper, and made funeral arrangements. They held the memorial service on what would have been their son's 26th birthday. At Recovery Works, Patrick's former treatment facility, his name and photo were added to a memory wall in a common room – another fatal overdose in a system full of them. Staff turnover in the treatment industry meant that soon enough hardly anyone there would remember Patrick at all.

Even for staff members at the facility who stick around, it can be hard to keep straight all the names and faces of the dead. In the months before Patrick's death, Sydney Pangallo, 23, a recent Recovery Works alumna, suffered a fatal overdose. Dan Kerwin, 23, attended a Recovery Works program in the spring, and his sister found him dead of an overdose during the July 4th weekend. Tabatha Roland, 24, suffered a fatal overdose in April – one week after graduating from Recovery Works. And in November, Ryan Poland, 24, died of an overdose. He too was a Recovery Works graduate.

There's nothing uniquely tragic about these results. The problem is not with heroin treatment at one facility in Kentucky over the span of a few months. The problem is with heroin treatment.

Chapter 2

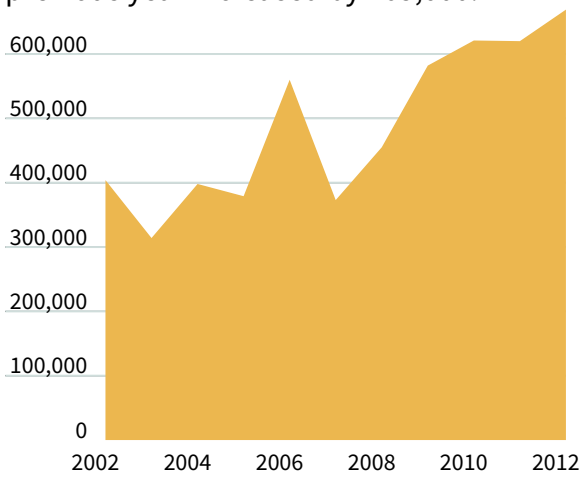
The charred remains of a trailer a dealer once used to sell heroin in London, Kentucky.
Jason Cherkis / The Huffington Post

The opioid epidemic took hold in the U.S. in the 1990s. Percocet, OxyContin and Opana became commonplace wherever chronic pain met a chronic lack of access to quality health care, especially in Appalachia.

The Centers for Disease Control and Prevention calls the prescription opioid epidemic the worst of its kind in U.S. history. "The bottom line is this is one of the very few health problems in this country that's getting worse," said Dr. Tom Frieden, director of the CDC.

U.S. HEROIN USE BY YEAR

Between 2002 and 2012, the number of people who reported using heroin within the previous year increased by 265,000.



Source: Substance Abuse and Mental Health Services Administration

"We had a fourfold increase in deaths from opiates in a decade," Frieden said. "That's nearly 17,000 people dying from prescription opiate overdoses every year. And more than 400,000 go to an emergency room for that reason."

Clinics that dispensed painkillers proliferated with only the loosest of safeguards, until a recent coordinated federal-state crackdown crushed many of the so-called "pill mills." As the opioid pain meds became scarce, a cheaper opioid began to take over the market – heroin. Frieden said three quarters of heroin users started with pills.

Federal and Kentucky officials told The Huffington Post that they knew the move against prescription drugs would have consequences. "We always were concerned about heroin," said Kevin Sabet, a former senior drug policy official in the Obama administration. "We were always cognizant of the push-down, pop-up problem. But we weren't about to let these pill mills flourish in the name of worrying about something that hadn't happened yet. … When crooks are putting on white coats and handing out pills like candy, how could we expect a responsible administration not to act?"

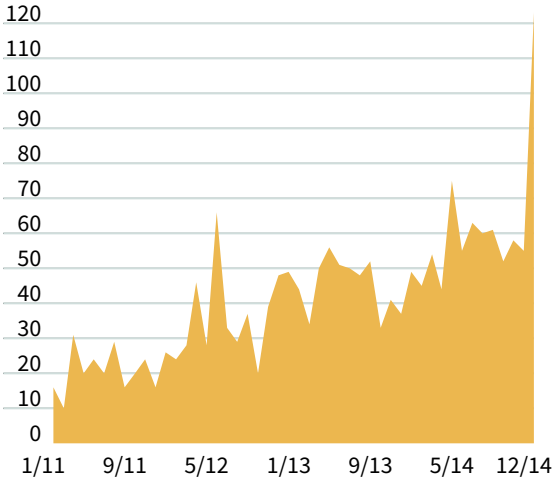
As heroin use rose, so did overdose deaths. The statistics are overwhelming. In a study released this past fall examining 28 states, the CDC found that heroin deaths doubled between 2010 and 2012. The CDC reported recently that heroin-related overdose deaths jumped 39 percent nationwide between 2012 and 2013, surging to 8,257. In the past decade, Arizona's heroin deaths rose by more than 90 percent. New York City had 420 heroin overdose deaths in 2013 — the most in a decade. A year ago, Vermont's governor devoted his entire State of the State speech to heroin's resurgence. The public began paying attention the following month, when Philip Seymour Hoffman died from an overdose of heroin and other drugs. His death followed that of actor Cory Monteith, who died of an overdose in July 2013 shortly after a 30-day stay at an abstinence-based treatment center.

In Cincinnati, an entry point for heroin heading to Kentucky, the street dealers beckoning from corners call it "dog" or "pup" or "dog food." Sometimes they advertise their product by barking at you. Ohio recorded 680 heroin overdose deaths in 2012, up 60 percent over the previous year, with one public health advocate telling a local newspaper that Cincinnati and its suburbs suffered a fatal overdose every other day. Just over the Ohio River the picture is just as bleak. Between 2011 and 2012, heroin deaths increased by 550 percent in Kentucky and have continued to climb steadily. This past December alone, five emergency rooms in Northern Kentucky saved 123 heroin-overdose patients; those ERs saw at least 745 such cases in 2014, 200 more than the previous year.

For addicts, cravings override all normal rules of behavior. In interviews throughout Northern Kentucky, addicts and their families described the insanity that takes hold. Some addicts shared stories of shooting up behind the wheel while driving down Interstate 75 out of Cincinnati, or pulling over at an early exit, a Kroger parking lot. A mother lamented her stolen heirloom jewelry and the dismantling of the family cabin piece by piece until every inch had been sold off. Addicts stripped so many houses, barns, and churches of copper and fixtures in one Kentucky county that the sheriff formed a task force. Another overdosed on the couch, and his parents thought maybe they should just let him go.

NORTHERN KENTUCKY HIT HARD BY HEROIN OVERDOSES

Between 2011 and 2014, heroin overdoses at five Kentucky emergency rooms outside of Cincinnati — Covington, Ft. Thomas, Edgewood, Florence and Grant County — increased by 669 percent.



Source: St. Elizabeth Healthcare

Chemistry, not moral failing, accounts for the brain's unwinding. In the laboratories that study drug addiction, researchers have found that the brain becomes conditioned by the repeated dopamine rush caused by heroin. "The brain is not designed to handle it," said Dr. Ruben Baler, a scientist with the National Institute on Drug Abuse. "It's an engineering problem."

Dr. Mary Jeanne Kreek has been studying the brains of people with addiction for 50 years. In the 1960s, she was one of three scientists who determined that methadone could be a successful maintenance treatment for an opioid addicted person. Over the years, various drug czars from both political parties have consulted her at Rockefeller University in New York City, where she is a professor and head of the Laboratory of the Biology of Addictive Diseases. According to Kreek, there's no controversy over how opiate addiction acts upon the brain.

"It alters multiple regions in the brain," Kreek said, "including those that regulate reward, memory and learning, stress responsivity, and hormonal response, as well as executive function which is involved in decision-making – simply put, when to say yes and when to say no."

A heroin addict entering a rehab facility presents as severe a case as a would-be suicide entering a psych ward. The addiction involves genetic predisposition, corrupted brain chemistry, entrenched environmental factors and any number of potential mental-health disorders – it requires urgent medical intervention. According to the medical establishment, medication coupled with counseling is the most effective form of treatment for opioid addiction. Standard treatment in the United States, however, emphasizes willpower over chemistry.

Dr. Mary Jeanne Kreek, a pioneering researcher who runs the Laboratory of Biology of Addictive Diseases at Rockefeller University in New York City. Damon Scheleur / The Huffington Post

To enter the drug treatment system, such as it is, requires a leap of faith. The system operates largely unmoved by the findings of medical science. Peer-reviewed data and evidence-based practices do not govern how rehabilitation

facilities work. There are very few reassuring medical degrees adorning their walls. Opiates, cocaine and alcohol each affect the brain in different ways, yet drug treatment facilities generally do not distinguish between the addictions. In their one-size-fits-all approach, heroin addicts are treated like any other addicts. And with roughly 90 percent of facilities grounded in the principle of abstinence, that means heroin addicts are systematically denied access to Suboxone and other synthetic opioids.

On average, private residential treatment costs roughly $31,500 for 30 days. Addicts experience a hodgepodge of drill-instructor tough love, and self-help lectures, and dull nights in front of a television. Rules intended to instill discipline govern all aspects of their lives, down to when they can see their loved ones and how their bed must be made every morning. A program can seem both excessively rigid and wildly disorganized.

After a few weeks in a program, opiate addicts may glow as if born again and testify to a newfound clarity. But those feelings of power and self-esteem can be tethered to the rehabilitation facility. Confidence often dims soon after graduation, when they once again face real life with a still-warped brain hypersensitive to triggers that will push them to use again. Cues such as a certain smell associated with the drug or hearing the war stories of other addicts could prompt a relapse.

“The brain changes, and it doesn’t recover when you just stop the drug because the brain has been actually changed,” Kreek explained. “The brain may get OK with time in some persons. But it’s hard to find a person who has completely normal brain function after a long cycle of opiate addiction, not without specific medication treatment.”

An abstinence-only treatment that may have a higher success rate for alcoholics simply fails opiate addicts. “It’s time for everyone to wake up and accept that abstinence-based treatment only works in under 10 percent of opiate addicts,” Kreek said. “All proper prospective studies have shown that more than 90 percent of opiate addicts in abstinence-based treatment return to opiate abuse within one year.” In her ideal world, doctors would consult with patients and monitor progress to determine whether Suboxone, methadone or some other medical approach stood the best chance of success.

A 2012 study conducted by the National Center on Addiction and Substance Abuse at Columbia University concluded that the U.S. treatment system is in need of a "significant overhaul" and questioned whether the country's "low levels of care that addiction patients usually do receive constitutes a form of medical malpractice."

While medical schools in the U.S. mostly ignore addictive diseases, the majority of front-line treatment workers, the study found, are low-skilled and poorly trained, incapable of providing the bare minimum of medical care. These same workers also tend to be opposed to overhauling the system. As the study pointed out, they remain loyal to "intervention techniques that employ confrontation and coercion — techniques that contradict evidence-based practice." Those with "a strong 12-step orientation" tended to hold research-supported approaches in low regard.

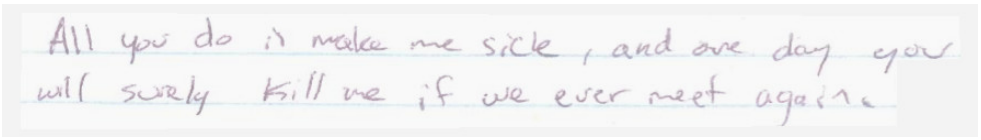
Researchers have been making breakthroughs in addiction medicine for decades. But attempts to integrate science into treatment policy have been repeatedly stymied by scaremongering politics. In the early 1970s, the Nixon administration promoted methadone maintenance to head off what was seen as a brewing public health crisis. Due to fears of methadone's misuse, however, regulations limited its distribution to specialized clinics, and it became a niche treatment. Methadone clinics have since become the targets of NIMBYs and politicians who view them as nothing more than nuisance properties. In the late '90s, then-New York City Mayor Rudy Giuliani tried unsuccessfully to cut methadone programs serving 2,000 addicts on the grounds that despite the medication's success as a treatment, it was an immoral solution and had failed to get the addicts employed.

A new medication developed in the 1970s, buprenorphine, was viewed as a safer alternative to methadone because it had a lower overdose risk. "Bupe," as it's become known, was originally approved for pain relief, but knowledgeable addicts began using it as a black market route to drug rehabilitation. Government approval had to catch up to what these addicts had already field tested. After buprenorphine became an accepted treatment in France in the mid-'90s, other countries began to treat heroin addicts with the medication. Where buprenorphine has been adopted as part of public policy, it has dramatically lowered overdose death rates and improved heroin addicts' chances of staying clean.

In 2002, the U.S. Food and Drug Administration approved both buprenorphine (Subutex) and buprenorphine-naloxone (Suboxone) for the treatment of opiate dependence. Suboxone combines bupe with naloxone, the drug that paramedics use

to revive overdose victims. These medications are what's called partial agonists which means they have a ceiling on how much effect they can deliver, so extra doses will not make the addict feel any different.

Whereas generic buprenorphine can produce a high if injected, Suboxone was formulated to be more difficult to manipulate. If an addict uses it improperly by injecting it, the naloxone kicks in and can send the person into withdrawal – the opposite of a good time.



Dan Kerwin writing to heroin. He fatally overdosed over the July 4th weekend in 2013. Courtesy of the Kerwin family

In the U.S., the more abuse-resistant Suboxone dominates the market, making it the most widely prescribed of the medically assisted treatments for opioid addiction.

Neither Suboxone nor methadone is a miracle cure. They buy addicts time to fix their lives, seek out counseling and allow their brains to heal. Doctors recommend tapering off the medication only with the greatest of caution. The process can take years given that addiction is a chronic disease and effective therapy can be a long, grueling affair. Doctors and researchers often compare addiction from a medical perspective to diabetes. The medication that addicts are prescribed is comparable to the insulin a diabetic needs to live.

"If somebody has a heroin dependence and they did not have the possibility to be offered methadone or Suboxone, then I think it's a fairly tall order to try and get any success," said Dr. Bankole Johnson, professor and chair of the Department of Psychiatry at the University of Maryland School of Medicine. "There have been so many papers on this – the impact of methadone and Suboxone. It's not even controversial. It's just a fact that this is the best way to wean people off an opioid addiction. It's the standard of care."

But as the National Center on Addiction and Substance Abuse study pointed out, treatment as a whole hasn't changed significantly. Dr. A. Thomas McLellan, the co-founder of the Treatment Research Institute, echoed that point. "Here's the problem,"

he said. Treatment methods were determined "before anybody really understood the science of addiction. We started off with the wrong model."

For families, the result can be frustrating and an expensive failure. McLellan, who served as deputy director of the White House's Office of National Drug Control Policy from 2009 to 2011, recalled recently talking to a despairing parent with an opiate-addicted son. The son had been through five residential treatment stays, costing the family more than $150,000. When McLellan mentioned buprenorphine, the father said he had never heard of it.

Most treatment programs haven't accepted medically assisted treatments such as Suboxone because of "myths and misinformation," said Robert Lubran, the director of the pharmacological therapy division at the federal Substance Abuse and Mental Health Services Administration.

In fiscal year 2014, SAMHSA, which helps to fund drug treatment throughout the country, had a budget of roughly $3.4 billion dedicated to a broad range of behavioral health treatment services, programs and grants. Lubran said he didn't believe any of that money went to programs specifically aimed at treating opioid-use disorders with Suboxone and methadone. It's up to the states to use block grants as they see fit, he said.

Kentucky has approached Suboxone in such a shuffling and half-hearted way that just 62 or so opiate addicts treated in 2013 in all of the state's taxpayer-funded facilities were able to obtain the medication that doctors say is the surest way to save their lives. Last year that number fell to 38, as overdose deaths continued to soar.

In multiple states struggling to manage the epidemic, thousands of addicts have no access to Suboxone. There have been reports by doctors and clinics of waiting lists for the medication in Kentucky, Ohio, central New York and Vermont, among others. In one Ohio county, a clinic's waiting list ran to more than 500 patients. Few doctors choose to get certified to dispense the medication, and those who do work under rigid federal caps on how many patients they can treat. Some opt not to treat addicts at all. According to state data, more than 470 doctors are certified in Kentucky, but just 18 percent of them fill out 80 percent of all Suboxone prescriptions.

There's no single explanation for why addiction treatment is mired in a kind of scientific dark age, why addicts are denied the help that modern medicine can offer. Family doctors tend to see addicts as a nuisance or a liability and don't want them

crowding their waiting rooms. In American culture, self-help runs deep. Heroin addiction isn't only a disease – it's a crime. Addicts are lucky to get what they get.

Chapter 3

A detox bed in Northern Kentucky. Jason Cherkis / The Huffington Post

Among Kentucky's taxpayer-funded rehabilitation options is a network of 15 facilities – eight for men and seven for women – created about a decade ago and known as Recovery Kentucky. It represents the state's central drug treatment effort, admitting thousands of addicts per year. Few if any of the hundreds of employees at the 15 facilities implementing the program are medical professionals, and because of this lack of a medical approach at the centers, the state doesn't technically define what they offer as "treatment." "We look at it as an education, self-help program," said Mike Townsend, the head of Recovery Kentucky.

The Recovery Kentucky network embraces the 12-step method pioneered by Alcoholics Anonymous. Its treatment centers are modeled after the Healing Place, also part of the network, in Louisville. “Clients work with peers in similar circumstances to motivate one another to adopt social skills and to learn core principles central to Alcoholics Anonymous and Narcotics Anonymous programs,” according to the facility’s promotional materials. “Our clients also learn the basics of responsibility and move away from a ‘street’ mentality.”

Karyn Hascal, The Healing Place’s president and CEO, said she would never allow Suboxone in her treatment program because her 12-step curriculum is “a drug-free model. There’s kind of a conflict between drug-free and Suboxone.”

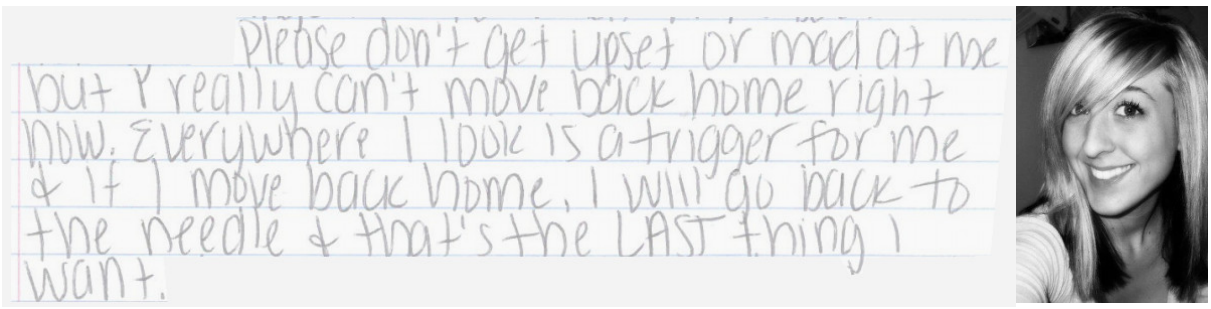
For policymakers, denying addicts the best scientifically proven treatment carries no political cost. But there’s a human cost to maintaining a status quo in which perpetual relapse is considered a natural part of a heroin addict’s journey to recovery. Relapse for a heroin addict is no mere setback. It can be deadly. A sober addict leaves a treatment program with the physical cravings still strong but his tolerance gone. Shooting the same amount of heroin the addict was used to before treatment can more easily lead to a fatal overdose.

Three counties in Northern Kentucky — Campbell, Kenton and Boone — are among the hardest hit by the state’s heroin crisis. In 2013, those counties had 93 fatal heroin-related overdoses, according to coroner records.

No central clearinghouse exists to gather background on overdose deaths, and so The Huffington Post relied on a variety of methods to learn more about these fatalities. Local coroners and their staffs were helpful in identifying victims and providing records. Family members were located independently and relayed information about their loved ones. Court documents also proved useful, as did corrections department records, jail wardens, defense attorneys and corrections officials from Kentucky and Ohio. HuffPost was able to obtain histories for 74 of the 93 victims.

Of the 74, 53 had some experience with 12-step or abstinence-based treatment. Their involvement in such programs ran the gamut from multiple long-term residential and detox stays to outpatient treatment and court-ordered attendance at Narcotics Anonymous meetings. These were addicts who wanted to stop using, or at least heard the message. They went to abstinence-based, military-themed rehabs and out-of-

state Bible-themed rehabs. Some had led meetings or proselytized to addicts in church groups on the power of 12-step. They participated in 12-step study nights. One lived with his NA sponsor.


Please don't get upset or mad at me but I really can't move back home right now. Everywhere I look is a trigger for me & if I move back home, I will go back to the needle & that's the LAST thing I want.

Writing to her mother from a 12-step facility, Kayla Haubner worries she'll relapse if she moves back home. She died from an overdose shortly after graduating. Courtesy of the Haubner family

In letters home from an abstinence-based facility in Prestonsburg, Kentucky, Kayla Haubner gushed about how she was taking to the program, but worried it wouldn't be enough. "I'm so ready to stay sober," she wrote in early 2013. "Believe me, I know how hard it's gonna be when I leave here + go back into the real world. I'm safe here." It was a sentiment that she would repeat often to family and friends during her time in treatment. In a subsequent letter, she confessed, "I'm so scared for when I leave here + go back home." Two weeks after graduating from the program, she fatally overdosed in a gas station bathroom.

For all the people who graduate from 12-step and abstinence-based programs and then relapse, many more drop out before completing them. Recovery Kentucky facilities across the state admitted to HuffPost dropout rates as high as 75 percent.

Chrysalis House, a Lexington treatment center for women, most of whom are mothers, has more success than most, with about a 40 percent dropout rate, administrators said, but among those who complete the program, roughly half will relapse within a year. Many, if not all, had previous treatment stays. (The facility is not part of Recovery Kentucky, but does receive public funding.)

Jennifer Stamper, Chrysalis House's treatment director, said the mothers can stay up to two years at the facility. Chrysalis House does not offer Suboxone, but it does accept mothers who are on the medication – although Stamper said they make up

less than 5 percent of the residents. Despite the clinic's failure rate, she has not considered making the medication more accessible. "I don't know how to answer that question," she said. "We are an abstinence-based program by nature."

The state's treatment providers have little idea how their patients fare once they walk out the door. Hascal of The Healing Place said she didn't know the relapse rate of her graduates. When Diane Hague, the director of the largest licensed addiction treatment facility in Jefferson County, was asked what happens to addicts once they leave, she replied, "How would I have that?" Right now, the surest way Hague and others know the fate of former residents is if they return after a relapse.

The high dropout rates have provoked neither an internal crisis nor a re-evaluation of programming. Stamper dismissed dropouts as "attrition by personal choice." An addict's failure is considered a result of not being ready for treatment, never an indication that there might be a problem with the treatment itself. "We welcome them to come back and try again," said Tony White, program director of the Morehead Inspiration Center, a Recovery Kentucky men's facility.

In order to track Recovery Kentucky outcomes, the state contracts with the University of Kentucky to conduct an annual survey. In its 2014 report, researchers claimed that 92 percent of all illicit-drug addicts who went through Recovery Kentucky were still drug-free six months after discharge. The figure, if accurate, would represent an astounding rate of success in an industry beset by failure.

The survey and its findings, however, didn't show the whole picture. Robert Walker, an assistant professor at the university's Center on Drug and Alcohol Research and a designer of the study, conceded that his team surveyed addicts early in their recovery. "You are probably seeing some honeymoon effect," he said. "If you had a follow-up 18 months out, you're not going to see that number." How long addicts' commitment to sobriety lasts after they graduate from Recovery Kentucky is "the bigger question," he said.

Another possible reason why University of Kentucky researchers came up with such a high success rate: the survey did not include addicts who quit or who were kicked out during the first few months of the program. That means a substantial percentage, potentially a majority, of heroin addicts treated by these publicly-funded facilities were simply not accounted for at all.

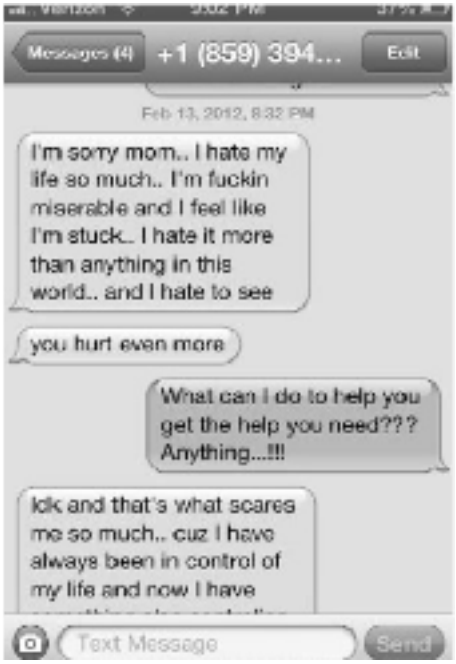
"This would really be picked apart by peer reviewers," said Dr. Yngvild Olsen, the medical director for the Institutes for Behavior Resources in Baltimore, who reviewed the study for the Huffington Post. "It speaks to the gap in really high-quality research that exists in this area."

Walker said he thinks his UK research team should include all addicts who enter Recovery Kentucky. "If I had my druthers I would include them," he said. "We would include everybody." But the parameters of the study are not up to him, he explained, but determined by Recovery Kentucky – the subject of the study.

The addicts who quit during those early stages weren't ready to accept 12-step so they don't count, explained Townsend of Recovery Kentucky.

But nobody wants to be a heroin addict. These were individuals who were desperate enough to seek help, who had often languished on long waiting lists to get it or who, if a court had ordered the treatment, faced incarceration if they dropped out. A rigorous study would include every addict who attempts treatment at the facilities in question. "That is your true outcome," said Dr. Johnson of the University of Maryland. "The outcome isn't a selective number of people who are devoted to the program."

What addicts face is a revolving door, an ongoing cycle of waiting for treatment, getting treatment, dropping out, relapsing and then waiting and returning for more. Like so many others, Tabatha Roland, the 24-year-old addict from Burlington, wanted to get sober but felt she had hit a wall with treatment. "I hate my life so much.. I'm fuckin miserable and I feel like I'm stuck.. I hate it more than anything in this world.. and I hate to see you hurt even more," she texted her mother, who wrote back, "What can I do to help you get the help you need??? Anything…!!" Roland replied: "Idk and that's what scares me so much."



Tabatha Roland texting her mother before suffering a fatal overdose.
Courtesy of the Roland family

Roland participated in an outpatient program, went through detox many times, quit in the middle of two different long-term residential stints, and completed a stay at Recovery Works, in Georgetown, before her fatal overdose a week later, on April 16, 2013.

For the treatment centers, the revolving door may be financially lucrative. “It’s a service that rewards the failure of the service,” Johnson said. “If you are going to a program, you don’t succeed and you pay X-thousand dollars. When you fail, you go back — another X-thousand dollars. Because it’s your fault.”

Johnson has received honors for his research, including a 2001 award from Hazelden, a Minnesota-based drug and alcohol treatment provider that helped to popularize the 12-step method, for having furthered “the scientific knowledge of addiction recovery.” In a recent interview, he called conventional 12-step treatments by themselves “inadequate care.”

Eliza Clontz has run abstinence-based treatment programs for opiate addiction in Kentucky and worked as a counselor in the state’s private and public sectors. She said the prevalence of the abstinence model for drug treatment parallels the faith-based approach to sex education. “They believe in the abstinence model because that’s what’s drilled in. You have a lot of the old-timers running the programs now. They

have been running them for years," said Clontz, who now works as a director of a substance abuse program that provides counseling for addicts including those taking medications. "They have this mentality of abstinence, abstinence, abstinence. … It's always been that way."

Since the heroin epidemic first hit, the 110 beds at the publicly-funded Grateful Life Center have become some of the most coveted real estate in Northern Kentucky. The facility for men, part of the Recovery Kentucky network, is located in Erlanger, just down the road from the Kenton County jail. Addicts can stay nearly seven months or longer in the program, more than at most facilities. Some addicts transitioning out of Grateful Life can also qualify for housing assistance if they meet certain requirements. The center is run by a defense attorney, and it is the place that judges and the Department of Corrections tend to send addicts under their jurisdiction. It is one of the first places that parents call to see if there are empty beds.

If you are a heroin addict looking to get sober, Mike Greenwell, the center's intake supervisor, is the first man you talk to. On a Saturday night in late March, Greenwell, 61, was still at his desk doing paperwork. He used to be a nightclub manager before alcohol and drug use got the better of him. He keeps a little radio tuned to classic rock. A Jesus bumper sticker is slapped on the wall above his desk.

I asked about a former resident, Keith Lillard, a 29-year-old who overdosed in October 2013. Lillard struggled with heroin for a decade and had been through Grateful Life, as well as The Healing Place in Louisville. He logged a turbulent history of rehabs, detoxes and relapses. The day before he died, he watched his 7-year-old son participate in a karate exhibition. His mother and sister would find him dead from an overdose in the room he was renting at a sober-living house.

Greenwell conceded that Lillard's fate was not unique. Two-thirds of addicts drop out or get kicked out of his program, he said. He estimated that only about 1 in 5 who complete the program have a "real shot" at staying off drugs. And that's being optimistic, he said. He later compared Grateful Life to the Marines: "Only the top 15 percent make it long term."

Might Suboxone have saved Lillard?

"Could have," Greenwell said. "But it's not sobriety."

Greenwell underlined his point. "It's being alive," he said dismissively. "But you're not clean and sober."

As the broader war on drugs is being reconsidered – even in conservative states like Kentucky – officials have concluded that an incarceration-first strategy is not only costly but also bad policy. Drug courts that shuttle defendants to rehabilitation facilities instead of locking them up are now ubiquitous. But a reforming justice system is feeding addicts into an unreformed treatment system, one that still carries vestiges of inhumane practices – and prejudices – from more than half a century ago.

John Peterson got hooked on heroin in the mid-1950s, soon after returning home to Los Angeles from a stint in the Army. He struggled to stay in college and to kick the drug. He tried to detox at home with codeine-laced cough syrup. He made regular visits to a clinic on West Pico Boulevard where he was injected with a mysterious brown liquid that he was told could cure him. The infusions were nothing but a painful hoax. "I didn't know anybody that cleaned up and stayed clean," Peterson, 81, said. "It was an impossibility."

Peterson thought of Charlie Parker's exuberant 12-bar blues "Relaxin' at Camarillo." It was more than a standout tune to him – it was a code: Camarillo was the state mental hospital where in the 1940s Parker had been sent to address his own heroin addiction. A decade later, Camarillo was still the closest approximation of drug treatment available. Peterson decided he could do it like Bird.

He entered the Spanish Mission-style facility, located 60 miles north of Los Angeles, under the wrenching spell of heroin withdrawal. In the room Peterson shared with 50 other patients, he was the only drug addict. Not once did a doctor treat him, a nurse attend to him or a psychiatrist hear his story. In the eyes of the staff, he recalled, all that distinguished him was that he was a little more sane than the rest of the patients. Instead of receiving treatment, Peterson was recruited for staff duties. He was ordered to help restrain other patients during electroshock therapy. "Either you are the shocker or the shockee," the orderlies told him.

Patients were forced to strip naked before bed and to leave their clothes in a pile outside the dormitory. After lights out, Peterson said, some residents would rape the weaker and more vulnerable. His best friend was an alleged murderer who had been deemed mentally incompetent to stand trial. As he had to do with others, Peterson was made to hold his friend down for shock treatments. But the friend understood

Peterson's dilemma, and he would serve as Peterson's bodyguard against the nightly threat of attacks. "The door was locked and you got 50 guys in various stages of insanity, so what happened happened and one tried to survive it," Peterson said.

Once signed into the facility, Peterson wasn't permitted to leave until his three months were up – precisely 92 days and five hours, he recalled. "It didn't make any sense to me then. It wasn't treatment," he said. "I don't know what you'd call it." Peterson relapsed immediately after he left Camarillo.

At the time, addicts were lucky to find a hospital bed to detox in. A hundred years ago, the federal government began the drug war with the Harrison Act, which effectively criminalized heroin and other narcotics. Doctors were soon barred from addiction maintenance, until then a common practice, and hounded as dope peddlers. They largely vacated the field of treatment, leaving addicts in the care of law enforcement or hucksters hawking magical cures.

Jails and prisons filled with heroin addicts. They became so despised by wardens that early in the Depression, the federal government established two model facilities just for addicts. (One of the two was built in Lexington.) They became known as "Narcotic Farms," places where addicts tilled rolling pastures and cared for livestock as part of their therapy. These so-called hospitals still bore all the marks of a prison, and at least 90 percent of the residents relapsed after leaving. To this day, getting locked up is the de facto treatment for a large percentage of addicts.

Given the options available to Peterson and other addicts mid-century, it's easy to see why Narcotics Anonymous – founded in 1953 as an offshoot of Alcoholics Anonymous – became such a success.

The philosophy of AA co-founder Bill Wilson, also known as Bill W., a former Wall Street analyst and a recovering alcoholic, offered empathy and promised lasting sobriety. Wilson's organization came out of evangelical Christian movements. His cure wasn't a jail cell or a scheme to separate addicts from their money but a meeting space where people shared their problems and admitted their vulnerabilities. This was considerably less frightening and more affordable than electroshock therapy.

The Big Book, first published in 1939, was the size of a hymnal. With its passionate appeals to faith made in the rat-a-tat cadence of a door-to-door salesman, it helped spawn other 12-step-based institutions, including Hazelden, founded in 1949 in Minnesota. Hazelden, in turn, would become a model for facilities across the country.

"The history of 12-step came out of white, middle-class, Protestant people who want to be respectable," said historian Nancy Campbell, a professor at Rensselaer Polytechnic Institute. "It offers a form of community and a form of belonging that is predicated upon you wanting to be normal, you wanting to be respectable, you wanting to have a stake in mainstream society."

In the mid '60s, the federal government decided that drug treatment should become more widely available. In ways that may be familiar to reformers today, government officials began to rethink incarceration policies toward addicts. Mandatory sentences fell out of favor, and a new federal law, the Narcotic Addict Rehabilitation Act, gave judges the discretion to divert a defendant into treatment.

The law also laid the groundwork for our current system by encouraging local communities to open their own treatment facilities. "There was a scramble away from centralized treatment at the Narcotic Farm and a scramble to get it in every city or small town," Campbell said. "Who was best positioned to provide care at the time [the law] went into effect? Faith-based and 12-step programs, despite the fact that they had little experience with drug addicts in the late 1960s and early 1970s."

The number of drug treatment facilities boomed with federal funding and the steady expansion of private insurance coverage for addiction, going from a mere handful in the 1950s to thousands a few decades later. The new facilities modeled themselves after the ones that had long been treating alcoholics, which were generally based on the 12-step methodology. Recovering addicts provided the cheap labor to staff them and the evangelism to shape curricula. Residential drug treatment co-opted the language of Alcoholics Anonymous, using the Big Book not as a spiritual guide but as a mandatory text – contradicting AA's voluntary essence. AA's meetings, with their folding chairs and donated coffee, were intended as a judgment-free space for addicts to talk about their problems. Treatment facilities were designed for discipline.

Something else has been lost with the institutionalization of the 12 steps over the years: Bill Wilson's openness to medical intervention. From the start, Wilson intended AA to work with, not against or instead of, the latest and best medical science to treat addiction. In 1965, he recruited Dr. Vincent Dole to become a member of AA's board of trustees. Along with Dr. Marie Nyswander and Dr. Kreek, Dole pioneered methadone treatment for heroin addicts.

In one of their mid-'60s papers, the three scientists wrote of the limits of non-medical intervention. They described the addict as being "functionally disabled" and the life of the addict as a cycle of relapsing and repenting. But they found that methadone treatment worked. "The present state of these patients is so dramatically improved over their previous condition, and the improvement began so soon after entry into the program, that there can be no doubt that these patients have made a significant response to treatment," they wrote.

Kreek recalled Wilson's pleading for a similar treatment for alcoholism. "Bill would say, 'Vince, please develop a methadone maintenance treatment for alcoholism. AA is very helpful, but as you know most relapse…And that's the bottom line,'" Kreek said.

In a Northern Kentucky detox facility, the definition of "manage," a sign above a bed and an inspirational quote. Jason Cherkis / The Huffington Post

Dole wrote about this episode in a 1991 article: "[Wilson] suggested that in my future research, I should look for an analogue of methadone, a medication that would relieve the alcoholic's sometimes irresistible craving and enable him to progress in AA toward social and emotional recovery."

The Twelfth Step calls on addicts to carry the program's message to other addicts, which is considered central to one's own recovery. But many rank-and-file 12-steppers took a hardline message from some of Wilson's written philosophy. Those who can't stick with the program are "constitutionally incapable of being honest with themselves," reads the Big Book. "They seem to have been born that way."

Charles Dederich, a gravel-voiced salesman and an alcoholic, built an empire on this harsh sentiment. After attending AA meetings in Southern California in the late 1950s, he grew to believe that they were not tough enough. The addict needed more than brotherhood. He needed to be challenged, and "to grow up." After a singular LSD experience, Dederich conjured up a drug-free commune for heroin addicts in Santa Monica.

Dederich held that addicts lacked maturity or the ability to handle freedom responsibly. They must be broken down to be built back up. "Comfort is not for adults," Dederich argued in a taped speech during the commune's early days. "Comfort destroys adults."

John Peterson was one of the first to move into Synanon, as the commune was called. It worked for him, though not for many others.

At Synanon, sobriety was achieved not just with mutual support but through mob-directed brainwashing. If an addict broke the rules, he faced public humiliation, such as being forced to wear a sign around his neck or shave his head. A centerpiece of the treatment was a confrontational form of group therapy that became known as the Game.

The Game was a primitive court-like spectacle where addicts sat in a circle and leveled indictments against their peers, screaming at each other in the hope of a breakthrough. Dederich once proudly described the Game's verbal spewing as "emotional bathrooms."

At one point, the verbal shock therapy went on three days a week, an hour or so at a time. The Game would evolve into longer versions that played out over the course of several uninterrupted days. Sleep deprivation was supposed to act as its own mind-altering drug. Many of Dederich's harsher prescriptions were unique to Synanon, but his basic idea – that addicts would improve themselves by punishing each other – gained currency throughout the U.S. treatment system and particularly in prisons.

Synanon's agonizing ordeals proved appealing to many addicts desperate for the promise of a cure. By the early 1960s, former members and others began branching out across the country forming their own versions of the Synanon model. These eventually were dubbed "therapeutic communities."

"It does sound harsh but you have to remember we were a community of drug addicts, recovering drug addicts, and these kind of punishments became rites of passage for many of us," said Howard Josepher, 76, who in the '60s was one of the first members of New York City's Phoenix House, which was a Synanon-type program when it was established. He went on to work there and became a regional director.

Daytop Village, also in New York, stood for "Drug Addicts Yield To Persuasion." In what eventually became common practice for other communities, addicts who wanted to get into Daytop were required to sit in a "Prospect Chair" and beg for help. The program also developed marathon versions of the Game. In its early years, if an addict threatened to leave Daytop, the staff put him in a coffin and staged a funeral.

One of Daytop's founders, a Roman Catholic priest named William O'Brien, thought of addicts as needy infants – another sentiment borrowed from Synanon. "You don't have a drug problem, you have a B-A-B-Y problem," he explained in *Addicts Who Survived: An Oral History of Narcotic Use In America, 1923-1965*, published in 1989. "You had all the freedom you wanted, and you couldn't handle it. Do what you're told. That's what they do for the first five months. The orders are coming from ex-addicts who are role models for them. It's much easier to obey them because they were there on that same floor some months earlier."

David Deitch, a former Synanon member who co-founded Daytop Village with O'Brien, now sees the philosophy as fundamentally flawed. "It brought about a conversion for some without a willingness to look at the great masses that it didn't work for," he said. "Those that became part of the inner circle had the best success rates, but the huge majority that went through this experience – as is true of all treatment for this disorder – relapsed."

True believers were promoted in the ranks and, when left unchecked, terrorized the more skeptical addicts. "Reward was dependent on gaining status, and with status came power – generally power over others," said Deitch. He left Daytop and then moved to Chicago, where he worked in public health helping to oversee a variety of drug treatment programs including innovative ones that integrated a softer version of the "therapeutic community" with methadone maintenance. He is currently an emeritus professor of clinical psychiatry at the University of California, San Diego, and director of its Center for Criminality & Addiction Research, Training & Application.

By the early '70s, variations of the Game used on addicts and other crude behavior-modification techniques caught the attention of Congress. A report from the Senate Judiciary Subcommittee on Constitutional Rights compared the extreme approaches of these group therapies to "the highly refined 'brainwashing' techniques employed by the North Koreans in the early 1950s." Congress was alarmed that these techniques were being applied to teenagers.

Official outrage soon dissipated, however, and widespread policy change is still slow in coming. Programs modeled after the "therapeutic community," seeking to break the spirit of addicts through punitive measures, remain influential to this day; humiliation, degradation, and the drive to "reprogram" addicts are still part of mainstream treatment. Anne Fletcher, the author of *Inside Rehab*, a thorough study of the U.S. addiction treatment industry published in 2013, recalled rehabilitation centers derisively diagnosing addicts who were reluctant to go along with the program as having a case of "terminal uniqueness." It became so ingrained that residents began to criticize themselves that way.

Zachary Smith, a Northern Kentucky resident, attended a South Carolina boarding school for issues with pills and marijuana in 2006. His mother, Sharon, remembered that he had to earn the right to sit in a chair, to drink anything other than milk or water, and to make phone calls. To move up in the ranks, he had to offer a series of confessions, but he was not considered convincing enough. She recalled a "therapy" session in which parents had to scream at chairs "to get the anger out." Smith died of a heroin overdose in June 2013.

In 2007, the U.S. Government Accountability Office published an examination of the deaths of several teens attending programs in which endurance tests were part of their treatment. In testimony before Congress, GAO officials quoted from one program brochure, which advertised that the first five days were "days and nights of physical and mental stress with forced march, night hikes, and limited food and water. Youth are stripped mentally and physically of material facades and all manipulatory tools." One young girl with a drug addiction died after collapsing on Day Three. The girl's parents had taken out a $25,000 loan to pay for the program.

Dr. McLellan, of the Treatment Research Institute, recalled a prominent facility he encountered in 2014 that made addicts wear diapers if they violated its rules. It was not a shocking find – he knew others that use diapers as a form of punishment. Maia Szalavitz, a journalist who covers the treatment industry – most notably with her

2006 book, *Help At Any Cost: How the Troubled-Teen Industry Cons Parents and Hurts Kids* – said that coercive techniques are still seen as treatment. "Addiction is a condition that is incredibly stigmatized, and because we still see addiction as crime more than a disease, that carries over into our treatment," she said. "What you end up with is something that in any other part of the medical system would be considered absolutely abhorrent bedside manner, [but here] is actually seen as the treatment itself."

According to Deitch, the Synanon-style approach continues to be particularly popular among administrators of prison treatment programs. In October 2013, he advised the mother of Jesse Brown, a 29-year-old Idaho addict who, as a precondition of his early release from prison, was compelled to enter a psychologically brutal "therapeutic community" behind bars. Years earlier, Brown had suffered a traumatic brain injury in a car accident. His short-term memory was shot, and he crumbled at the slightest sign of stress. But if he didn't participate in the program and endure the terrors and public humiliations, he would have to serve all of his time.

Once enrolled in the prison's program, Brown was no longer allowed to sit on his bed during the day or to speak during meals. Inmates in the program played a version of the Synanon Game. The leaders and fellow participants "singled people out in the room and talked about how they were not up to code," Brown said. No matter how untrue the allegations were, you had to admit fault and apologize to "the family." If your apology wasn't deemed sincere enough, you could lose phone privileges for days, even weeks, or be made to wear an embarrassing sign around your neck. This adaptation of the Game went on all day.

Brown didn't last more than two days in the program. His mother, panicked that he would be penalized, contacted Deitch, who helped her make her case to prison administrators. The officials compromised, and Brown was permitted to take a different class to gain an early release.

The question was not whether Brown would have succeeded in the program, Deitch said, but "would he have been able to survive?" Brown compared being in the "therapeutic community" to torture. "It felt like you were a prisoner of war," he said.

Chapter 4

The Grateful Life Center in Erlanger, Kentucky. Jason Cherkis / The Huffington Post

Central to drug treatment in Kentucky is the idea that addicts must not just confront their addictions, but confront each other. On a Monday morning in late March, the confronted was a reticent 44-year-old man. He sat in the far corner of a second-floor room at the Grateful Life Center, dressed in jean shorts and a T-shirt, looking isolated and forlorn. Around him sat a few dozen fellow addicts–a jury of much younger peers–keen to let him have it. He was accused of leaving his coffee cup unattended.

This disciplinary proceeding drew from the spirit of the Synanon Game, and it fed off the mutual suspicion and instinct for punishment that have become ingrained in drug treatment. Grateful Life holds these trials, what the staff calls "Community," several times per week. Each session can last as long as two hours. For all but the newly admitted, attendance is mandatory. On this day, the men took seats along a wall in mismatched chairs. The room was painted a dull hue – what one staffer called "anxiety-inducing yellow." More than half the room was empty and dark. The clock on the wall looked like it had been cadged from an elementary school sometime around 1983.

A staffer called out, “Good morning, Community!” In unison, everyone greeted him. This was followed by a recitation of the Serenity Prayer. By the last line, it had become a chant. The younger residents, dressed in baggy jeans and sweatshirts, appeared restless and as yet unscarred from their addictions. The older ones, with rounded shoulders and last-call faces, rested their hands on their knees, as if bracing themselves for the onslaught. The 44-year-old with the coffee-cup charge had the bad luck to face 22-year-old Kenny Hamm, the equivalent of the facility’s Grand Inquisitor.

Kenny Hamm outside the Grateful Life Center.
Jason Cherkis / The Huffington Post

Hamm was the first heroin addict the Grateful Life staff had introduced me to two months earlier, and for good reason. He was as close to a true believer as the program produces. For Hamm, an abandoned coffee cup wasn’t just an abandoned coffee cup. It was a warning sign of underlying dysfunction and inner turmoil. It was proof that this man’s demons were on the march.

The man confessed that he knew better than to leave a dirty cup in a common area, but it had slipped his mind. He said he regretted having lied about it when caught. Hamm went in for the kill. He turned to the whiteboard where another addict was recording all the group’s concerns, listing the proposed punishments in increasingly

crowded columns. “Put ‘self-worth’ and ‘God’ up on the board,” Hamm ordered in his deep drawl. This addict, Hamm decided, didn’t believe enough either in himself or in God. The pile-on began.

“You believe in God?” another addict asked the defendant. “You have a Higher Power?”

“Yes, sir,” he answered. His short reply was taken as a sign of weak faith, and it was proposed that as punishment he write 1,000 words on the theme “Only God can judge me,” attend the rehab’s beginner classes on the Big Book again, and complete close to a dozen other writing assignments aimed at probing the depths of his beliefs and his self-esteem.

Hamm was an earnest champion for the program, but he wasn’t there by choice. He had been sent to Grateful Life in October 2013 as a condition of his probation; more than half the residents wind up there courtesy of the Department of Corrections and a judge’s order. Some years before, Hamm had won a partial baseball scholarship to a small Kentucky college but had dropped out after a few semesters because of his addiction. After a childhood friend fatally OD’d in Hamm’s bedroom, Hamm spiraled downward. He slept under a bridge and at a homeless drop-in center and tried killing himself several times with an overdose of heroin and Xanax. He began thinking of himself as a ghost. There were attempts at treatment, as well, all ending in relapse.

Initially at Grateful Life, Hamm wasn’t allowed to bring in non-spiritual materials like novels or newspapers — a restriction inherited from the older “therapeutic community” models — or to wear street clothes. He attended classes in light blue surgical scrubs, a public humbling that all newbies were subjected to. Later, if he failed to show up for class or violated some other rule, he could be forced to wear the scrubs again as punishment. Despite the deprivations, Grateful Life beat jail and it gave addicts time to think. Many took the place and its staff as inspiration. They spent their nights filling notebooks with diary entries, essays on passages from the Big Book, drawings of skulls and heroin-is-the-devil poetry.

Hamm rose up the ranks, graduating from barracks-style accommodations with bunk beds and communal showers to semi-private quarters. He lived on the third floor in a spartan room he shared with another addict. His room was nearly spotless, with a brown comforter smoothed on his small bed and nothing on its pale blue walls but a painting of a horse, which had been salvaged from a Louisville hotel and donated to

the facility. (Horse prints seemed to be everywhere at Grateful Life.) Hamm's only personal items were a small clock/CD player on top of his dresser and a mini coffeemaker that his mom had bought him.

He filled notebooks with class work based on the 12-step program. In the middle of one page, he wrote in bold ink, "I HAVE TO WORK THESE STEPS!!" Above those words he wrote, "Write down your resentment you encounter in a day and see what the issue really is." And just below he wrote, "Ask any question, don't feel like it's a dumb idea." On another page, he had scrawled, "Wasted Youth," a tribute to a hardcore band he knew well.

Hamm's role at Grateful Life made him feel important. Yet despite his embrace of the program, there was still a small part of him that worried that all the classwork and Narcotics Anonymous meetings weren't enough.

During one rehab class in early February focused on vulnerability, another student leader boasted about the strength of his own righteousness in the face of future temptation. "If you're worried about being on the streets, bro, you don't trust God enough," he thumped, standing before the whiteboard.

But Hamm, seated near the middle of the class with a binder in his lap, wasn't buying it. He interrupted the man and began to talk about the limitations of his own faith. Mere belief, he knew, wouldn't be enough to keep him from using again.

"It's hard to say, man," Hamm told the others. "We're all addicts. We all have these behaviors. It's just, turn your will and your life over to the care of my God and put in the action." Sobriety required constant vigilance, he suggested. "It's not just, 'I'm going to do it three days and then skip two.' This shit is no fucking joke, man. I'm telling you."

By then, Hamm had earned the right to attend Narcotics Anonymous meetings off campus. A week after the February class, the addict who was his ride to the meetings relapsed and was kicked out of Grateful Life – as was the staffer who hadn't reported the relapse. Soon enough, the middle-aged addict with the coffee cup issue would be expelled, according to the administration, for "wasting our time and not being engaged or following the rules."

Hamm's mother, Cindy, wanted him to stay in the program as long as possible. "I'm just afraid, and I guess I'll always be afraid, [that] being so young that they could go right back to it, that his brain's not healed yet," she said. "And I don't think Kenny's real

comfortable talking to me about how low he's been. That's like admitting to your mom all the bad things that you've done. I would rather know how he feels, that he feels he can be strong enough to get through this, because it's a lifelong battle he's going to have. I want to know how he feels, if he feels like he can do it. On the other hand, I don't want to know. What if he says, 'I can't do it'?"

That spring, a few weeks before Hamm graduated, he seemed relaxed, if tired from long days that now included mentoring new residents. "We work a new person every single day," he said. "I want to give them the information that I got when I came in here." He walked the halls in scrubs not as a penance but as a way to reflect on how far he had come.

Hamm shed his haunted demeanor. He cut his bangs so they no longer shielded his eyes, and his manner became more direct. Late one evening, in the second-floor library, Hamm gave a new resident a pep talk. The newbie had detoxed at a separate facility, but during his three-week wait to enter Grateful Life he had relapsed. He was still in an early phase of the program, sleeping in a bunk bed in a communal room, and declaring that being in treatment was the greatest thing ever.

Hamm told the young man that he might not get it yet, but he would eventually. Without his realizing it, the program would suddenly click. And the feeling, Hamm promised, would be worth it. "It's a blessing, man," he said, "You will be amazed before you're halfway through. And just, like I said, sit on your hands, man, and watch — watch this. It's beautiful." The 12-step testimonial Hamm performed for him would be recognizable to anyone in the treatment community.

When he finished the Grateful Life program, Hamm could have stayed on as an employee, but he chose not to. He had already started a landscaping job and lined up a room to share in a sober-living house in nearby Covington. He felt good. On his first night out of rehab, he stayed up late, too excited to sleep.

He kept up with his meetings and the Grateful Life aftercare program. But less than three months into his living on his own, his phone buzzed. An old friend asked if Hamm wanted to get high. The two of them drove to Cincinnati, bought $100 worth of heroin and shot up together in Hamm's seven-year-old Toyota Camry. Hamm later blamed his relapse on a bad day at work, among other reasons. "It was just kind of like a storm that fell on me," he said, describing the pressures he had been under. Later that night, he attended a Narcotics Anonymous meeting. The next day he shot up the remaining heroin.

“I didn’t use the spiritual kit or the tools that they give you,” Hamm said of Grateful Life’s teachings.

Hamm took a drug test that weekend, knowing he would fail. A week later, he delivered himself to his probation officer and soon after he was booked into the Campbell County jail. But before that, he had called Greenwell, Grateful Life’s intake supervisor. Hamm had begged to be allowed back into the program. Greenwell had turned him down.

“It’s heartbreaking,” Greenwell said. “I really think he’s a great guy. He tried to call me personally many times. Unfortunately, I told him he was no longer in our program. He has to call his probation officer. You have to be true to the process. You just have to take accountability for yourself. The bottom line is you got to become a man at some point.”

Hamm might be able to come back eventually and participate in a shortened version of the program, Greenwell said. But there was a three-month waiting list. Greenwell said, half joking, that he wanted to make T-shirts that read, “One in 10 make it. Are you the One?”

In late September, Hamm was transferred back to Grateful Life for another try. He completed the program and on Christmas Eve he moved back into his mother’s house in Florence.

Chapter 5

Jason Merrick working with addicts in Northern Kentucky. Jason Cherkis / The Huffington Post

Six years ago, Jason Merrick was one of the first addicts treated by the newly opened Grateful Life facility. After completing the program, he became an employee, and he now works weekend nights. On a Saturday in late March, the stocky 43-year-old sat at the front desk, keeping an eye out for trouble.

As residents filtered in after attending off-site NA and AA meetings, the lobby was a blur of faces and not-so-hidden scars. Merrick was like a bouncer, but instead of checking IDs he was checking for any sign of a relapse.

“Been drinking?”

“What’s your sober date?”

“Did you get high tonight?”

Some residents he wasn’t sure about, and he ordered them to exhale into a plastic breathalyzer. Merrick didn’t think the device was working. With each attempt, there was only a flicker on the digital readout, maybe just part of a 5, maybe half of a 0. Merrick kept administering the test and pretending to see readings that weren’t there, and he laughed at the futility of the exercise.

Merrick spoke soothingly to a 22-year-old man who approached the front desk feeling guilt over not being there for his younger brother. He reprimanded a resident who had recently failed to wake up on time for his morning classes, and ordered him to change into scrubs as punishment.

During the week, he will stop by the facility on his days off. Merrick seems to know the names and backgrounds of all the more than 100 addicts who call Grateful Life home. And he knows how many have failed. Recently, he's been grappling with concerns about the institution.

"This is a place that saved my life literally, pulled me out of a grave and put me on my feet, gave me a place to live, fed me for a year and still continues to give me a place to be close to the people in recovery that I love," Merrick said. But he's seen a lot of residents drop out and some die.

Merrick helped put together a memorial display to former residents who didn't make it. One man's face sticks out among the R.I.P. photos and newspaper obituaries. In his photo, taken at the facility, he is beaming. He is holding up a Grateful Life certificate, his "Life on Life's Terms Award." He was a heroin addict, and Merrick remembers him well. He fatally overdosed the day after Merrick expelled him from the program, for doctoring a medical form and showing up high.

Grateful Life was originally set up to treat addicts like Merrick, older guys who did most of their self-destruction with alcohol. The majority of addicts coming through now are a lot more like Kenny Hamm and Patrick Cagey. As chairman of the Northern Kentucky chapter of People Advocating Recovery, Merrick has advocated for greater access to naloxone, the drug that can revive a heroin overdose victim, tirelessly passed out free naloxone kits, and pressed the medical establishment to start treating addicts with Suboxone. "The model that is geared toward alcoholism doesn't effectively address heroin addiction," Merrick said. "In a perfect world, we would have a 12-step model integrated with medically assisted therapy."

At least some of the top officials overseeing Kentucky's response to the opioid epidemic are as open to medications as Merrick is. "My perspective is whatever gets them sober, gets them well, is what we need to do," said Van Ingram, the executive director of Kentucky's Office of Drug Control Policy. "I don't think we should close the door on any type of treatment that's effective."

Dr. Allen Brenzel, medical director of Kentucky's Department for Behavioral Health, Developmental and Intellectual Disabilities, testified in November of last year before state legislators that medication and counseling is "the most appropriate treatment."

Such official endorsements are not winning policy debates. A recent windfall from the state's settlements with pharmaceutical companies over allegations of corrupt practices has meant more than $30 million in new funding for addiction treatment and prevention programs. None of it is being used on medically assisted treatment.

At the same hearing in which Brenzel testified, Katie Stine, a state senator representing northern Kentucky, compared being on medications like Suboxone to being "in bondage." Audrey Haynes, the Secretary of the Cabinet for Health and Family Services, said her department was lobbying to tighten restrictions on Suboxone.

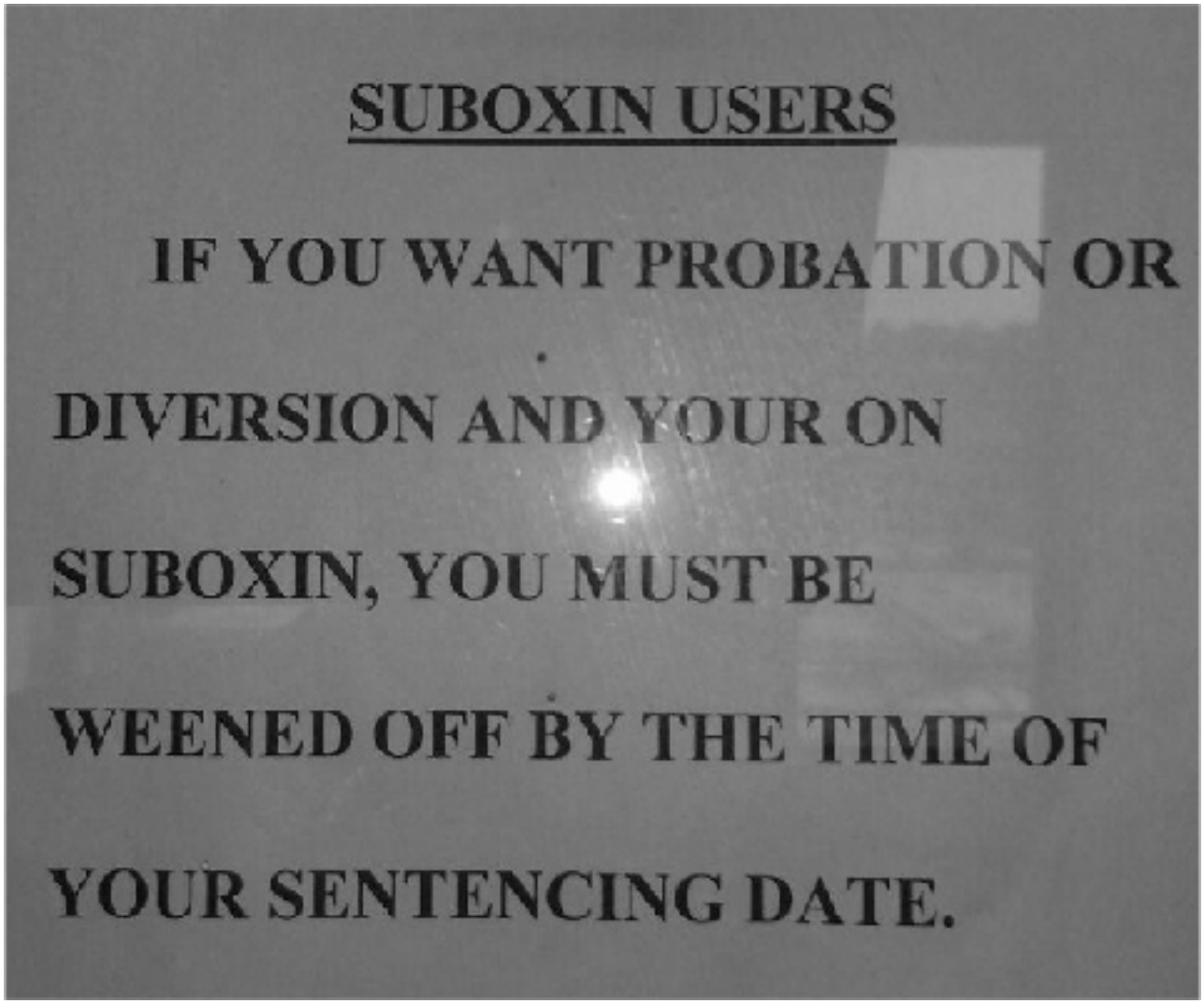
Among Suboxone's most unyielding critics are the people with the most power to dictate treatment options. The drug court judges in Northern Kentucky's Campbell, Boone and Kenton counties are adamant in their refusal to make Suboxone available to the addicts who come through their doors. Judge Gregory Bartlett, who started the first drug court in the area in 1998 and currently presides over Kenton County's drug court, won't allow Suboxone as part of a defendant's treatment plan. His reasoning: defendants in his court "have to be off drugs."

Bartlett thinks one solution to the heroin epidemic might be a mandatory stint in a detox facility. After detox, the defendants would be brought back to his courtroom to discuss further treatment options. But when it was suggested that detoxing without medication can lead to overdoses, Bartlett came up short. "I'll take your word on that," the judge replied. "I'm not an expert on what works and what doesn't work."

Judge Karen Thomas, who handles felony drug court in Campbell County, said that her opiate-addict defendants haven't failed treatment just once or twice, they may have failed treatment upwards of 10 to 15 times—and relapses often mean jail time. She will not allow Suboxone as part of sentencing options. If a guilty defendant wants to avoid jail time and receive treatment diversion, Thomas said, she orders that person to quit Suboxone if they're on it or their methadone treatment program if they're in one.

"I understand they are talking about harm reduction," Thomas said. "Those things don't work in the criminal justice system." In a subsequent interview, the judge added, "It sounds terrible, but I don't give them a choice. This is the structure that I'm comfortable with."

Thomas is simply following state court policy. A sign was recently posted outside a Kenton County courtroom addressed to all "Suboxin users." It warned: "IF YOU WANT PROBATION OR DIVERSION AND YOUR ON SUBOXIN, YOU MUST BE WEENED OFF BY THE TIME OF YOUR SENTENCING DATE."

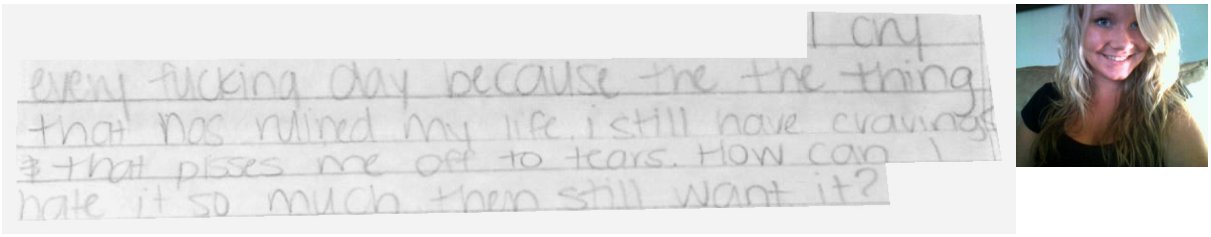


A sign posted outside a Kenton County courtroom. Jason Cherkis / The Huffington Post

For many addicts, the biggest barrier to being prescribed Suboxone is incarceration. As hard as it is to get Suboxone through drug treatment on the outside, it's nearly impossible to get a prescription behind bars. Among the 93 overdose fatalities in

Northern Kentucky in 2013, there were a good many who died shortly after leaving jail.

Shawn Hopper overdosed three times within three weeks of his release from jail; the third was fatal. Michael Glitz overdosed 10 days after leaving jail. Amanda Sue Watson died of an overdose a week after being transferred from jail to an abstinence-based halfway house. Henry Lee fatally overdosed one day after being released from the Kenton County jail. Desi Sandlin fatally overdosed the day she was released from jail.



Desi Sandlin had been in and out of rehab for a heroin addiction. She died of a heroin overdose the day she was released from jail. Courtesy of the Sandlin family

Brianna Ballard, 30, was revived by paramedics following a 2011 overdose, but was then arrested for the overdose. Released from the Kenton County jail on Feb. 1, 2013, she then fatally overdosed three days later in her bedroom at her mother's house in Villa Hills, Kentucky. Her mother, Dotie Oliver, said Ballard sought treatment in jail, but didn't receive any.

"She knew she had a drug problem, and she wanted to get better because of her son," Oliver said. "She wanted treatment. She needed it, and she knew she needed it."

Several other heroin addicts who died in 2013 were, like Ballard, still dealing with charges stemming from earlier overdoses at the time of their fatal ODs. It's a cruel joke of Kentucky's system that getting locked up for a heroin overdose may be easier than getting a Suboxone prescription to prevent one.

When the opioid epidemic hit, Mike Townsend, who has managed the Recovery Kentucky system for a decade, said he saw no reason to offer more than the existing 12-step program. He reasoned that the brain has healed once an addict manages to overcome the physical pain of withdrawal, and that the rest of the recovery is spiritual and psychological. It didn't matter whether one's drug of choice was heroin, crack cocaine or alcohol. "This is just my perspective," he said. "I'm not a doctor."

While mainstream medical research doesn't support his views, Townsend has more power over treatment in Kentucky than any doctor. Not only does he run Recovery Kentucky, but, according to emails obtained through an open records request, he also serves as an unofficial drug policy advisor to Jane Beshear, Kentucky's first lady. She in turn serves as a co-chair on what is considered Recovery Kentucky's advisory board.

Recovery Kentucky, Townsend said, would never include the use of Suboxone. When asked, he said he was not aware of its success in lowering overdose death rates. "Show me some research that has Suboxone results," he said.

Executives at Transitions Inc., the company that runs Grateful Life, one of the facilities in the Recovery Kentucky network, said they wanted to take a more science-based approach. In 2011, on what they described as an extremely limited basis, the company started offering Suboxone in its detox, shorter residential rehabilitation and outpatient programs – which are not part of Recovery Kentucky and therefore not subject to its norms.

Transitions would provide Suboxone at Grateful Life as well if it could overcome Recovery Kentucky's bias against the medication, company administrators said. "Some [of it] is the old-time, Big Book-thumping AA members," said Karen Hargett, Transitions' assistant executive director. "These were the same people who were telling me that you couldn't be sober if you were taking antidepressants. It's a lack of understanding. It's a lack of knowledge."

Transitions Executive Director Mac McArthur agreed. "It's an ideological thing," he said. "It's not a medical thing. It's not a statutory thing. It's a philosophical position of the people who started the Recovery Kentucky movement," who, he said, want to prove "that the 12-step works as well as anything else."

Simply by telling HuffPost that he favored integrating Suboxone into Grateful Life's efforts, McArthur said, he was risking rebuke from his fellow treatment providers. "We're getting ourselves in trouble, man," he said.

Chapter 6

A view of the Recovery Works cottages where Patrick Cagey struggled to overcome his addiction.
Jason Cherkis / The Huffington Post

The Hazelden Clinic in Minnesota is perhaps the most influential treatment center in the country, noted not just for its rehabilitation facilities but for its academic publishing arm. Founded in the late 1940s on a farm, the clinic brought order and professionalism to the 12-step method. Hazelden's recent merger with the Betty Ford Center has made it an even more powerful force. Administrators made headlines in early 2013 when they integrated buprenorphine into their treatment of opioid addicts.

A few years ago, Dr. Marvin Seppala, 58, the clinic's chief medical officer, began noticing that not only were more and more opioid addicts coming into his care, but they were rebelling against Hazelden's message and conspiring to smuggle narcotics onto campus. Former residents were also dying a few weeks to a few months after leaving the clinic.

Given Hazelden's long history of treating addicts, Seppala could have stubbornly stuck to the brand. But he was willing to consider alternatives. He'd come to Hazelden in the mid-'70s, as its first adolescent resident, for an addiction to drugs and alcohol. "I blamed myself so much," he recalled. "I really hated myself. I can't put that strongly enough. I didn't understand why I did all these things." His experience at Hazelden

was powerful. He met people just like him who felt the same bottomless craving and the shame that went with it. Still, he relapsed five days after graduating from the clinic. It would take him another year and a half, along with a platoon of understanding adults, before he found sobriety through another 12-step program. Now, as a physician, he knew he had to track down the clinic's dropouts and their families, and ask them what Hazelden was doing wrong.

The dropouts told Seppala and his team that they had felt neglected at the clinic and that the program, which covered all types of addictions, didn't speak to them. "The degree to which we ignored opioid dependence was significant," Seppala said. "The fact that people were dying from relapse was not being fully addressed either." Heroin addicts who relapse are more likely to fatally overdose than other drug users, but Hazelden hadn't integrated that fact into its curriculum.

Seppala thought that if he was going to reach these addicts and keep them from relapsing, Hazelden needed to revamp its curriculum and start prescribing buprenorphine and other medications. The biggest challenge, he knew, would be his own staff's resistance. "It's a real 12-step culture throughout our whole organization around the country," he said.

He spent all of 2012 planning to integrate maintenance medications into the program and working to win over staff, some of whom he found avoided treating heroin addicts at all. A small group of employees still thought that heroin addicts seldom got better and therefore Hazelden shouldn't put in the effort to treat them.

In one of the first staff meetings on the subject, a colleague of Seppala's who was running the session asked the room a simple question: Who here has had a former resident die from an opioid overdose? Three-quarters of the staff members raised their hands. "We said, 'This is why we're doing this,'" Seppala recalled. "We are trying to save lives. This is a crisis. It's essential that we do everything we can, so we cannot base our decision on philosophy or preference. We have to base it on science. We have to base it on research."

Seppala was well aware of the latest research on treating heroin addicts with buprenorphine. He had worked at an outpatient clinic in Portland, Oregon, that gave addicts both the medication and the 12-step philosophy. He saw how the addicts stuck with that program. The success in Portland was no anomaly. In November 2004, Stanley Street Treatment and Resources, a nonprofit in Fall River, Massachusetts,

introduced Suboxone into its mix of detox, short residential and outpatient therapies. In 2014, more than 300 addicts were enrolled in the program. Nancy Paull, the facility's CEO, reports a relapse rate of about 10 percent.

Seppala and his staff consulted with a clinic in Washington, D.C.; a former drug czar; and William White, a respected drug treatment historian and researcher who has written about the value of AA. White explained in an email that his reaction to Hazelden's plan was "one of pleasant surprise that a leading addiction treatment program would so value the emerging addiction science and be so committed to improving recovery outcomes that it would be willing to weather potential controversy that could affect its business interests."

Seppala also sent a team to study other clinics around the country. His staff went to facilities in Oregon and Missouri that were offering a mix of medically assisted treatments and 12-step. The team came back optimistic. "They saw in action how this could actually work," Seppala said.

After introducing medically assisted treatment in 2013, Seppala saw Hazelden's dropout rate for opiate addicts in the new revamped program drop dramatically. Current data, which covers between January 1, 2013 and July 1, 2014, shows a dropout rate of 7.5 percent compared with the rate of 22 percent for the opioid addicts not in the program. In the first year, no addict in the new model curriculum died from an overdose.

Phoenix House, another giant in the treatment world, started out in the 1960s following the Synanon model. The New York City-based operation had previously used buprenorphine only sporadically for detoxing its opioid-addicted residents. Now, it is dramatically increasing the use of buprenorphine in its more than 120 programs in multiple states. The shift is taking place under the watch of Dr. Andrew Kolodny, who took over as Phoenix House's chief medical officer a little more than a year ago. From 2003 to 2006, Kolodny worked for New York City's health department, during which time he sought to increase access to buprenorphine as a way to reduce overdose deaths.

At Phoenix House, Kolodny said, they would no longer accept the norm of addicts leaving their short-term abstinence programs only to relapse days later. "In our shorter-stay program, we want to see a significant number of patients walk out the door on buprenorphine," he said. "And we're going to be measuring our ability to do that."

Kolodny suggested that the latest opioid epidemic exposes the deficiencies of the U.S. treatment system in ways the previous ones didn't. In the late '60s and '70s, the epidemic mainly hit major cities, but there addicts had access to the new methadone clinics. Now opioid deaths are occurring in the suburbs and rural communities, where methadone clinics are few and far between, making the need for a new medical model that much more apparent. "You got all these people with this disease who need treatment," he said. "There's a medication that could really help us tackle this problem, help us dramatically reduce overdose death, and people are having a hard time accessing it."

The anti-medication approach adopted by the U.S. sets it apart from the rest of the developed world. France established buprenorphine's effectiveness years ago. Between 1995 and 1999, the country reduced overdose deaths by 79 percent as buprenorphine use in treatment became widely accepted. The medication, along with methadone treatment and needle exchange initiatives, also helped cut in half the HIV rate among intravenous drug users. By 2004, almost all of Australia's heroin addicts in treatment were on methadone or buprenorphine, and the country had reduced its overdose deaths. Even in Iranian prisons, addicts can access methadone programs. In 2005, the World Health Organization added methadone and buprenorphine to its list of essential medicines.

France successfully embraced the medical model because there was no entrenched 12-step system, like the one in the U.S., and no political opposition hardened by endless fights over methadone clinics, said Dr. Marc Auriacombe, a professor of addiction psychiatry at the University of Bordeaux and an addiction psychiatrist at the Charles Perrens Hospital. His research team has written extensively on buprenorphine and began experimenting with the medication in a lab setting in the mid-'80s.

"Everyone agreed that we couldn't continue doing what we had been doing," Auriacombe said. "People were not satisfied, including those that were the most abstinence-oriented."

France's acceptance of buprenorphine wasn't immediate. Some feared that it could be just as addictive as heroin or painkillers, and the first doctors who prescribed it were dismissed by their peers as "white-collar dealers." Those attitudes dissipated as addicts and doctors saw that using buprenorphine did not simply mean replacing one

drug with another – it worked. "Buprenorphine became the first-line treatment," Auriacombe said, adding that the medication has helped to change public and law enforcement perceptions about addicts.

An article in the May issue of the New England Journal of Medicine called for wider U.S. use of medication-assisted therapies for addicts, commonly referred to as MATs. It was written by Dr. Nora Volkow, director of the U.S. National Institute on Drug Abuse – which helped research Suboxone before it earned FDA approval in 2002 – along with CDC Director Frieden and two others. Baltimore was held up as an example of progress. The authors cited a study showing that the publicly funded Baltimore Buprenorphine Initiative, aimed at increasing access to medical treatments, helped spur a roughly 50 percent reduction in the city's overdose deaths between 1995 and 2009.

Frieden suggested to The Huffington Post that medically assisted treatments are vital. They "have a lot of potential and haven't reached their full potential," he said. "So we want to increase the number of patients who are on medically assisted treatment for opiates."

Many U.S. states, however, remain as loyal to abstinence-only treatment as Kentucky does, and not enough doctors are willing to prescribe the medications. In a University of Washington study released this month, based on 2012 data, researchers found that 30 million Americans lived in counties without a single doctor certified to prescribe Suboxone. The majority of these counties were in rural areas.

As of mid-January, in hard-hit West Virginia, there are just 235 doctors who are certified to dispense buprenorphine, according to the Drug Enforcement Administration. There are 183 in Nevada, 89 in Arkansas and 60 in Iowa. In all of Texas, a state of roughly 27 million people, there are only 1,046 doctors certified to prescribe the medications.

Federal stats presented at a June forum showed that out of 625,000 eligible physicians nationwide, only 25,000 are certified to prescribe buprenorphine. A mere 2.5 percent of all primary care doctors have gone through the certification process.

"I cannot say it enough," said then-Sen. Carl Levin (D-Mich.) at the meeting. "Unless primary care physicians can identify the disease of addiction and know how to intervene, we will make slower progress than we should," Levin said. "And as long as

we have too few doctors certified to prescribe bupe, we will be missing a major weapon in the fight against the ravages of addiction."

Primary care physicians who are willing to care for opioid addicts are limited by federal regulations in how many they can treat. Certified doctors can prescribe Suboxone or buprenorphine for only 30 patients at a time during their first year and 100 at a time for each year afterward. Treating a few patients over the cap can mean a visit from the Drug Enforcement Administration.

Dr. Preston Gazaway had been prescribing Suboxone for a decade in Maryland's Baltimore and Howard counties. After the other doctor in his practice became gravely ill in 2012, Gazaway took on his partner's Suboxone patients. Worried about what might happen to the addicts if they were suddenly cut off from their medication, he went over his 100-patient limit. A few months later, two plainclothes DEA agents appeared at his office with a letter from the Department of Justice giving them permission to inspect his patient files.

"The first thing you have to do is take your own pulse, take a deep breath," Gazaway said. In his head, he repeated this one thought: I haven't done anything wrong. But he was treating 10 addicts more than the law allowed. The agents questioned him for 45 minutes about his practice, and about patient files they had randomly selected. They warned him that he needed to cut off 10 addicts.

Gazaway said he has yet to comply. He currently has 106 Suboxone patients. "I'm working to get it down," he said. "I just can't kick somebody out because I'm over census and they're doing well."

In Maryland, partly because of Baltimore's initiative, 888 doctors are certified to prescribe buprenorphine. The state has more bupe-certified doctors than many more populous states, such as neighboring Virginia with its 456 certified doctors. Yet Gazaway said that he still has to turn away between two and five addicts a day who call his office to request the medication.

The DEA agents let him off easy. Vermont, a state with a long waiting list for medically based drug treatment, suspended a doctor's license over incomplete paperwork.

As doctors face scrutiny from the DEA, states have imposed even greater regulations severely limiting access to the medications, according to a 2014 report commissioned by the federal agency SAMHSA. Eleven state Medicaid programs put lifetime treatment limits on how long addicts can be prescribed Suboxone, ranging between

one and three years. Multiple state Medicaid programs have placed limits on how much an addict can take per dose. Such restrictions are based on the mistaken premise that addiction can be cured in a set time frame. In the report, the researchers wrote that the state restrictions seemingly go against established medical practice. "Such limits on addiction medications appear to be inconsistent with clinical evidence and best practices," they concluded.

Ronni Katz, a former public health official in Portland, Maine, recalled the devastating impact of the state's two-year lifetime limit on Suboxone. She said Medicaid recipients were cut off at the beginning of 2013 from their prescriptions and many relapsed. "People were suddenly left without their dose," she said. "They had to do something. It drove people back into the street. We definitely saw the effects."

The squeeze of regulation has left the door open for more opportunistic forces, such as cash-only clinics and shady doctors. A vibrant black market has sprung up. As NPR put it in 2012, "the street is the only marketplace keeping up with demand(http://www.npr.org/blogs/money/2012/07/26/155424108/meet-the-drug-dealer-who-helps-addicts-quit)" for Suboxone. It's an old problem. In the 1970s, addicts self-treated with illicit methadone because of the severe restrictions on the medication and limited access to clinics.

While any illegal trade in a medication should be a concern, there is scant evidence that Suboxone is being used as a gateway to drug use in the U.S. Addicts say taking the medication just helps them feel normal again. An addict who has taken it both with and without a prescription described the "high" off the first few doses as akin to drinking a really strong cup of coffee. The medication "helps with the mental state, you know, it helps me feel regular and it's not like I'm taking it to get high," another addict explained to researchers in 2011 studying illicit use.

In a 2009 U.S. study, researchers found that a majority of the addicts they surveyed were buying Suboxone on the black market in an attempt to get sober. Seventy-four percent were using Suboxone to ease withdrawal symptoms while sixty-four percent were using it because they couldn't afford drug treatment. The researchers noted: "Common reasons given for not being currently enrolled in a buprenorphine/naloxone program included cost and unavailability of prescribing physicians." Even when purchased on the black market, regardless of the intentions of the user, the medication works as intended – as harm reduction.

One 22-year-old woman addicted to Percocet told researchers in that 2011 report that the stigma of medical treatment for addiction motivated her to buy buprenorphine on the black market. “I wanted to try to do it myself because at first I didn’t want my family to know that I was on [pain pills],” she said. “So if I could get off of them without making it obvious, like by going to treatment and stuff, then I would.”

The gaping lack of a medical model in the U.S., one without the baggage of residential treatment, has not gone unnoticed by policy makers. “If buprenorphine is being used and being bought on the street to self-treat addiction, that’s a reflection of a need to have better medically assisted treatment programs out there,” said the CDC’s Frieden.

Dr. Herbert Kleber, a professor of psychiatry at Columbia University and director of the New York State Psychiatric Institute’s Division on Substance Abuse, argues that the robust black market is a sign that the benefit of the medication outweighs the risk. “There is no medication without risk. People die every year from aspirin. People have penicillin allergies,” he said.

Kleber has been a pioneer in the use of medically assisted treatments since founding a methadone clinic in the ’60s, and he was among the first to open a Suboxone clinic in the U.S. He suggested that in places like West Virginia and Kentucky, where addicts might be hours from the nearest doctor who can prescribe the medication, loosening the regulations may be necessary – as long as the use of the medication is tied to therapy. “Although many patients may do well with buprenorphine alone, many – probably most – need counseling along with the medication,” Kleber said.

Dr. Brenzel, the medical director of Kentucky’s Department for Behavioral Health, Developmental and Intellectual Disabilities, which oversees drug treatment in the state, said he was unaware of any addicts who had used Suboxone as a gateway drug to other opioids. Current and former addicts in the Louisville suburbs, in Lexington and in Northern Kentucky said they bought Suboxone from friends not to get high but to combat withdrawal when they tried to get sober on their own.

Inmates in the Kenton County jail have been caught smuggling the medication into the facility. Warden Terry Carl took it as a constructive hint: he now wants to start treating inmates with legal Suboxone prescriptions. “I’d be in favor of it,” Carl said. “Shoot, to prevent death? Absolutely.” He has argued for converting part of his jail into a drug treatment center. But he has been stymied by budget cuts and overcrowding. As of early August, he had 710 inmates in a facility meant to hold 602. He said one-quarter of them are relapse cases from drug court.

Judges just don't know enough about Suboxone, according to Carl. "Something like that they're always leery about starting, first of all. And I'll be honest with you, it's an election year," he said this past summer. "They don't want to do anything that is going to upset the public."

In November 2013, The New York Times published "Addiction Treatment With A Dark Side," a piece that linked hundreds of deaths in the U.S. to buprenorphine and Suboxone.

The most resonant claim of the piece, quoted widely on the Internet, was the assertion that "the addiction drug was a 'primary suspect' in 420 deaths in the United States reported to the Food and Drug Administration since it reached the market in 2003." But a caveat that appeared more than 120 paragraphs later received much less attention: "The F.D.A. cautions against assuming that a 'primary suspect' drug was indeed a cause of death."

FDA spokeswoman Morgan Liscinsky told HuffPost that the person making the "primary suspect" designation need not necessarily have read any autopsy or lab reports before identifying Suboxone as the culprit. Nor must the person making the claim have any special credentials. "For the outcome of 'death,' there is no certainty that a suspected product caused the death," explained Liscinsky. "The event or death may have been related to the underlying disease being treated, may have been caused by some other product being used at the same time, or may have occurred for other reasons."

The Times story also cited a buprenorphine study by researchers in Sweden that looked at "100 autopsies where buprenorphine had been detected." According to the Times, the study found that "in two-thirds, it was the direct cause of death, mostly in combination with other drugs." It was a misreading of the study. Its author, Tor Seldén of Sweden's National Board of Forensic Medicine, told The Huffington Post in an email that the Times' claim "is not supported by our findings."

Matt Purdy, the deputy executive editor in charge of enterprise and investigative reporting, defended the story in an email: "Our article was a nuanced portrait of an addiction treatment," he said.

Dr. Robert Newman, a longtime advocate for the use of methadone to treat heroin addiction, was quoted in the Times article as saying that buprenorphine "is associated with a large number of deaths." Reached by HuffPost, he said the Times story was

harmful to those in the recovery community. “I am not an expert in buprenorphine,” he said.

“The New York Times story made it less likely than ever that legitimate, knowledgeable, passionate physicians get involved with treating addiction with buprenorphine or anything. And that is a tragedy of the story,” Newman said.

Overdosing on bupe is “almost impossible,” according to Dr. Seppala of Hazelden.

“It’s really rare for that to happen,” he said. “Someone would have to have a lung disease. It’s almost unreported because it’s so rare.”

Researchers have found that the far more common overdose risk with Suboxone occurs when an addict shoots up the drug intravenously in combination with a respiratory depressant, such as a benzodiazepine like Xanax.

The Times article did not question the efficacy of Suboxone when used properly.

Frieden, the CDC director, said he has been stunned at the level of opposition to the medication from some in the treatment community. “I was at an event about prescription overdoses and I mentioned buprenorphine and I got booed,” he said. “I hope they would kind of understand that other people are going to want to use buprenorphine. … One size doesn’t fit all.”

Seppala faced similar treatment. “We had some people tell us such things as we’ve ruined AA,” he said. Some 12-step-based halfway houses have even refused to take in Hazelden graduates.

“I talked to the people at the [Narcotics Anonymous] national office. And NA privately recognizes that it is extremely important that there’s treatments for opioid dependence besides just abstinence,” Seppala said. “They recognize that. However, their public stance is as it always has been if you’re on a maintenance medication – methadone or bupe – you can’t hold an office in a meeting or service position nor can you speak at the meetings.”

Jane Nickels, public relations manager for the national Narcotics Anonymous office, didn’t dispute Seppala’s account of the conversation. But she clarified that because meetings are run autonomously at the local level, there is no uniform policy on how to receive those who are taking Suboxone. “Some meetings, and I don’t know which ones, may allow members on medications to speak and some do not,” she said. “Others may allow them to set up the coffee [or] welcome people to meetings.”

Nickels did stipulate that NA is a "program of abstinence" and explained that a member who takes a medication like Suboxone or methadone violates that philosophy. "They are taking a drug to treat their addiction," she said. "They are not clean in our eyes."

Alcoholics Anonymous takes no position on its members using medications that help them stay sober, according to an AA spokesperson who requested anonymity. The spokesperson said the group welcomes any serious efforts to treat alcoholics – and that includes the efforts of the medical profession.

The spokesperson cited an Alcoholics Anonymous pamphlet that reads, "No A.A. member should 'play doctor'; all medical advice and treatment should come from a qualified physician."

As part of Hazelden's program revamp, Seppala said, the organization has added "stigma management" training to teach those on buprenorphine how to talk about their medication at NA meetings and where to find supportive ones. "In our country, we don't have good integrated understanding of addiction, let alone good integrated treatment," he said. "If you walk into a 12-step, it's going to be immediate bias."

Addicts in Northern Kentucky report facing the stigma in meetings when they begin taking the medication. Phil Lucas, a 32-year-old Suboxone patient, said he tried local NA meetings but no longer attends. "They acted like I was still a heroin addict basically," he said, adding that people at the meetings kept asking him when he was going to get sober.

Diana Sholler, 43, another Suboxone patient in Northern Kentucky, attends local AA meetings. She said she is permitted to speak at meetings but that other members are openly critical of her decision to take the medication. "AA really looks down on it," she said. "They don't call it clean time when you are on Suboxone." She said members don't allow her to share how long she's been sober. To them, her sobriety doesn't count.

Heaping shame on those who use Suboxone or methadone doesn't just happen in 12-step meetings. Addicts hear the abstinence message from all corners, and many just stop taking medication because of it. According to Dr. Kreek, roughly 25 percent of methadone patients drop out over the course of the first year, and that's with good counseling and proper dosing. Other studies show that the rate of methadone dropouts can be higher.

Dr. Michael Fingerhood, an associate professor of medicine at Johns Hopkins University in Baltimore, is the medical director of a primary care practice that treats 450 patients with buprenorphine. In 2009, the practice found that some 40 percent of its patients dropped their Suboxone regimen after a year. Some transferred to methadone; others left the program after losing their health insurance. Fingerhood said another major reason was the pressure from friends and relatives who considered Suboxone a "cop-out." They wanted to be sober, but were told by family they had do it without medication.

"At least half have felt the pressure of people saying you shouldn't use the medication to help you get clean," Fingerhood said.

Quenton Erpenbeck used heroin for 16 months. For 13 of them he was trying to get off it, his mother, Ann, recalled. He did a 30-day, 12-step-based residential program and followed up with attending 90 AA or NA meetings in 90 days before relapsing. Toward the end of his life, he started taking Suboxone. Although he was doing well on the medication, he felt tremendous guilt because his parents were paying hundreds of dollars out of pocket for the prescription and clinic visits. Ann wasn't worried about the money, but the issue weighed heavily on Quenton. "I think he just felt like a loser taking it," Ann said. He decided to try abstinence-based treatment.

At his graduation from a program in Michigan that lasted 45 days called A Forever Recovery, Quenton told her he was worried about leaving. "I don't know, Mom. I'm safe here," Ann recalled him saying. "I said, 'Quenton, you don't have to go home.' He said, 'No, Mom, it's time to start my life.'" Two days after he left the program, in April 2013, Ann found her son dead from an overdose in his Cincinnati bedroom.

Chapter 7

For doctors in Northern Kentucky, treating heroin addicts makes for a lonely career path. Dr. Mina Kalfas was certified to prescribe Suboxone soon after it came on the market. When he began having good results with addicts in his private practice, he brought up the idea of using Suboxone at the 12-step rehabilitation facility where he worked as medical director.

His colleagues balked and his superiors declined. Kalfas said he was told he could make his case again during the monthly pharmacists' meeting. "They called me an hour before the meeting," he said, "when I was seeing patients 40 miles away." The administrators, he concluded, had no intention of considering his proposal.

Kalfas thought he might have been more successful if he had found more allies. "There wasn't a push anywhere," he said. "No pressure from the community. No public outcry. One dying here or there of an overdose — it wasn't considered a big public health issue. Insurance wasn't demanding anything different like an evidence-based approach."

He eventually left his post at the rehabilitation facility in 2011. "I was stuck in an abstinence model that didn't work," Kalfas said. Administrators of the facility "really need to be confronted with their success rates. In AA, the definition of insanity is doing the same thing over and over again and expecting a different result. They should think about that." Over more than a decade prescribing Suboxone in his private practice, Kalfas said, none of his patients have fatally overdosed on heroin, with fewer than 20 percent dropping their prescription and going back to their drug habit.

But Kalfas can serve only so many. Taylor Walters went through a detox, then a three-month outpatient program, and in late December 2012, a 45-day inpatient program. His mother, Sheryl, was desperate for a doctor who would prescribe him Suboxone. She spent three days working the phones, pleading with doctors. "I was crying and begging," she said. She managed to find Kalfas, but he couldn't help because under the federal regulations he had reached his legal ceiling for Suboxone patients.

"I cannot in words, write how deeply sorry I am to everyone, for everything," Taylor wrote in a note left for his father shortly before entering the 45-day rehabilitation center. He relapsed the day after he completed the program and died of an overdose two weeks later, in February 2013. He was 20 years old.

Kalfas estimates there are only a handful of doctors in Northern Kentucky willing to prescribe Suboxone. One of them is Dr. David Suetholz, who also happens to be the Kenton County coroner. In the past few years, he and his coroner's office staff have investigated dozens of heroin overdose fatalities.

"The first thing you have to look at is relapse rate," Suetholz said. "What is the relapse rate of individuals who have gone through inpatient [abstinence-based] treatment? I would say it's very high. From a coroner's perspective, I look at relapses in the form of a death certificate."

In his private family practice, Suetholz has treated opioid addicts with Suboxone for years. With a base of 100 patients, he said he has a Suboxone dropout rate of only about eight percent over the course of six months and he has never had a patient on the medication die of an overdose. Like Kalfas, he has pushed area doctors and state officials to embrace this medical model. Because his pleas have gone ignored, he has a waiting list of about 100 addicts hoping to get on the medication.

One of his patients, a woman in her mid-50s, had a son who was being treated at Grateful Life, a program that she didn't quite trust. It was a temporary solution. Her plan was to taper off her own Suboxone usage so that her son could take her spot as Suetholz's patient.

"We just see how things go from month to month," Suetholz explained this past fall. "We discuss her issues, and we discuss her son at the same time."

Five weeks ago, the woman's son went AWOL from Grateful Life and overdosed. He had to be revived by paramedics. Now he faces charges stemming from the incident.

St. Elizabeth Healthcare, Kalfas's former employer, announced in mid January that it intended to implement Hazelden's medically assisted treatment curriculum in its rehabilitation facilities across Northern Kentucky. This followed a previous promise to open a Suboxone clinic. But that project has yet to get off the ground.

Dr. Jeremy Engel, a family practitioner with St. Elizabeth who has become an outspoken advocate for a medical response to the heroin epidemic, said there is a good reason for the slow pace. His months-long effort to recruit doctors for the proposed clinic has been met with reluctance from his fellow physicians.

"There's no incentive for primary care doctors," he said. "[Addicts] are difficult to deal with. They're manipulative. It's a high-risk population." It was only last fall that Engel began treating addicts with Suboxone.

"They know that this is an issue that needs to be addressed but I don't think any of 'em are interested in being heroes," Engel said of his fellow doctors. He estimates that it may take a year for the new curriculum to be in place. "It's going to tip. It's just a matter of how many people will die before that."

As the epidemic hit, addicts ended up in emergency rooms, places of last resort, where they faced the disdain of medical personnel.

Three years ago, Holly Specht took her son Nicholas, an addict threatening suicide, to an ER. Nicholas protested that the effort would be a waste of time, and he was right: A doctor discharged him after a mere 15-minute consultation. “Nicholas was angry,” Specht said. “I remember him laying in that silly little bed, and I’m sitting in this cold, armless chair hoping and hoping someone could help us.”

On their way out, Specht pleaded with a nurse, who finally dashed off a handwritten list of six or seven treatment facilities. Nearly every place on the list either was shut down, cost too much or didn’t provide detox. Nicholas ended up going to The Healing Place to detox and later went through another detox before completing a 12-step treatment program. He fatally overdosed in August 2013. He was 30.

Coroner records show that Travis Yenchochic, 29, overdosed five times in the 18 months before his fatal OD in 2013. Doctors never mentioned Suboxone as an option during any of his trips to the ER, said his father, John. Many times, he said, the doctors appeared indifferent to his son’s condition. “They just treat them and get them out of there,” he said. “That was hard for me…it tore me up. You just can’t explain how you see your son lying there and almost dying. There’s a couple times that I was really upset. I was mad at my son, really upset. Then there was some times where I just felt so sorry for him. I don’t know what to do. I just feel like I’m lost. I don’t know anything about this stuff.”

Even for doctors trained in addiction medicine – motivated to treat opioid addicts with buprenorphine and able to work within Medicaid’s numerical limits – there are still roadblocks. Kentucky’s Medicaid program, like those of many other states, requires prior authorization before it agrees to pay for the medication. One managed care organization mandates such authorization every month. And negotiations, Kalfas said, can take an illogical turn: Medicaid has tried to deny payment for Suboxone if a patient has failed a drug test while it has also used clean tests to deny payment. Why pay for Suboxone for a drug-free patient?

The state requires its Medicaid patients to go to counseling while they are taking Suboxone. But Dr. Molly Rutherford, an addiction specialist based in La Grange and the president of the Kentucky chapter of the American Society of Addiction Medicine,

said that when she sought help for addicts, she found that many counselors refused to treat her patients who were on Suboxone. “It was a flip of the coin whether the counselor agreed with medically assisted treatment,” she said.

Officials who oversee Medicaid in Kentucky concede that the state doesn’t have enough counselors to serve these patients, despite the opioid epidemic. Before Kentucky’s adoption of the Affordable Care Act, counseling for drug addicts was not covered by Medicaid. “It takes time to respond and build up,” explained Dr. John Langefeld, the medical director for the state’s Medicaid services.

Addicts going outside Medicaid face potentially prohibitive costs. At Droege House, a publicly subsidized detox center in Northern Kentucky operated by Transitions, Inc., addicts must pay $410 up front if they want Suboxone and additional fees depending on whether they enroll in an outpatient or a residential program. It can end up costing them thousands of dollars. Laura Duke, who was recently the detox unit’s supervisor, said the cost put the medication out of reach for all but 1 to 2 percent of the addicts she saw.

Detoxing is a first step towards sobriety. To overcome the inevitable pain of withdrawal from opiates without medication—going “cold turkey”—is excruciating. The ordeal may take a week or longer, and there is little relief from sleep deprivation, depression, and loss of bodily functions. For detoxing addicts without access to Suboxone, Droege House offers the Big Book and multiple NA or AA meetings per day in its small lounge.

From February 2013 to February 2014, Duke said, two addicts not taking Suboxone quit the detox program against staff advice because they couldn’t handle their withdrawal symptoms and fatally overdosed within days. Another addict without the medication died shortly after completing the detox. The list to get into Droege House is long, and an additional five to six addicts died while waiting for an open slot, Duke said.

Duke had come to work at Droege as a way to honor her brother Josh, 28, who fatally overdosed on heroin on January 13, 2011 – six days after completing a 45-day rehab in Cincinnati.

The Ohio facility offered medically assisted treatment, but Josh had refused. He had bought into the ideology. “He told me at that point, ‘Why would I substitute one drug for another drug?’” Duke recalled. “I just agreed with him. It made sense at the time.”

Chapter 8

Jim Cagey and Anne Roberts with a photo of their son Patrick at their Lexington, Kentucky home.
Jason Cherkis / The Huffington Post

Roughly five months after Patrick Cagey's death, his parents wrote the facility where he had been treated to request their son's medical records. Jim Cagey hand-delivered the letter to Recovery Works – he didn't want to risk it getting lost in the mail. When the facility didn't respond, Jim and Anne followed up with multiple phone calls. When Recovery Works administrators still failed to respond, there was only one thing left for them to do.

On an overcast day in early April, Patrick's parents drove to the treatment center to confront administrators in person. They first stopped for lunch at Ramsey's, a family favorite and the place they met Patrick for dinner every Sunday when he was in college. They still had dinner there on Sundays, now usually with Patrick's former girlfriend and his best friend. After lunch they threaded their car in the rain through Lexington's downtown and past the University of Kentucky, where their son had gone to school.

Jim and Anne headed onto Route 25 toward Recovery Works. Jim kept the car just a hair above the speed limit. There wasn't a lot of talking between them. They weren't compelled to return to the rehab facility by anger but by grief. They had trusted Recovery Works to look after their only child at the most vulnerable point in his life. Now, maybe, if they had their son's records, they could make better sense of his death. What did Patrick confide to his counselor at Recovery Works? What did the staff think about Patrick's chances of relapsing? What could Jim and Anne have done differently? At the very least, they would learn more about their son's last month alive. That would be something.

Three days earlier, the University of Kentucky men's basketball team had advanced to the Final Four. Before her son died, Anne had never watched the games. Now she did. "I put Patrick's UK basketball shirt on that smells like him, and I watch a few minutes of the basketball game," she said. When the team won, she got tearful because Patrick wasn't there to see it. After the game, she took the shirt off, folded it and put it back under her pillow.

They reached the exit and turned off the highway onto a country road. "Oh, here we are, right here," Jim said, easing onto the corkscrew drive that led up a hill onto the Recovery Works property. "Comes up on you pretty fast." To the left was a series of small brick cottages where the residents lived. The road ended at the main building, which housed the detox wing, communal rooms and administrative offices. Behind the building, a few addicts stood on a patio hunched in the cold, smoking cigarettes. Woods and the sounds of the highway enveloped the campus.

"Looks like there's more cars here than there'd usually be," Jim said.

This parking lot was where Jim had taken the last picture of his son. "Reminds me of Patrick," Anne said as she got out of the car. "Coming to visit him and having such hope." Jim and Anne would go see their son every weekend, squeezed together in a loud, communal space with other families. It could be so hard to talk to Patrick over the noise.

Jim and Anne gave their names to the receptionist and told her that they had brought a letter requesting Patrick's records. "He was here as a patient," Anne said. "His name was Patrick Cagey. And we wanted to talk to someone that could maybe let us read them." The receptionist mispronounced Patrick's last name as "Cagney."

They were told that the executive director, Ricky Holcomb, was at lunch, and they were shown to a small waiting area. A garbage bag of clothes slumped against a wall in a nearby office; an addict was either getting discharged or signing in. The residents circulating through looked tired – too pale and too young. Within a few minutes, Holcomb, a large man with a shaved head, beckoned them to his office.

Early in the meeting, which Jim recorded, Anne told the story of her son's death, how he had died four days after coming home from Recovery Works. "I guess I'm trying to find out some answers," she said. "It's, it's just so painful. I, I, I just, I don't understand it. … I just, I'm at a loss…I'm just at such a–"

"Did you all do any family sessions with him or anything like that?" Holcomb interrupted.

"We never met with the social worker," Anne said. "She did not have time and …"

"We tried a couple times to, you know," Jim said.

"To set a time," Anne said.

"To talk to her," Jim said.

"She only said, 'You know, Patrick's doing fine,'" Anne recalled.

Holcomb said he wished he knew more, but he wasn't yet employed at Recovery Works when Patrick attended. And Holcomb didn't have Patrick's medical records nor did he offer an explanation of where they were. Instead, he offered a traditional 12-step response. He had his own recovery story to tell.

"You know, it's tough to lose somebody to the same thing you were doing too," Holcomb said. Neither one of Patrick's parents has ever been addicted to drugs.

"You know, I'm in recovery," Holcomb said. The nameplate on his desk included his sobriety date: October 10, 1987. "I've been hospitalized several times back when I was using. I actually got sober in '87 when I was 30. I feel very fortunate."

"I think about it today," he continued. "I'm 57 now, and most of the people I ran with and used with are not with us." Jim and Anne kept quiet through Holcomb's testimonial.

Holcomb said he was brought in to take over Recovery Works, in late 2013, for a reason. "They were doing something different here and wanting to make changes and improve services," he said. "That's kind of – I'm here trying to turn this into a good

program."

Later in the meeting, Holcomb warned Jim and Anne not to talk to reporters "out of respect" for Recovery Works. The company, he said, was "just trying to protect their own interests."

The meeting ended with paperwork. Another administrator had gathered together a set of medical records request forms requiring that Patrick's parents provide proof of his death. In the adjacent room, their son was memorialized on the Recovery Works death wall.

A death certificate would do, Holcomb said.

Jim and Anne didn't receive Patrick's records that day. Holcomb assured them that once the paperwork was reviewed, releasing the records would be a mere formality. He even offered to have a staff member go over the records with them once they were on hand. But it took Jim and Anne another three months of calling and emailing. At one point, Recovery Works told them they needed to fill out another form. When Jim hand delivered the additional paperwork, he discovered that the facility had lost their original, notarized request. They would have to fill out a new request and again get it notarized – which they did. Eventually, Holcomb stopped returning their calls, and they had to turn to Recovery Works' corporate office for assistance.

Holcomb, who has since left Recovery Works for a job at another Kentucky treatment center, recalled that after his meeting with Jim and Anne, his supervisors took down the facility's death wall that had included Patrick. "They didn't think it was a good idea," he told The Huffington Post.

Holcomb blamed red tape for any delay in getting Jim and Anne their son's records. "I tried to speed it up as much as I could, because I felt bad for the family," he said. "I've been through that a lot in this field." At some point, he said, he got a chance to read over Patrick's records. He recognized a sadly familiar pattern of care. "That's almost the standard in treatment," he said.

When Patrick's parents finally got the records, they realized they couldn't bear to read them. Anne made it only halfway through the first page of her son's intake form before she had to put the papers down. She placed the records in a box on a shelf of the living room TV stand, along with Patrick's autopsy report and condolences from his memorial service.

The records show that Patrick entered Recovery Works on heroin, having shot up on the morning of his arrival. At intake, he admitted to decade-long issues with "frequent anxiety" and episodes of depression, for which he was prescribed medication. The rest of the file reads more like a child's report card than the treatment history of a man with a complicated disease. Staff assessed Patrick's performance during his group meetings on the Big Book, checking off boxes for "listens attentively" and "good" participation level. On a daily basis, staff registered which of the 12 steps he was working on. In the few individual therapy sessions he received, staff used the time to go over rule violations, such as his misuse of his cell phone.

SHARE YOUR STORY

To share a story about your or a loved one's experience with drug treatment, write to treatmentstories@huffingtonpost.com(mailto:treatmentstories@huffingtonpost.com) or leave a voice mail at 860-348-3376. Please include your phone number.

Patrick's Recovery Works treatment included something called "cinema therapy." At one session, he and his fellow addicts watched "The Blind Side." At another, it was "Braveheart." He learned about sobriety through role-playing games on "how to say no when approached" about using drugs and how to "have fun in recovery without the use of alcohol or other drugs." In another class, he filled out a worksheet asking him to identify his favorite color and other favorite things that might help him relate to other addicts.

Despite the story the records tell of Patrick's generally happy disposition and his willingness to role-play his way to sobriety, he still hadn't shed the self-doubt he had carried with him into treatment. Nor had he shaken the vicious cravings of his addiction. The day before his discharge Patrick again told staff what he had been telling them off and on for weeks. He thought he would relapse.

Additional reporting by **Ryan Grim** and **Shane Shifflett**.

Produced by **Shane Shifflett**, **Hilary Fung** and **Jan Diehm**.

Audio editing and production by **Ibrahim Balkhy** and **Brad Shannon**.

Cincinnati video production(http://www.leapframe.com/) provided by **LEAPframe / Cincinnati**.

Post-production courtesy of **Center City Film & Video(http://www.ccfv.com/) / Philadelphia**.

For a documentary about Suboxone, audio from Cagey's parents, and more, read this story on HuffingtonPost.com: http://huff.to/1CzLlz5