Opioids and Appalachia

Sally Satel

Richard fisher of ironton, ohio, is realistic about his town. "Drugs are the economy here," he says. "You either sell them, buy them, or treat people for abusing them."

The 66-year-old retired chemical-plant operator was talking to me from behind the counter at Iron Town Coffee Lab on South 2nd Street, the café and performance space he opened in January 2019. Richard was among a handful of Irontonians who poured their love and money into revitalizing the downtown area; others included two best friends who opened a boutique selling crafts and essential oils, a hardware-store owner who had expanded his business, and a troop of volunteers who were restoring the Ro-Na Theater — a once-glorious movie house on 3rd Street.

Yet on the margins of town, ragged folks pushed their possessions from place to place in Kroger's shopping carts — "borrowed" from nearby Ashland, since Ironton had no major supermarket chains — or pedaled around on one-speed bikes, their clothes crammed into cardboard boxes tied to the handlebars. "They're on drugs, poor guys," Richard said when I told him about my sightings. "So down and out they don't even have a car to live out of."

These highly visible lives of despair could one day end in deaths of despair, a phenomenon famously described by Princeton economists Anne Case and Angus Deaton in 2015. The lethal triad includes suicide, liver disease (due to heavy drinking), and drug overdoses — the last claiming the lion's share of preventable fatalities. Deaths from such causes have averaged 70,000 per year between 2005 and 2019, with the harshest impact on people living in the Ohio Valley and New England.

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Those most affected include white men and women between the ages of 25 and 54 without college degrees or access to gainful employment.

Case and Deaton's analysis strongly implicated opioids as the primary cause of these premature deaths, citing the abundant supply of OxyContin and the demand for its palliative effect by a despairing populace. They date the start of the problem to the late 1990s, which was when OxyContin became available in the United States.

Their timeline is reasonable. But after conversations with a dozen Appalachian physicians in their 60s and 70s, I propose a more comprehensive story that begins many decades before OxyContin was introduced. This story draws on the social, economic, and clinical traditions of a region that has long made its physicians uninhibited in their use of opioids — and its residents particularly susceptible to the false deliverance that drugs can promise.

PAIN RELIEF IN THE ERA OF BIG COAL

The story begins during the first half of the 20th century, in the coal camps of eastern Kentucky and West Virginia. Since the late 1800s, most Appalachian coal miners and their families had lived in small communities owned by their employers. From the houses they rented and the schools where they sent their children to the churches in which they prayed and the graveyards where they would be buried, almost every facet of their lives was overseen or owned by the coal companies.

Rising before the sun and returning home in the winter's dark, the coal workers of Appalachia drilled as far as three miles into the mountains. The bituminous coal they wrested from the earth powered steam engines, smelted iron and steel, and brought incandescent light into millions of American homes. Their toil industrialized a nation.

In the miners' gloomy lamp-lit realm, stoicism was prized and camaraderie was tight. Six days a week, they laid tracks for coal cars, set timber props between floor and roof, and loaded coal onto railroad cars. Although many of them loved the work — a legacy passed down from father to son — it ravaged their knees, shoulders, and spines. Men of slighter build worked the "low coal" seams — narrow beds with only four or five feet of headroom where miners maneuvered like contortionists, bent over double for hours on end. Some had to wield a pick while lying on their sides. "I learned to crawl fast like a mole," said one man who worked an eastern Kentucky seam that measured just two feet

high. When George Orwell spent several weeks as a worker in a coal mine in the 1930s, he marveled at the men "shifting monstrous quantities of coal" on their knees. The "almost superhuman job . . . would kill me in a few weeks," he admitted.

Indeed, danger was everywhere. Mine collapses crushed workers, odorless methane and carbon-monoxide gas asphyxiated them, rock-wall blasting blinded them, gruesome machine accidents maimed them, and explosions of flammable gas incinerated them. "The demons of death often come by surprise," sang Merle Travis, a son of Kentucky, in his 1946 song "Dark as a Dungeon": "The fall of the slate and you're buried alive."

"[C]asualties are taken for granted almost as they would be in any minor war," Orwell reported. By the time miners retired, says sociologist Kai Erikson, many were living out their remaining years "with amputated limbs, sightless eyes, and torsos that [had] gone limp as the result of spinal injuries."

Men were fearful on the job. "[N]inety percent of the coal miners are scared to death all the time they are in there," a 50-year mining veteran told Erikson. "You get hurt, you dread going back in there, but you try to forget it — or at least I did." In 1952, two psychiatrists introduced the term "miner's syndrome" in the *American Journal of Psychiatry* based on interviews with 100 coal miners in eastern Kentucky who had sought help for their "nerves." The pair described the men as variously "agitated," "restless," "shaking," "trembling," "fidgeting," and "pacing." It was, as Erikson put it, "battle fatigue in every meaning of the term."

To help assuage both the pain and the fear, miners turned to the camp doctor, who prescribed gentle sedation and mild euphoria with morphine pills and tinctures of powdered opium dissolved in alcohol. As hydrocodone and oxycodone became available in the 1920s and late 1930s, respectively, he added these remedies to his repertoire.

Coal-camp doctors prescribed opioids out of a mix of motives. Their clinical imperative, of course, was to control their patients' pain, which was mostly physical, though sometimes psychic. But the doctors were also practical: Just as sports-team doctors today dispense steroids and painkillers to injured players to get them back on the field, coal-camp doctors — who were employed by the camp to maintain the labor force — dispensed drugs to get miners back into the mines. They knew that pain relief was not only a form of social insurance that allowed

their patients to keep earning a living, but a way to keep themselves in their employers' good graces.

Even if miners never saw the sun except on Sundays, they wanted to work, as the stakes were particularly high. "[J]obs, status, and earnings depended upon the miner's skill and capacity for hard physical labor," historian Crandall Shifflett wrote in *Coal Towns: Life, Work, and Culture in Company Towns of Southern Appalachia, 1880-1960*. Before unionization began to take hold in the 1950s, mine operators could expel a disabled worker at a moment's notice. If one of the miner's sons could not replace him, the company could evict the former worker from his home and pass it on to a new recruit.

Nor were women in the camps spared. Every day, mothers, sisters, daughters, and wives braced for the sound of sirens or the preacher's knock at the door. In cases of tragedy, it fell to the women, Shifflett wrote, to "provide whatever supplementary labor and support they could to insure against catastrophic loss." If a miner died, his family was pushed into the "rat rows" of neighboring towns, subsisting on meager checks from company insurance and whatever crops could be coaxed out of the depleted soil.

Even without sudden tragedy, women in the camps worked endless chores: cleaning, sewing, canning, fetching water, feeding and slaughtering animals, tending gardens, laying fences, caring for up to a dozen children, and sweeping—forever sweeping the coal dust that coated dishes, bed sheets, and furniture. One woman raised in Wise County, Virginia, recalled her mother's nightly ritual of "wiping out our nostrils, producing perfect black rings on her white washrags." An ornery husband who drank up his modest wages and abused his wife when inebriated only added to these burdens.

For the women, "pain pills" and "nerve pills" were enlisted to manage dis-ease in the broadest sense. Communities accepted the use of prescription drugs "to help wives cope with their depression and their 'depressing' surroundings," researchers at the University of Kentucky reported. These prescriptions included not only opioids, but also tranquilizers like barbiturates. As one historian wrote, doctors "simply dispensed handfuls of sedatives [that] calmed the jittery females and subdued them to a more tolerant acceptance of their lot."

Physicians at the time in less isolated settings may have rarely used opioids for chronic pain (reserving them instead for cancer and terminal

pain), but generations of Appalachian physicians did not restrict themselves: They employed opioids to medicate manual laborers' aching backs and limbs, calm the nerves of anxious women, and grease the gears of the local workforce and the nation's economy.

big government replaces big coal

Ironton social worker John Hurley, with whom I ran group therapy in the town during the year I spent there in 2018 and 2019, moved from Pittsburgh to southeastern Ohio in 1982 after accepting a job in a mental-health center in Portsmouth. Once there, he sought to educate himself about the culture of the population he would be serving. A professor recommended he read *Night Comes to the Cumberlands*, a landmark book by former Kentucky lawmaker and lawyer Harry Caudill. "I was moved by it more than any other book I have ever read," Hurley told me. Having been familiar with the region mostly through unflattering television portrayals of "hillbillies," he says the book changed his perspective.

The story of the region, he came to learn, was a story of plunder — first of mineral rights and timber, then coal — as well as dependence. "I began to think of Appalachians, culturally, as proud, independent people who had pushed on beyond the Allegheny Mountains," he recalls. But the coal companies kept their laborers from gaining appreciable ownership of anything, and over time, Appalachians became "dependent on Big Coal for housing, medical care, and supplies."

The region's coal industry produced 630 million tons of coal at its peak in 1947. Thereafter, rapid mechanization of mining produced large waves of layoffs. Doctors, who had once used pills primarily to soothe the pain of punishing manual labor, began prescribing them to relieve the emotional ordeal of losing work. "Bit by bit," recalled Caudill, "[the miners'] self-reliance and initiative deteriorated into self-pity."

Federal welfare benefits also came to Appalachia in the 1930s as part of the New Deal. Lawmakers hoped the policy would ease the misery of the Depression and, after that, the major downturn in jobs when the mining industry began to automate after World War II. Payments from states and union funds became available as well. By that time, large swaths of the population "had not heard a work whistle in 10 years," Caudill wrote. "Dejected and submissive from long unemployment, hopeless of ever again finding jobs, the Welfare grants became their only hope."

Of course, the men could receive the benefits only if they demonstrated disability. As Caudill observed, "[i]f they could find enough symptoms of illness, they might convince the physicians they were 'sick enough to draw.'" So-called "Welfare doctors" bent to demands from patients to classify them as physically unfit for work so they could collect sorely needed financial support. As most of the men were illiterate (the 1960 census showed that 19% of the residents of the Cumberland Plateau could neither read nor write), they could not perform other kinds of work.

By 1963, unemployment in the Appalachian region was 12.5%—over twice the national average. The state and federal welfare programs that filled the employment vacuum had predictable side effects. "[I]nstead of abolishing poverty," welfare "encouraged a mentality geared to permanent dependence on society," wrote Rena Gazaway in her 1969 book, *The Longest Mile*. A nurse with a doctorate in anthropology, Gazaway spent two years living with and working alongside bone-poor families in a Kentucky hollow during the 1960s. "[F]amilies who have had welfare as a pattern of life, particularly those who have been on various programs for a long period, literally work at getting aid and keeping it."

The publication of Caudill's *Night Comes to the Cumberlands* in 1963 focused the nation's attention on the plight of Appalachia, stirring President John Kennedy to establish the Appalachian Regional Commission to push for legislation to aid the region. In 1965, President Lyndon Johnson signed the Appalachian Regional Development Act, which made the commission a federal agency and sought to unleash a new wave of jobs in the area. "The dole is dead," Johnson declared upon the act's passage.

But it wasn't. Bill Peterson, a reporter for the *Louisville-Courier Journal*, chronicled the years of broken promises made by the politicians and poverty workers of the Great Society programs targeted at eastern Kentucky, where schools were still dismal, utilities remained spotty, and corruption of local officials was rife. When Peterson asked shopkeepers where he could interview the "proud, fiercely independent" mountain people he'd heard about, they told him, "[t]he welfare done got them all."

By the end of the 1960s, local physicians had taken the place of coal-camp doctors. Among their patients were men still working in the mines. "A lot of them wanted opioids because they wanted to keep

carrying 100 pounds of equipment in each hand to make good wages with an eighth-grade education," John Linton, dean of the School of Medicine at West Virginia University's Charleston Campus, told me. For these men, pain-management programs were not a realistic option: They were scarce and expensive, and required time off for lengthy testing and evaluation. Treatment with opioids was cheaper for most companies' insurers — that is, when companies offered insurance.

Caudill recalled the doctors' impotence in an interview. "[N]ot having anything else to do for" these men, the doctors prescribed "tranquilizers, mostly Valium, and [patients took them] by the — just in huge quantities all the time." Thus, long before OxyContin ever made landfall, "plenty of [miners] were already steeped in a culture of opioid painkillers" wrote journalist Chris McGreal. "Vulnerable populations have always been susceptible to easy fixes," says Hurley. "Alcoholism was one such fix. Opioids became another."

OxyContin Arrives in Appalachia

When Purdue Pharma began marketing OxyContin to physicians in 1996, Appalachia was among the first regions that the company's drug representatives visited — in part because its physicians tended to be frequent, high-volume prescribers of opioids. On any given day, Purdue had eight to 10 OxyContin sales representatives working in West Virginia. They "descended like locusts," said one journalist, exceeding the deployment in similarly sized markets.

Purdue intended OxyContin to replace another Purdue product that had been on the market since 1984. MS Contin (short for "morphine sulfate controlled-release"), a slow-release form of morphine that doctors often used to treat pain from cancer and end-of-life illnesses, had lost its patent protection and therefore its profitability. The company also hoped that OxyContin, which is pure oxycodone in high doses, would take the place of immediate-release opioids such as Percocet (which contains oxycodone at lower doses) as a treatment for a broader spectrum of chronic discomfort.

Around the same time Purdue was marketing its new opioid, efforts to treat pain more aggressively were gaining momentum. For much of the preceding century, medical-care providers deployed prescription opioids sparingly, in fear of addicting their patients. Finally, in the 1980s, concerned oncologists and pain specialists — then the dominant

prescribers of pain relievers for chronic use — teamed up with their counterparts at the World Health Organization to initiate a campaign to persuade non-specialists to take pain seriously in patients with terminal illnesses.

Of course, while physicians in larger cities began to feel the pressure from hospital systems and health regulators to prescribe opioids, health officials in Appalachia had to do little to encourage local doctors to intensify their management of pain. "Policies promoting better pain treatment didn't make it too deep into Appalachia," Dr. P. Bradley Hall, a third-generation West Virginian and director of the West Virginia Medical Professionals Health Program, told me. If they had, said John Linton, "I imagine that a lot of doctors would have said, 'Hell, I've been prescribing heavily for my pain patients for years. The rest of the world is just catching up with what we have been doing in rural West Virginia for decades!'"

Federal law — specifically the 1914 Harrison Narcotics Tax Act — was also a key player in Appalachia's unusually high opioid-addiction rates. Congress designed the act to single out racial minorities using heroin in urban areas. According to historian David Herzberg, "the punitive regime established by the Harrison Act allowed for much wider prescribing leeway in classically white, rural areas where drug consumers did not match the stereotype of inner city 'junkies.'" Regional physicians, then, were not only liberal prescribers because their patients needed relief, but because federal agents looked the other way.

So when the Purdue sales force arrived in small towns across Appalachia, many doctors were already predisposed to accept OxyContin. Gifts from drug representatives (meals, trips, and the like) and the coupons they provided (which patients could redeem at a pharmacy) almost surely led to more OxyContin use, but doctors would have been inclined to treat pain with opioids even without such inducements; the sales reps were pushing on open clinic doors. Prescribing OxyContin became medicine as usual. By 2000, doctors in Appalachia were prescribing the drug at five to six times the national rate.

AN EPIDEMIC OF ADDICTION

In the 1980s, oxycodone, hydrocodone (Vicodin), diazepam (Valium), and alprazolam (Xanax) joined marijuana and some moonshine in Appalachia's underground exchange. People commonly chewed or

crushed Tylox pills (containing acetaminophen, or Tylenol, along with oxycodone). The infamous Preece family of Kermit, West Virginia, sold these gray-market opioids out of a trailer parked beside the town hall, hanging up a sign that read: "Out of Drugs. Back in 15 minutes" when its supplies ran low. (FBI agents finally arrested them in 1986.)

This trafficking infrastructure was easily adapted for illicit distribution of OxyContin. And when the new drug arrived on the scene in 1996, the consumer base was ready and waiting.

But OxyContin was a different kind of pill. It could be lethal because it contained very high doses of oxycodone. The contents of the OxyContin pill were meant to be released slowly, but some users pulverized the pill to snort or inject, thereby ingesting the contents quickly and creating significant risk of addiction. Even when taken orally as directed, each pill (despite being promoted as a slow-release medication) discharged a burst of active ingredient within the first hour. This is how OxyContin converted many people who engaged in low levels of substance abuse into full-blown addicts.

"I would describe it as if a pharmaceutical atom bomb went off," Lisa Roberts, a public-health nurse in southern Ohio, told a reporter. "There'd been prescription abuse for decades, probably more than other regions of the country," says Dr. Art Van Zee of Lee County, Virginia, "[but people could] walk away from it without becoming opiate addicted." Dr. Luther Hall, a native of eastern Kentucky whom I met in Ironton, told me, "docs where I grew up were always writing for pain meds. People took boatloads of them, and benzo and moonshine, but it wasn't really considered a problem until OxyContin came along." By 2001, 50% to 90% of newly admitted patients in treatment programs in West Virginia, Pennsylvania, Kentucky, and Virginia were identifying OxyContin — also known as "hillbilly heroin" — as their most abused drug.

Reports of OxyContin abuse spread quickly down rural areas of the east coast, eastern Ohio, and Appalachia — all places with little economic opportunity, large populations of chronic-pain sufferers and disabled people, and some of the highest alcoholism rates in the country. During a December 2001 congressional hearing on OxyContin, Asa Hutchinson, head of the Drug Enforcement Administration, characterized the problem as a "looming battleship on the radar screen."

The Food and Drug Administration was caught off guard by the rampant abuse of the drug. The agency reported that it had based

its judgment on OxyContin in part "on the prior marketing history of a similar product, MS Contin, . . . [which had been] used in the medical community since 1987 without significant reports of abuse and misuse."

But MS Contin proved to be a bad model for predicting the abuse potential of OxyContin for several reasons. First, doctors prescribed MS Contin almost exclusively for cancer and end-of-life pain, while OxyContin was prescribed for broader purposes. Second, morphine — the active ingredient in MS Contin — is about half as potent as oxycodone, and it crosses the blood-brain barrier less efficiently, resulting in a slower onset of effect and less of a buzz. Third, twice-a-day MS Contin behaves more like a true slow-release formulation than OxyContin, steadily leaching its contents out of the body's gastrointestinal tract. Fourth, unlike OxyContin, MS Contin does not produce an early (i.e., addiction-enhancing) spike in the blood. Finally, Purdue did not mount the kind of aggressive marketing campaign to sell MS Contin that it did with OxyContin.

The people who would become addicted to OxyContin had many ways to discover the drug. Within the tight kinship and social networks of rural life, gossip about its allure diffused rapidly. Frequently the line between users and dealers blurred. "It's dealt by word of mouth," said one former addict. "I call a friend in Colorado and explain it to him, 'Hey, I've got this crazy pill, an OC 80, an OC 40. You've got to go to the doctor and get it. Tell him your back hurts.'" Tom R., one of my patients in Ironton, was prescribed Oxy 20s for back pain, but he admitted to also taking them for pleasure. One day, he took a pill in front of his friends, who laughed and told him "no, you don't swallow it. . . . " Soon Tom was regularly waking up to his personal "breakfast of champions": a big glass of strawberry Nesquik milk and a line of crushed Oxy 80, accompanied by his old standby, cocaine. He would snort three or four more Oxy 80s to keep him going throughout the day.

Word of mouth was also effective in spreading news of pill mills — bogus pain clinics posing as legitimate pain-management centers. These cash-only "practices" employed shady physicians who performed cursory medical exams (if any), billed insurance companies, and prewrote prescriptions to be handed out by their secretaries. One doctor doled out "goodie bags" of prescription painkillers, muscle relaxers, and anxiety medication to anyone with cash. To prove their injuries or pain conditions, patients could purchase forged MRIs and a note

on official hospital letterhead describing their alleged condition, along with a phony patient identification number signed by a real or fraudulent doctor. The phony clinics often operated alongside pharmacies that asked no questions; some pill-mill doctors even owned dispensaries themselves. In Scioto County, where the first major pill mill in southern Ohio opened in 1999, prosecutors had sent nearly 20 doctors and pill-mill owners to prison as of 2019.

The shadow industry's nerve center, however, was south Florida — in part because of the state's permissive pharmacy laws that allowed doctors to dispense narcotics and addictive medicines in their offices or clinics. The region was home to a massive network involving hundreds of pill mills. In 2007, my patient Tom drove down to Broward County 10 times, where he collected the pills — hauls of Xanax and Roxicodone (immediate-release oxycodone) — then turned around and drove back to Ohio. When he delivered the drugs to a dealer, he took his own commission in pills.

Tom was hardly alone in this regard; the highly sought-after drug soon became high-value currency in an illicit regional barter system. As Tom said of Oxy 40s:

> They were gold in color and they were like gold. I knew a place in downtown Ironton where I could eat and drink all evening. I would slide the girl or guy an Oxy or two, which would have sold on the street for a dollar per milligram, to pay for the check. You could also pay for car repairs, gas, pizzas, and girls. People took care of their grandparents just to use the pills they had or drove them to the doctors in exchange for pills.

"I had the occasional patient who gave some of his or her pills to the landlord in lieu of rent or to meet car payments," Dr. James Becker, a vice dean at Marshall University's medical school in Huntington, told me. A former small-town family practice doctor, Becker had cared for nearly every kind of down-on-their-luck soul: laid-off miners, mothers on welfare, people scraping by on disability payments, the never-employed, elderly people subsisting on fixed incomes, and minimum-wage workers at Walmart. Most of the doctors knew about the informal exchanges, Becker recalls. "Patients were often honest about it. And I didn't like it, no one liked it, but we did it."

Indeed, some physicians were active participants in the OxEconomy themselves. According to the Huntington Drug and Violent Crime Task Force, Medicare and Medicaid, which covered OxyContin, helped "too many doctors" in West Virginia "[supplement] their income by writing improper prescriptions." The physicians would bill the insurer, and the patient would pay a small co-pay to Medicare and Medicaid. Afterward, the patient would sell some or all of his pills at a dollar per milligram to a dealer for a substantial profit. The bartering scheme, called "bills for pills," paid better than most of the available jobs in the region.

The churn of pills — diverting, using, and selling them — soon had eastern Kentucky, southeastern Ohio, and West Virginia pulsing with crime. Realtors routinely told home sellers not to leave pills in their medicine chests during open houses. Funeral directors and hospice nurses cautioned the bereaved not to mention in obituaries that their loved ones had succumbed to cancer — a red flag signaling that huge bottles of pills were likely on the premises. In eastern Kentucky, local law enforcement was often stymied by close ties between people within communities. Loyalty within large families and fear of retaliation by neighbors made it hard to cultivate informants and to impanel neutral juries that would convict when prosecutors proved their case.

In 2017, Eric Eyre of the *Charleston Gazette-Mail* won a Pulitzer Prize for "courageous reporting, performed in the face of powerful opposition, to expose the flood of opioids flowing into depressed West Virginia counties with the highest overdose death rates in the country." The corruption he uncovered ran deeper than the criminal doctors who blithely wrote streams of prescriptions and pocketed millions; sheriffs and local judges were also reluctant to clamp down on rogue physicians. Meanwhile, companies called "distributors," which took purchase orders from pharmacies and delivered the pills to them from the manufacturer, failed to reliably report pharmacies with "suspicious orders" of painkillers in numbers that abruptly spiked from one month to the next.

Eyre also discovered that the West Virginia Board of Medicine treated errant physicians with a velvet glove. The West Virginia Board of Pharmacy was inundated with complaints but did little when notified of suspicious orders by distributors. The Drug Enforcement Administration had precious knowledge about distributors' deliveries but resisted efforts by Congress and the courts to pry the data out as

long as it could. Then there was the state's attorney general, who had business-related conflicts of interest with one of the distributors.

Appalachians seemed to take the corruption in grudging stride. In one survey, 90% of over 100 Kentuckians working in law enforcement, health, and community governance said the rural OxyContin problem in the early 2000s was "fueled by a cultural acceptance of drug misuse." Indeed, many residents tolerated unlawful activity, since it generated revenue for the community from sales of pills to outsiders. This happened in places like Williamson, West Virginia — dubbed "Pilliamson" — where the local Wellness Center was a hub of reckless prescribing. Cash-laden out-of-staters flocked there to buy painkillers and, in a small area near the center, trade and sell those pills.

"Pablo Escobar and El Chapo couldn't have set things up any better," wrote Eyre. "The coal barons no longer ruled Appalachia. Now it was the painkiller profiteers."

epidemics do not emerge from nowhere

Eyre exposed an ecosystem of laxity and corruption that allowed the OxyContin juggernaut to acquire a powerful grip on the Appalachian region. While none of the derelict parties he identified were new to the scene, the wild commercial success of OxyContin brought out new levels of venality. At the center of that ecosystem was an endemic culture of prescribing in which painkillers had long served several roles.

For workers today, pills remain essential. Their other option is to fight for disability compensation, which usually isn't enough. A miner from Williamson, West Virginia, who was on his knees 16 hours a day, told a journalist that his crew "wouldn't show up if they didn't have pain pills." He listed "Lorcets, Norcos, Roxicodone. Whatever people could get to get them through the day." Fear, too, remains an occupational hazard. "A lot of people are scared on the job," one miner told a *Washington Post* reporter. He had seen one friend lose an arm to a rock hauler and another electrocuted by a 900-volt mining cable. "They'll use alcohol, anything" to dull their nerves.

People also continue to rely on pills for emotional pain. "They want to be numb," Mark Sullivan, a professor of psychiatry at the University of Washington, told a journalist in 2014. "It's much more convenient for both patient and physician to speak in the language of physical pain, which is less stigmatized than psychological pain." A colleague of

Sullivan's suggested these patients were suffering from a condition that might be called "terribly-sad-life syndrome."

The history of opioid pain relievers in Appalachia is a prime illustration of the fact that drug epidemics rarely burst onto the scene out of nowhere. Instead, they find their place in regions that are already home to an established base of individuals who abuse similar drugs. Thus illicit OxyContin, a more potent opioid, efficiently gained popularity over Percocet and Vicodin in the same way heroin would substitute for prescription opioids as the latter grew scarce after 2010.

Today, opioid pills are no longer pouring into Appalachia as they once did; highly lethal products like fentanyl-laced heroin, methamphetamine, and counterfeit fentanyl pills are what people are selling. Fentanyl makes Richard Fisher nervous. He sold the Iron Town Coffee Lab in 2020 but visits often and drinks his coffee in a window seat with its front-row view of Ironton. He still sees men who balance their worldly possessions on the handlebars of a bicycle.

But also, more and more, he's seeing some young entrepreneurs begin to repopulate the town. With time and providence, he hopes, they may help the economy run more dependably on optimism and ambition — and less on drugs.