Serenity woke up under the I-90 Copley Square bridge overpass in Boston to the uncomfortable sensation of Oscar’s calloused hands closing in around her neck and squeezing. She couldn’t breathe. He whipped her onto her back, jumped onto her chest, and pinned her down.

“I know what you’re doing, bitch,” he screamed. “You’re making eyes at those dudes across the way. And I’ll fucking kill you. I don’t care. I’ll go back to prison, because in jail I’m somebody, and out here, I’m nobody. Keep fucking with me bitch!”

When he let up his hands slightly, she screamed back at him. “What the fuck is wrong with you? I wasn’t doing anything. I swear to God. You know I can be a flirt, but I swear to God I wasn’t doing anything. I don’t know if you need your meds or something, but you’re having a lot of angry outbursts for nothing, Oscar. I didn’t do nothing. You know I wouldn’t. We’re together. I’m not playing with you.”

The next morning, she took her backpack and rolled out from beneath Oscar’s heavy arm. She crawled out from under the bridge where they had been sleeping the last week—Oscar had been too jealous to allow them to continue staying in the homeless shelters—and made her way to the church in Copley Square. She had scraped together some money last night for their early morning fix, and she sat down in the cool darkness of the early summer morning, prepared herself some heroin, and prayed to God. Send me back to jail, God.
I first met Serenity, a forty-three-year-old white woman originally from a small town in Vermont, in 2010. She had come to Boston eight years earlier seeking recovery from heroin addiction. After several month-long stints in and out of rehabs and detox programs, and after she had graduated from, failed, or dropped out of these programs, she had stayed in Boston. The drugs were plentiful, and to go home would have been to return to the source of her ongoing pain and grief. She could never stop blaming herself for missing the signs that her son was being sexually abused by his grandfather. She would sometimes hear his six-year-old voice innocently asking her, tormenting her, “Why did grandpa make me put his pee-pee in my mouth?”

There was something safe about being in jail, the Boston jail formally known as the Suffolk County House of Correction (figure 1). Maybe it was just that she felt safe from Oscar’s hands on her neck or the constant threat of having her belongings stolen by other people in the shelter or on the street. Perhaps, most importantly, she felt safe from her own destructive drug use. Upon admission, users were forcibly detoxed from opioids. Like many other women, the longest amount of “clean” time she had ever accumulated was when she was incarcerated. Even though there was a fairly regular supply of heroin in the jail, she didn’t have the money, or the desire, to use inside.
Serenity tells me more when I see her in jail: “I feel calm here. It’s crazy. I’m very institutionalized. I’m afraid that if I leave here that I’m just going to be in the spoon [using heroin] by noon.”

As a fledgling medical student in the late 2000s, I became fascinated by the questions surrounding why and how women like Serenity had taken up heroin, or why a heroin habit had taken up in them, and their ongoing struggles with using and quitting drugs. When Serenity wasn’t incarcerated, she was enrolled as a patient in the Lemuel Shattuck Outpatient Buprenorphine Opioid (OBOT) Clinic in Boston, Massachusetts, one of the community treatment sites where I conducted ethnographic fieldwork (figure 2). There, at weekly appointments, she received a medication called buprenorphine-naloxone (Suboxone) to keep her cravings for heroin at bay. Prescribed by certified primary care doctors, psychiatrists, or addiction specialists, the medication, if taken regularly, could eliminate her cravings and keep her off more dangerous opioids like heroin or fentanyl.

Yet taking buprenorphine couldn’t erase the abuse Serenity’s children had suffered, the neglect she felt that she had subjected them to, or the guilt that she felt for abandoning them in search of drugs. “Is grief a health condition?” she asked me once, in tears. Serenity would log onto Facebook every chance she could get—on the computers of
homeless shelters or job readiness programs or at public libraries—in order to send them messages of love, birthday greetings, and other small reminders that she was thinking of them from several hundred miles away. She was thankful for access to medication, but it couldn’t solve her problems of joblessness, homelessness, or multiple-drug-resistant HIV. What it could do was prevent her from being in opioid withdrawal (commonly known among people who use drugs as “dopesick” or simply “sick”) and keep a needle out of her arm for that day, or at least for a couple hours.

As a medical student, I saw patients like Serenity in the community clinic where I was completing my third-year medical clerkship in the Roxbury neighborhood of Boston. Many of the patients there struggled with substance use disorders, mental health conditions, and other chronic diseases associated with poverty and lack of access to steady healthcare. Some patients wouldn’t show up to their follow-up appointments and were dutifully marked “no-shows” by the clinic’s secretaries. The office would call their phone numbers, which were often not in operation, as many patients lived month-to-month and were unable to keep paying their cell phone bills. Several months later, some would reappear saying they had been incarcerated and then released without medications or any assistance. They were arguably worse off after these stints in jail. What happened to them inside? What happened to Serenity as she was incarcerated over and over again, and how could she ever break this cycle?

Getting Wrecked: Women, Incarceration, and the American Opioid Crisis explores what happens to women with opioid addiction inside the prisons and jails in Massachusetts and in the aftermath of incarceration. I wanted to understand this world that was geographically so close to my life at Harvard Medical School in Boston and the Department of Anthropology across the river in Cambridge and yet somehow had such very different lifeworlds and experiences. Thus, I embarked on two years of difficult—at times, seemingly impossible—ethnographic research in the Massachusetts prisons, jails, and drug treatment community to understand how the prison had become a centralized node in the increasingly fraught politics of addiction treatment and recovery. During this time, I conducted semi-structured interviews with over thirty women at these three sites and followed them longitudinally forward as they moved in and out of jail, prison, and home.

Rooted in the methods and theories of sociocultural anthropology as a means to understand how inequality becomes embedded into physical
bodies, I sought to explore how medicine, punishment, and drug use became bound up in politics and in the realm of the social. I learned, for example, that my ability to treat addiction effectively would entail addressing far more than what was at my disposal in the clinic as a physician and much more than any single prescription. I could give Serenity a medication to take away her cravings, but I couldn’t stop the worlds she lived in from harming her or the ongoing harm she did to herself. My ability to effectively help someone like Serenity escape the cycle of problematic substance use lay rather in understanding and addressing deeper structural and social inequalities, deep-seated social mores and stigmas, and the punitive policing and legislation that contributed to her frequent bouts of incarceration.

Opioids, pain pills, heroin, and fentanyl seem to have dominated news cycles in the last several years as overdose deaths in the United States have reached new heights in fatalities, with over seventy thousand overdose deaths in 2017 noted by the Centers for Disease Control, with the numbers still rising or showing little sign of abating. While opioids are not a new drug, there is newfound and rising awareness of their ubiquity and possible harms, as they increasingly are seen to affect white, suburban, and rural households. I use the term American “crisis” here (as opposed to other frequently used terms like “epidemic”) in order to highlight this renewed attention and opportunity to address and intervene on the deaths of a structurally vulnerable group within our country. These deaths are preventable, thus tragic, as a result. But there can be significant harms besides death.

In the pages that follow, I explore the experiences of women on heroin and other opioids who are subjected to everyday violence, oppression, and inequality from many realms: within and from themselves, within their relationships, within their communities and within the judicial system. I followed them as they sought treatment in the community, as they tried to care for themselves in the prison and jail and after release, and as they cycled in and out of various regimes of care intermingled with punishment. These women have struggled mightily with self-care and caring for others throughout addiction, recovery, and incarceration while navigating various biochemical, spiritual, and socially prescribed forms of dependence and freedom.

Anthropologists Eugene Raikhel and William Garriott suggest that we might be able to learn much more about drugs, drug use, and historical and current moral orders by tracing people over time and across space and their substance use via addiction trajectories. As they write,
“Addiction cannot be reduced simply to a biological condition, a social affliction or the symptom of some deeper malaise. Rather, it must be seen as a trajectory of experience that traverses the biological and the social, the medical and the legal, the cultural and the political.” This is where anthropology’s methods—of close and deep ethnographic investigation over time—can elucidate the complexities of a deep social problem like the American opioid crisis. Following the paths of women who used heroin, I kept finding myself at the gates of the local jail or the state prison. Reckoning with women’s drug use in America meant reckoning with the carceral state.

This book takes readers through the epistemological orientations and practical applications of the treatment of women who use heroin or other opioids as in criminalization has become one of the primary social responses to the problem of opioid misuse and addiction. In the tradition of critical ethnographies of drug use that draw attention to the uneven playing field upon which the poor precariously build their lives, I use ethnography to interrogate what it means to treat others on a variety of registers. On the broadest level, how do we enact policies or legislation to treat the social problem of drug use? Do we have any means to understand the realities of these policies and practices when they travel behind bars? And what does it mean for the women at the center of such sociopolitical debates, as they dream of better lives for themselves and their families?

Heroin had been a presence in Boston for decades before Serenity found herself running its streets in the mid-2000s; its presence dates back well before the current iteration of an American opioid crisis that swelled again in the mid-1990s. Like other large urban centers in the northeastern United States, Boston struggled with the problem of drugs and drug deaths during an early wave of heroin use in the 1960s and 1970s that was also called an “epidemic” at the time. In this context, President Nixon had famously declared drugs “America’s public enemy number one,” setting off decades of complicated and punitive waves of legislation around heroin, cocaine, and marijuana. And like other major urban cities, Boston also struggled with crack cocaine in the 1980s and waves of other substances including amphetamines, synthetics, and problems related to licit substances such as alcohol and tobacco.

In the summer of 1977, one of my informants, Jean, found herself scared and alone—only 14 years old—in the middle of Boston’s infa-
mous “Combat Zone,” a small cluster of streets near Downtown Crossing and the Chinatown district. The Combat Zone ate up everyone who came to play. It was an equal-opportunity space for destruction or bliss. The Pussycats, the Naked I Lounge, and the Glass Slipper all promised ephemeral or forbidden pleasures. During its worst years, a Harvard football player was stabbed to death in a robbery gone awry, the House Ways and Means chairman Wilbur Mills was seen dancing onstage at a burlesque house, and a Tufts associate professor of anatomy murdered his mistress. In a profile of the so-called Combat Zone, two *Boston Globe* reporters noted that places like the Combat Zone always seemed to exist in big cities “as long as society, and life, has the ability to maim, and then ostracize the maimed, there will be a place for the maimed and the ostracized . . . a place where all acts and people who commit such acts, rejected by society, congregate.”

It was here that Jean first tied a belt around her arm and experienced the rush of intravenous heroin. Like many other teenagers, she had tried a couple of drugs before. When she was ten, she would occasionally sneak her grandfather’s beers from the refrigerator when her mother wasn’t looking. With an older boyfriend, she had smoked weed and even done quaaludes. But she had never done heroin, also known on the street as dope, H, smack.

Jean had recently run away from home, dreaming of getting into the fashion business. The reality she landed in was dismal and couldn’t be further from a life in fashion: she was sleeping in the park and begging for food and spare change. One day, Jean was panhandling in a corner of Boston Common near the subway when a group of teenage girls approached her asking if she wanted to party with them. Too young to be properly scared, she followed them into an alley off the intersection of Beach and Essex Streets in Chinatown in pursuit of a good time.

The girls trooped down into a basement room that was dark and full of broken beer bottles and dirty mattresses on the floor. There were small clusters of people in various states of euphoria and consciousness lying around. Sugar, the ringleader of the group of teenagers, told Jean to offer up her virgin arm in the eerie candlelight of the basement. “It’s fun,” she said. “You’ll like it.”

Someone tied a belt as a tourniquet around her skinny arm. They told her to squeeze her fist tight and shut her eyes. Sugar saw a flash of blood return and knew she was in the vein, then she emptied the chamber
into Jean’s arm. Was it over, Jean wondered? She looked down at the needle in her arm and felt a wave of nausea rush over her. Then everything was black.

“Where’s the bathroom?” she managed to ask. She ran toward the dirty toilet in the dark shooting gallery, hugging the bowl, her stomach churning in distress.

Jean was confused, wondering to herself: “What the hell? Why do people do this shit? Everyone else seems to like this, and I’m throwing up.” Jean thought maybe she got a “bad bag,” so the next day, she tried it again. This time, she told me, she became “hooked” on the feeling. The rush of physical and emotional relief it provided was like nothing else she had ever experienced in her life. Since Sugar had offered her a place to stay, acquiring and using heroin several times a day simply became part of their daily routine together.

Three weeks later, Jean recounted, “I started waking up craving it.” She had no idea that she would become physically sick if she didn’t have it, that she was now physically dependent on opioids, her brain chemistry already acclimated to the presence of the substance. Now her body would be wracked with the anxiety, nausea, and flu-like pains of opioid withdrawal if she was unable to access heroin.

In the beginning, it was hard for Jean to hit her own veins. She had to pay people to shoot her up by giving them some of her dope. But as generous as heroin addicts can be, sharing dope gets old. It always creates tension: “Who used too much?” “You didn’t leave me any.” The dope becomes all-consuming. Jean soon learned to find her own veins.

Money in the Combat Zone came fast and easy. The drugs were plentiful. Jean was able to wield her childlike, light-skinned African American features to chat up older men who would take care of her, set her up in apartments in Dorchester and Roxbury that they kept on the side, hidden from their wives. She was able to do it all: buy nice high heels, shop, shoot dope, go to a different club every night. These men paid for her car and her rent and gave her a little spending money on the side. But they were respectable, middle-class black businessmen in Roxbury with families, and they didn’t like the idea of dope. Dope was dirty. They liked a little bit of danger but not that kind of danger.

They especially did not like needles. One of her sugar daddies found out about her secret habit at breakfast one day in a local diner. She went into the bathroom to shoot a speedball (cocaine and heroin mixed together in one injection)—because it was a “bad day” if she had to shoot just plain dope in the morning. When she came back to the table,
her eyelids began to droop. She nodded out into her stack of chocolate chip pancakes. Two hours later she found herself homeless, again.

Sometimes Jean just thought she had bad luck because she stayed in bad neighborhoods, rife with street violence, drugs, and police officers eager to arrest drug users. One day, she decided to try to get away from her own bad habits and escape her local dealers. She picked out on a map a place she had never been to: Arizona. It seemed like a nice, warm place to someone coping with New England’s long winters and heavy blizzards. Dopesick on the plane, and not knowing a single person in Arizona, she climbed into a cab and asked the taxi driver to take her to the worst neighborhood he could think of. She shot dope that very same day.

Jean’s drug of choice, so to speak, was “more.” The only time in the next thirty years she would stop using heroin was when she was in jail: “That was my detox. I’d go to jail. Whatever sentence I had—three months, six months, a year—I’d stay clean for that amount of time. When I’d get out, I’d go back to the same people, same everything and it would start all over again.”

Jean thinks maybe she wouldn’t have used heroin for as long as she had if she had had a family that actually cared where she was, that wondered if she was okay at night. Her mom never called to check in on her, and her stepfather didn’t even care that she had run away. She thinks she was “addicted to the hustle” and wonders wistfully what her life would have been like if she had “seen a different way of life, since all I had ever seen was chaos and craziness.” For Jean, just like Serenity, jail was “the only period of normalcy that I had, routine, wake up, you feel good, and you don’t have to run and get some dope.” Going to jail was simply a fact of life, since “you’re going to get knocked eventually, it’s just part of the game.” For her last sentence she was actually sent to prison—MCI-Framingham, the sole women’s prison in the state—and it was her longest period of confinement (figure 3). Prison, unlike jail, is where women are sent to serve sentences of generally greater than one year.

This time, the crime involved was more serious than using illegal substances. That particular day, Jean and her boyfriend were smoking crack in their tiny kitchen. Child Protective Services had just taken away their daughter, Kiara, because of their destructive drug use. Jean was on a tear. She had been accessing daily treatment with the methadone clinic to keep her off heroin, but she was continuing to smoke crack and drink alcohol in order to deal with the devastating loss of her daughter. Kiara
had been the only good thing about her life, and now she was gone. And then her boyfriend accused her of stealing the remainder of the leftover drugs. With the crack coursing through them, they both felt emboldened, aggressive, and violent.

Jean’s boyfriend punched her in the face, knocking out her two front teeth, and then he put his hands around her throat. Backed up against the sink, Jean reached for whatever she could find, and stabbed him several times in the chest with a kitchen knife. She went to prison for three years for assault. The upside was that it was the longest time she had ever had, she said, to “clean myself out.”

The prisons and jails in the United States are tasked with the problem of addressing, correcting, and treating substance use disorders in the wake of decades of legislation since the early 1900s that increasingly criminalized the consuming, selling, or buying of certain drugs such as cocaine, opium, and marijuana. Yet even the history of scheduling specific substances into the Controlled Substances Act and other such legislation, determining which drugs were most harmful versus possibly beneficial, was fraught, arbitrary, and often politically motivated by media portrayals of racialized fears of Mexican, Chinese, or black men.
tempting and tainting white women with substances like marijuana, opium or cocaine.⁴

Then it was not clear or consistent how these laws were enforced. According to the 2017 National Survey on Drug Use and Health, approximately 30.5 million Americans reported some form of illicit drug use in the previous month (or 1 in 9 Americans).⁵ Clearly not everyone goes to jail for this use. As I continued in my research, I increasingly realized how fine the line was between behavior deemed normal versus pathological in our existential responses to suffering and quests for well-being. I wondered how, exactly, and in what specific ways, the consumption of certain drugs had been made into a criminal act. When my medical school classmates at Harvard traded or popped each other’s benzodiazepines or stimulants in order to self-medicate against the mental anguish and physical limitations encountered on the arduous and stressful path to becoming a doctor, they certainly were not sent to drug treatment facilities or prison. They were applauded for staying up all night studying or working in the hospital. Or if they did psychedelics, like mushrooms or LSD, they were applauded for the creative writing or insights they produced in that context. As recreational or functional drug users of certain means, they were often protected from police. Even if they developed dysfunctional or problematic substance use, the societal treatment of so-called “impaired” physicians or nurses contrasts sharply with the entrenched system of incarceration for poor women.

Furthermore, examining the drug use of physicians provides evidence refuting the notion that people with substance use problems or drug dependency cannot make valuable contributions to society. Medical historian and physician Howard Markel chronicled the lives of two famous cocaine users in his book.⁶ He explored the complicated lives of Dr. Sigmund Freud, one of the fathers of modern psychotherapy, and Dr. William Halsted, a famous surgeon at Johns Hopkins who is considered one of the founders of the modern surgical field. Halsted, who was treated for his cocaine addiction with daily morphine injections at Butler Hospital in Providence, Rhode Island, subsequently became physically dependent on morphine (a close chemical analog of heroin) for the next four decades of his life. And yet despite his substance use, at times very problematic, he still managed to make significant contributions to the medical field. So how are some lives deemed worth saving, handled with expensive and long-term interventions and treatments, while others, lacking a means to pay and a social network of support, face prison or jail?
Prison is a difficult and contradictory place to get better. People often lose private and public health insurance upon incarceration, and by law, prisons and jails must provide health care to people incarcerated within their walls. In fact, the incarcerated are the only population in the country specified in the US Constitution to have a right to adequate health care, as the Supreme Court ruled in *Estelle v Gamble* (1976); deliberate failure to provide adequate medical treatment was ruled as cruel and unusual punishment, a violation of the Eighth Amendment. Carolyn Sufrin, an anthropologist and an obstetrician-gynecologist, examined some of the tensions of providing care in these spaces in her recent compelling ethnography of the San Francisco County Jail. For the women that Sufrin cared for, jail is a multifaceted, complex space, at times providing relief and respite, at other times trauma and isolation.

For Jean and Serenity, accessing health care and drug treatment in jail and prison were similarly fraught endeavors. For Jean, the experience of incarceration could be contradictory and sometimes conflicting. While she encountered occasional kind souls, brief moments of humanity from guards or other prison staff, striving for care and well-being within a place of punishment was an impossible contradiction. Yet it was, after all, the only place she was ever able to be abstinent from drugs. She was able to take her medications regularly and always would gain weight from regular access to meals. But she refused to talk to a counselor or go to a group regarding her drug therapy, asserting that it was her own business and not the business of some freshly graduated white social worker who would lecture her about her poor life choices.

The enormous size of the jail and prison populations and the complex effects flowing from the increasing reliance on prisons as a social solution within American communities has led sociologists, criminologists, social scientists, historians, and increasingly anthropologists to assess the sweeping impact of these institutions. Lorna Rhodes’s seminal work on maximum security prisons, documenting the tasks and tensions of custody and treatment, questioned the underlying rationality of such a system. James Waldman also interrogated these tensions in his study of a Canadian prison working to habilitate sexual offenders. Who were prisons for? Waldman argued in *Hound Pound Narratives* that the process of treatment, or therapy, is achieved by “glossing over the complexities of human sociality to make being moral seem as unambiguous as possible. Therapy is offered to inmates, not so much to make their lives better, as to make our lives better.”

For women like Jean and Serenity, what happens after they are marked as dangerous, bad, and criminal, has largely gone unwitnessed. This book builds on the expanding body of critical prison ethnographies in the tradition of the anthropologists noted above in order to understand how such women move across carceral spaces and time during what is now called America’s opioid crisis, as they represent the feminization of the American “War on Drugs.” Their stories are just a few out of many thousands. In this country, rates of incarceration of women have increased 834 percent since 1978. As the nonprofit research group Prison Policy Initiative notes, this growth is fueled by mostly state prisons as well as county jails, and efforts at decreasing or decarceration have benefited men disproportionately (the total number of men in state prisons from 2009 to 2015 fell by 5 percent while the number of women in state prisons over the same period fell by only 0.29 percent).

Jean and Serenity’s heroin use exposed them to a criminal justice system that did little to treat their underlying disease processes or cure them of the purported immorality that led to criminal behavior. They are part of a social story in which some substances and the people who use them became symbols of danger, contamination, and evil, posing threats to ideals of safety, virtue, upright living, and public morality. What does the current dominant policy response of criminalization actually look like for the women most directly affected?

The law intercedes in the lives of most people in the United States, but among poor women who use drugs it especially rears its head in a myriad of violent, jarring ways, adding to the many forms of violence they have experienced throughout their lives. While people of all classes engage in the purchase and consumption of a staggering array of pills, potions, and charms in search of health, happiness, and well-being, only the consumption of the poor is heavily policed, regulated, and viewed as pathologically excessive and out of control.

Heroin in particular is often still linked with crime in the American public imaginary as part of decades of concerted efforts by the Drug Enforcement Administration and partnerships with parent groups to link the two notions. In a forum on the implementation of medical marijuana in Massachusetts, a group of concerned mothers from the South Shore suburbs of Boston spoke of the dangers they felt existed regarding the increasing availability of marijuana. One woman stated that she was against a proposed medical marijuana law because she felt that, “with heroin there is a rise in drug-related crimes, fatal and non-fatal
overdoses . . . and there is definitely a risk of home break-ins and that type of problems.”

Drug use has been a consistently vilified and targeted proxy for the problems arising from poverty, racial discrimination, and perhaps most especially in certain populations and neighborhoods—largely African American and Latino American—what sociologist William Julius Wilson calls “concentrated disadvantage.” Instead of looking at complex historical race relations, at the systematic oppression of marginalized groups in terms of schooling, housing, and employment, at racist policing practices and subsequent social policies of systemic discrimination and exclusion, as Wilson and sociologists of poverty urge us to do, we instead think narrowly and myopically about specific issues such as the problem of heroin or fentanyl. Across various political cycles, politicians continually fall back on demanding “law and order” and “cleaning up” the streets—arresting drug users and dealers, locking them up and throwing away the key.

This mind-set has had a distinctly racial bent over the past several decades, targeting low-income communities of color. Over decades in this country, the American War on Drugs has morphed several times (fears of heroin, crack cocaine, methamphetamines, marijuana, tobacco, and alcohol), yet people still continue to consume drugs—in largely the same proportion as they always have done—and communities of color have disproportionately been ravaged by the effects of the prosecutorial and policing apparatus that continues to police these substances and those who use them. Anthropologist William Garriott has called the apparatus and mentality of drug war rhetoric in local, state, and federal governance in America “narcopolitics.” This deep entrenchment makes both analysis and subsequent action to change difficult.

The contemporary American opioid crisis is not our first, and not our first drug scare with concurrent misinformation, misguided law enforcement, and scare tactic efforts by the government. Waves of crises have occurred since the prohibition of alcohol, including heroin, crack cocaine, methamphetamines, and others, and such crises will continue to occur unless we see dramatic cultural paradigm shifts. This current crisis, though, is in many ways deadlier than ever before, because of the adulteration and contamination of street heroin with illicitly manufactured fentanyl.

As I sat in a downtown courtroom waiting for Serenity’s case to come up at the Boston Municipal Court, I wondered what the process of
criminalization of opioid use actually looked like. I mused about how “law and order” politics played out in the lives of the women I had met. At this point, I had known Serenity for over two years, following her in and out of jail and in and out of treatment at the local state-funded buprenorphine-naloxone clinic at the Shattuck Hospital in Boston. This time, she told me, the charges against her were trumped-up ones from over a year ago, including drug possession and a “hand-to-hand” in a school zone. It turns out her case was part of what became known as the Hinton drug lab scandal, which revealed the vast state prosecutorial and political apparatus bearing down on women like her.

After waiting two hours, Serenity’s case was finally called. Her young, harried female public defender shuffled through a set of papers, files of people like Serenity who were too poor to hire a private lawyer. Serenity had been brought up in her street clothes—tall leather boots and a jean jacket—not her jail jumpsuit, and she looked out into the galley, smiling at Steve, her on-and-off man—twenty years older, with whom she occasionally smoked crack. He had come to support her. Her attorney looked at the prosecutor and they awkwardly addressed each other using antiquated terms still used in Massachusetts calling each other “my brother” and “my sister.” Serenity had told me before she didn’t respect her lawyer (a “public pretender”) but didn’t know how to get another one.

The judge seethed with visible anger at the prosecutor representing the Commonwealth: “This case is a year and a half old,” she said, referring to the February 2012 charge of selling in a school zone. “Have you received the discovery?”

The prosecutor pleaded for more time to get the physical evidence, or the discovery, saying, “We understand the final discovery was requested, but we understand this was a Hinton lab case.”

The judge interrupted her angrily, “That doesn’t matter. It’s a year and a half later. Where’s the discovery?”

The state district attorney asked for more time again, saying, “Your Honor, we’re asking for another day to provide the discovery.”

“You’re not getting it,” the judge said. “After a year and a half, they still don’t have any bench drugs. You still don’t have discovery?”

The judge then asked about the distance from the school; the DA pleaded that they thought they had measurements attesting to the school zone distance. The judge wanted to know about the drugs again: “February 2012? But you don’t have the lab results? Why? Somebody’s not doing their job here.”