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SOS:

Stopping Opioid Slaughter

A small group of donors is up against the worst drug epidemic ever. They need help.

By Caitrin Keiper

To the day he died at 101, Oliver Hubbard was ahead of his time. By the age of 21, he had served in World War I, graduated from the University of New Hampshire, and turned a Boy Scout project raising hens into a family business that would eventually become a multinational company. Hubbard Breeders was a leader in genetics research and other poultry technology that paid off in a big way. Hubbard and his wife, brothers, and sons all became generous donors, largely focusing on science and UNH.

In his later years, Hubbard was troubled to read about drug problems among New England's youth. To help, he made an unusual gift in 1996 to the New Hampshire Charitable Foundation to create a new division on drugs and alcohol—an area where few if any other community foundations had substantial programming. Hubbard didn't know that something else happened that very year that would escalate addiction across America. But two decades on, his $43 million endowment couldn't have been available at a better time.

A disease of despair

1996 was the year that Purdue Pharma released its new painkiller OxyContin, billed as a non-addictive wonder drug for chronic pain. Anyone who has picked up a newspaper in the last few years knows how catastrophically wrong that characterization turned out to be. The drug release was accompanied by an aggressive marketing campaign, and helped dramatically increase the use of opioids in America.

Opioids are known for two things: powerful pain relief, and extreme addictiveness. Poor research wielded during the OxyContin introduction convinced many doctors that the addiction problem had been solved, while playing on their compassion for suffering patients. The new narcotic and others like it were prescribed liberally. This revolution in medical practice coincided with a host of other changes: Decreasing time doctors could see their patients. A more pill-centric attitude to treatment overall. Medicaid reimbursement practices. Incentives that

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trapped people with a temporary problem on permanent disability. Social attitudes that made pharmacological relief from both physical and emotional pain seem like the first or only option. A hollowing out of communities, resulting in painful isolation.

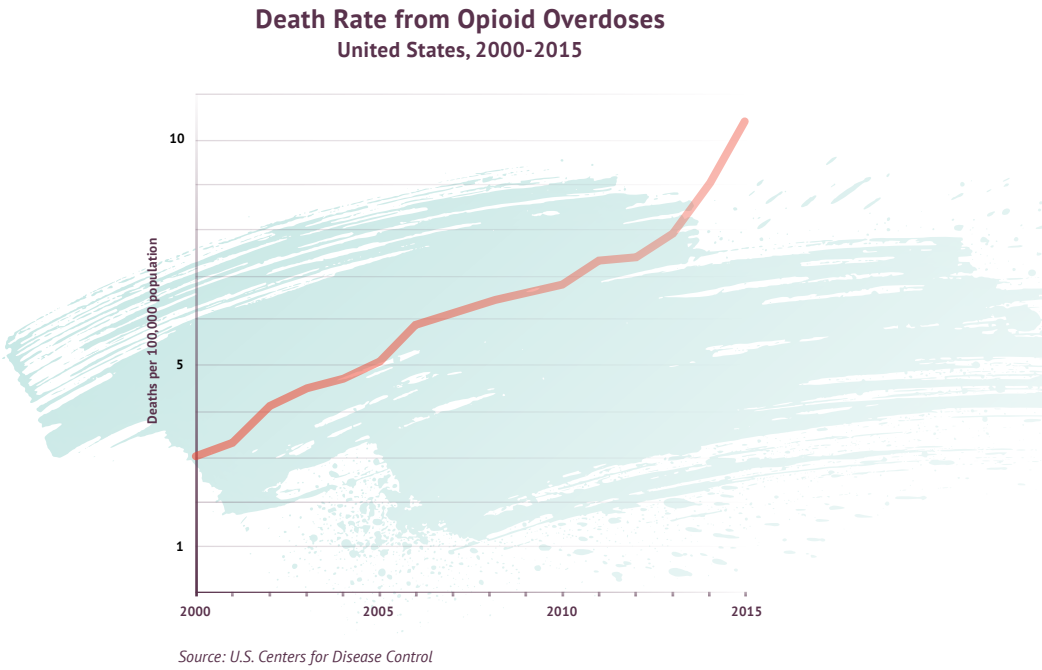
Millions of patients became dependent on opioids. As body tolerance increased, average doses ratcheted up. Large quantities of leftover medications made their way to experimental users, who in turn became addicts, often crushing the pills to attain an instant and powerful high. These prescription drugs seemed safer than illegal substances. But 80 percent of all opioid addictions begin with prescription pills, and any opioid can easily trigger a fatal overdose. (About 2.5 million of the 22 million Americans who struggle with a drug or alcohol problem are opioid addicts, but most overdose deaths come from this group.)

Eventually, an opioid-dependent person runs out of his legal supply, or finds the cost of pills prohibitive. A cheaper substitute is readily available: heroin. Once exotic and taboo, heroin has infiltrated middle-America thanks to cunningly low-profile new patterns of drug trafficking, as described in books like *Dreamland* by Sam Quinones.

In recent years, the opioid epidemic has mutated. Attempts were made to reduce over-prescription. New pills hit the market designed to be harder (though by no means impossible) to misuse. But many heavily dependent people cut off suddenly from pills went quickly into the arms of heroin. With demand established, supply will come from somewhere.

Lately, most street dope is laced with fentanyl, a synthetic opioid 100 times more powerful than heroin, or even the elephant tranquilizer carfentanil, an astounding 10,000 times more potent. The value per volume of these substances makes them easy and attractive to transport, but just a tiny dose can kill you. Today's spike in overdoses has also been fueled by users combining opioids with sedatives or anti-anxiety medications like Valium, Xanax, and Klonopin. Both substances depress breathing, and together they are far more likely to bring about respiratory arrest.

Drug overdoses, along with alcohol-related illnesses and suicides, are called "diseases of despair." They correlate closely with family decline, social failure, and isolation. The rate of opioid overdoses among never-married and divorced individuals is six times higher than among married persons.



Source: U.S. Centers for Disease Control

In 2015, Princeton economists Angus Deaton and Anne Case made a startling announcement: these diseases of despair have risen so sharply as to actually increase the overall death rate of middle-aged white Americans. In almost every other health category, the march of technology, better medical treatment, and improved health education has lowered death rates. But drug addiction is such a destructive force that it is actually damaging the average U.S. lifespan.

Drug overdoses have now passed car crashes as the leading cause of accidental death nationwide. They have become the leading cause of death overall for Americans under 50. And of the 64,000 fatal drug overdoses in 2016—quadrupled since 2000—53,000 of them involved opioids.

Start with prevention

If we could just rewind the clock, the philanthropy in this area with the best return, dollar for dollar, would be drug-use prevention. The federal Substance Abuse and Mental Health Services Administration estimates that one dollar spent on prevention could save $18-30 down the line. Other authorities produce more modest guesses. Whatever the real multiplier, a good prevention program will head off future suffering.

The California-based Conrad Hilton Foundation, one of just a few national philanthropies involved with drug issues, has made prevention the centerpiece of its effort, spending $124 million on such work since 1982. A lot has changed in our knowledge of effective techniques during that time. Focusing on teens and young adults, though, is clearly the best starting place.

"Addiction is a pediatric disease," says Dr. John Knight of Harvard Medical School. Between 75 and 90 percent of people who become addicted to drugs or alcohol first started using as teenagers. Dr. Richard Whitney, an addiction specialist whose main patient population used to be "middle-aged alcoholics," sees the increased availability of large quantities of opioids as a powerful social experiment. "Had these opiates not appeared, I think we'd have seen a similar number of alcoholics, but later in life," he says in *Dreamland*. "It usually took 20 years of drinking to get people in enough trouble to need treatment. But with

the potency of these drugs, the average age has dropped 15 years and people get into trouble very quickly."

Yet few pediatricians learn about addiction in medical school. Nor do psychiatrists, or emergency-medicine doctors, or primary-care physicians. Most doctors spent no more than 30 minutes learning about addiction in all of their training, despite the fact that the issue looms large in many afflictions of health.

Without appropriate training, they may not have much more to go on than any other adults, who research shows have a giant mismatch with teens in their perceptions of drug use. In one survey, reports David Sheff in *Clean*, "most parents assumed that the number-one reason kids used drugs was that 'drugs are fun.' When kids listed their reasons for using, however, 'drugs are fun' came in fifteenth on a list of sixteen," far surpassed by motivations like "forget their troubles," "deal with problems at home," and "cope with school pressure." Needless to say, responding to the right underlying problem makes a critical difference.

The Hilton Foundation has created programming that helps health-care providers and other youth-service professionals talk to young patients about drugs. Its so-called SBIRT program (for Screening, Brief Intervention, and Referral to Treatment) offers training in skills to screen adolescents for stress, trauma, anxiety, and untreated mental illness that can lead to coping with alcohol or drugs, including opioids. It changes the conversation from "just say no" to "just say why," says Alexa Eggleston, Hilton's director of youth substance-use prevention.

Patients already in trouble are referred directly into treatment, while those at low to moderate risk open a dialogue about substance use. The health-care provider presents factual scientific information about the effect of drugs and alcohol on the body and brain, and discusses strategies that teens can use to avoid them, cut back, or quit altogether. Eggleston notes that when she talks to young people who have struggled with addiction, one message emerges over and over: "I had no idea who to talk to. My teacher knew that I was starting to fail, the coach kicked me off the team," but not a single authority figure stepped in with a positive response. So far, SBIRT has trained 28,000 doctors, nurses, and social workers to be this person in a kid's life.

Timothy Rourke of the New Hampshire Charitable Foundation partnered with Hilton to roll out SBIRT in his state. Inspired by the community foundation's leadership on substance issues, an anonymous donor recently gave $3 million to aid pregnant women and young mothers struggling with addiction. This funds hospital-based social workers, research into better care for babies affected by prenatal substance use, and family therapists and other supports at treatment centers and halfway houses that foster good parenting and long-term recovery.

Oliver Hubbard's donation doesn't go to direct services. Hubbard funds must be used to create overarching strategies like New Futures, an advocacy nonprofit that educates the public and lawmakers about drugs and alcohol, and helps brainstorm solutions. Its past achievements include advocating for better insurance coverage for addiction care, making underage driver's licenses vertical in orientation so as to be easily distinguished at places serving alcohol, and diverting a significant cut of state-sponsored liquor sales to prevention and treatment. Until then, says Rourke, "the amount of money the state of New Hampshire spent on substance-abuse services of any kind was only $25,000."

One highly visible New Hampshire program is called Safe Stations. Drug users in crisis can present themselves at fire stations in larger cities and be connected to whatever resources they need to begin treatment and recovery. About nine out of ten of those who ask for help are on Medicaid (which per the Affordable Care Act covers substance-use treatment), and for the rest, someone works with them to find a treatment option. Nonprofit organizations ranging from the United Way to Catholic hospitals pitch in to ensure no one is turned away. In the program's first year, the overdose rate in Nashua dropped by 24 percent.

Equipping doctors

"I find out what the world needs. Then I go ahead and try to invent it," said Thomas Edison. When General Electric, the company he founded, moved its headquarters to Boston in 2016, the corporate foundation wanted to follow Edison's lead, and undertook a listening tour of Massachusetts to find out what was most needed in the community. A "pain point" that came up over and over, says the GE Foundation's Jennifer Edwards, was the opioid epidemic—which in Massachusetts kills five times more people than cars do.

The foundation committed $15 million to a range of initiatives focused on substance use. One idea it developed is GEMS Boxes. Following the model of heart defibrillators, these publicly positioned boxes contain emergency kits of naloxone, a drug which restores breathing in persons overdosed on opioids. A nonprofit called We Are Allies trains volunteers to use the kits, and educates other citizens.

The GE Foundation is also helping medical professionals deal better with addiction, and the related area of pain management. This includes helping family doctors add substance-use treatment to their services, and fellowships to increase the number of addiction specialists. The foundation's chief medical officer David Barash, an emergency physician, notes that when patients arrive at an E.R. with an addiction issue, there is often no expert to call, even though a large fraction of E.R. admissions are related in some way to drugs or alcohol.

Drug overdoses are now the leading cause of accidental death nationwide. And of the 64,000 fatal overdoses in 2016, 53,000 of them involved opioids.

In her book *Drug Dealer, MD*, psychiatrist Anna Lembke says she didn't feel prepared to treat patients addicted to drugs or alcohol, having received literally no training on the subject in medical school, and not much more in residency. In practice, she gradually became aware, often by accident, that many of her patients were entangled in one substance or another, and that this was central to their problems. So she spent the last two decades studying and treating addiction. We need many more such experts.

Boston's position as a leader in medicine, and regional center for many of the communities hardest hit by opioids, make it an excellent location to improve drug training. And thanks to a $25 million donation from John and Eilene Grayken, a landmark addiction research and treatment effort has just been launched at the Boston Medical Center. This is the largest donation ever to BMC—which treats more low-income patients than any other hospital in New England. It is also the biggest private gift for substance treatment anywhere in many years. Eilene revealed to the *Boston Globe* that addiction has touched her own family. "This is a disease that doesn't respect gender, class, social status, or money. It can literally be anybody susceptible to this."

But the opioid problem is far worse among less-educated populations, so she and John chose to fight back not through one of Boston's glittering medical colossi, but rather at a gritty hospital that serves a poorer clientele, near Boston's "Methadone Mile" where drug dealers catch patients coming in and out of clinics. The new Grayken Center for Addiction Medicine opened at the Boston Medical Center in early 2017 and got right to work launching new initiatives and research projects, and recruiting top talent. Two of its physicians, one working in clinical care and the other in emergency medicine, will soon be honored by the Rosenthal Family Foundation for their promising breakthroughs.

The bellwether

Several hundred miles west of Massachusetts, Ohio has been hit even harder. In the county surrounding Dayton, opioid deaths doubled from 2016 to 2017. In the county surrounding Cleveland, the number of people who died in 2016 from fentanyl was more than double all previous years combined. "It's a growing, breathing animal, this epidemic," a coroner told the *Columbus Dispatch*.

Following news that Ohio was leading the nation in total overdoses, the Columbus Foundation issued a Critical Need Alert in late 2016, asking givers to contribute to a special fund which would be matched by three donors within the community foundation. Local givers from the $100 to $10,000 level answered the call, and more than half a million dollars was collected. This money was spent on a crisis hotline, public-health research, first-responder training, and a smartphone app that addicts in recovery can use to reach out for instant support. The foundation is also working with local businesses to aid employees with addiction in their family.

"Columbus is a big city that functions like a small town," says director of grants management Emily Savors, and a tight-knit group of local funders, businesses, public agencies, nonprofits, and treatment organizations is talking about how best to complement each other's efforts. It's very much a grassroots endeavor. "Nobody can do it on their own," says *Dreamland*'s Paul Schoonmaker, whose son died of an overdose. "But no drug dealer, nor cartel, can stand against families, schools, churches, and communities united together." He now volunteers on college campuses, spreading the word about the perils of drug use and the options for students in crisis.

Ohio is vulnerable for several reasons. It's been afflicted by blue-collar job loss that builds personal and economic depression. This state more or less invented the pill mill, where disreputable doctors ran clinics that did nothing but dispense opioid prescriptions for cash. Ohio features just the sort of rural and suburban communities, away from big-city dope gangs, that the new heroin dealers targeted.

Though Ohio tumbled into the opioid problem before most other states, it now also has a head start in fighting back, reports Quinones. The same towns where pill mills got started, which used to attract drug-seekers from all over the state and even across state lines, are now where people migrate to get clean. Schools and counseling centers are energetically expanding their training and treatment offerings. There is an air of openness and problem-solving where secrecy and shame used to prevail. Strangely, the battle against opioids has broken down the isolation of households and encouraged community bonds.

Shot in the dark

An opioid overdose occurs when the drug attaches to so many "receptors" in a person's brain that his body forgets to breathe. Naloxone reverses this within seconds by knocking the opioids off the receptors. It offers no high, nor any other clinical effect on someone not on opioids, so there is no potential for misuse. But it can save a life.

The price of naloxone has been rising precipitously in the past few years. But it could still be manufactured very cheaply, according to biotech entrepreneur Michael Hufford. This is critically important because a person who has overdosed on a powerful synthetic opioid like fentanyl may need multiple doses to be revived. Sometimes emergency personnel revive someone in the morning only to be called back to do it again that night. Some counties have been running out of their entire month's supply of naloxone in a single weekend.

The public costs, and speculations that having naloxone around enables overdosing, have prompted council members at cities around the country to openly question whether naloxone should be administered

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to people who have overdosed multiple times. Something like a "three strikes" rule has been proposed—perhaps not entirely seriously, but in what Hufford interprets as "a desperate call for help." He has what he hopes will be an alternative.

Hufford, who has worked in drug development for many years, saw a presentation a few months ago by the director of the FDA's Center for Drug Evaluation and Research. The agency would like someone to bring to market a cheap, over-the-counter version of naloxone; the FDA had even gone so far as to pre-approve a draft label that a drug company could adopt. To his knowledge, says Hufford, this is the first time the agency has ever done that. Yet there is still no sponsor company.

So Hufford founded a new nonprofit drug company called Harm Reduction Therapeutics, with a mission to prevent fatal opioid overdoses by making low-price naloxone widely available. "I just kept thinking, someone has to raise capital, get regulatory approvals, find suppliers, line up retailers. I became convinced that the best way to do that in this case is as a nonprofit." If the model succeeds, Hufford sees a role for nonprofit pharmaceuticals in developing other therapies for unmet needs that serve public health.

Dr. Sally Satel, a psychiatrist and fellow at the American Enterprise Institute, is enthusiastic about the proposal. "Naloxone is the quintessential second-chance drug," she says. "Ideally, the person who is revived is shocked at how far she has let herself fall and how close she came to death. She enters treatment and embarks on lasting recovery. In truth, the scenario is often more rocky, but at least naloxone keeps someone alive.... The drug must be financially available to rescue personnel so they are not put in the awful position of allocating their budgets in a way that forces them to leave some lives unsaved."

"I don't care if I save someone 50 times," says Jan Rader, fire chief of Huntington, Kentucky ("overdose capital of the country"), in the recent documentary *Heroin(e)*. "That's 50 chances to get into long-term recovery."

Incrementalism in Indiana

So you've been brought back from the dead with naloxone. Now what? At this vulnerable moment, you might be receptive to drastic help. But most hospital emergency rooms, where you are likely to be taken, are not equipped in any way to tackle addiction.

"You can't just sprinkle naloxone on everyone and think this will get better," emergency physician Krista Brucker told AHA News. That's why Dr. Brucker and her colleagues at Eskenazi Health in

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Indianapolis created Project Point, which connects overdose patients to more lasting help. It assigns "recovery coaches"—former users stably living in sobriety—to come in and do an intervention, point the patients to community treatment resources, and be their support system going forward. Especially when there's a gap between the E.R. visit and the next available opening in treatment, as there usually is, recovery coaches help participants stay on track in the interim. Participants also receive hepatitis C testing and take-home naloxone kits.

Funded by the Richard M. Fairbanks Foundation, Project Point has already begun to change the way that doctors and patients interact. E.R. personnel used to seeing the same drug users on an endless loop express relief that "I can actually do something for them now." Patients are surprised and grateful that someone at the hospital is "taking the time to care."

Project Point is just a small piece of the Fairbanks Foundation's big push on opioids. Founded by broadcasting magnate Dick Fairbanks, the group focuses on health and education within greater Indianapolis. (The nearby Fairbanks drug and alcohol treatment center, though not a product of the foundation, is named for Dick's grandmother, Cordelia.) It gave Indiana University $20 million in 2009 to establish the state's first school of public health, which is now central to its strategy on the opioid crisis: Research. Prevention. Harm reduction. Treatment. All of this carefully evidence-based.

The foundation's president is Claire Fiddian-Green—previously an education policy adviser to then-governor Mike Pence. As the foundation was freshening its vision in 2015, the whole state was taking in a strange emergency: a sudden spike of 200 cases of HIV and hepatitis C in one rural county (up from one or two a year at most), caused by drug users sharing needles. Governor Pence went against his previous stance to allow for an emergency needle exchange, which brought the outbreak in Scott County to a halt, but in the ensuing investigation into causes it turned out there was almost no drug treatment available in the area—a prime opportunity for philanthropy to step in.

In her new Fairbanks Foundation perch, Fiddian-Green surveyed her region and heard the same thing over and again. One sheriff estimated that 80 percent of the people he locks up have drug or psychological issues. "When I got into this business I thought I was in the law-enforcement business. It turns out I am in the addiction and mental-health business." In response, the foundation helped create a Mobile Crisis Assessment Team to accompany police on 911 calls that involve drugs or mental disturbance. If the individual is dangerous he proceeds to jail, but if justice would be better served by diverting him into treatment, the crisis team is there to make that happen.

The foundation's other efforts include a program called Ascend Indiana that encourages workforce development, both by training new social workers specializing in substance issues, and thereby providing support to other workers dealing with addiction

so they can remain gainfully employed. Another Fairbanks grant contributes to quadrupling the capacity of a residential treatment program in the state for pregnant women and young mothers. It is also funding news coverage of the opioid epidemic, and sponsoring research aimed at producing statewide recommendations. Fairbanks has taken the lead in convening groups from the philanthropic, private, and public sectors to coordinate efforts.

The foundation's Ellen Quigley notes that there is strong interest in the opioid problem, "but not a lot of direction, not a lot of clarity around what needs to be done." Physician and economist Anupam Jena recently compared the opioid crisis to car safety, noting that there are now more fatalities each year from opioids (53,000) than from automobiles (37,000), and noting how many incremental efforts were required to cut the auto fatality rate in half in recent decades. "Think of all the things that we do to make sure people don't die from motor-vehicle accidents," he wrote in *The New Yorker*. "We have air bags, speed limits, cops giving out tickets for speed violations," many modifications in car design, and so on.

The opioid epidemic similarly calls for many, various interventions. It's bigger than the mechanical question of car safety, and more difficult than the other diseases to which it's often compared, as both the symptoms and solutions are directly related to behavior. All the more reason to cast a wide eye for opportunities to intervene, from the individual to the cultural.

"This issue hits education. It hits economic development and job training. There are medical aspects," says Fiddian-Green. "So there is a role for every kind of funder, regardless of focus area."

Renovating rehab

The world of rehab is a wild and woolly place. Because addiction treatment has developed largely outside of established medicine, there is a wide range of care and counseling practices, many with little to no medical component whatsoever, and no real common standards to refer to. People desperately seeking help for themselves or a family member are often flying blind in the face of conflicting information.

Enter the Laura and John Arnold Foundation, which has just launched a major new strategy to fill in the information gap about effective treatment. The Houston-based foundation is gathering evidence on what practices patients, insurers, and policymakers should look for to determine which methods are most successful. It is funding over a dozen projects aimed at improving treatment and measuring its outcomes. Work with a Johns Hopkins psychiatrist, for instance, will test a mix of medical therapy and family engagement. Behavioral nudges like small financial incentives are included in many of the projects.

One trial will put opioid users waiting for a spot in rehab or counseling on buprenorphine, a drug that tempers opioid highs while reducing cravings and withdrawal symptoms. The trial expands on a 2016 pilot study that showed 68 percent of subjects on buprenorphine staying free of illicit opioids over a period of 12 weeks, as opposed to 0 percent of subjects not on it. In addiction treatment, medication alone is not enough, but it does restore chemical stability so patients can focus on rebuilding other aspects of their lives.

The nexus between drug use and crime is a major interest of the Arnold Foundation. Seven out of ten prisoners today have a history of regular drug use. And of the estimated $193 billion annual societal cost of drug use, two thirds is crime-related. Arnold wants to see if treatments can be less expensive or more effective than imprisonment. Administering methadone costs $4,700 a year, compared to $24,000 or more for incarceration.

"Our goal is to intervene at multiple points where we can change the direction of substance use," says program officer Julie Williams. Early treatment before users take up criminal activity, diversion from prison into treatment, treatment within prison: At every one of these junctures there is an opportunity to turn a life around, save money, and improve society.

The Arnold Foundation is also supporting some experiments in harm reduction "too difficult for government to fund." An independent philanthropy is able to try things that no public bureaucracy will. "Government does not fund innovation," notes Dr. Paul Jarris, chief medical officer of the March of Dimes. "Federal funds support ideas from ten years ago." New ideas, risky ideas, and the experiments needed to test them out, have to come from elsewhere.

Williams doesn't expect all, or even most, of the Arnold Foundation's trials to be resoundingly successful. Some will work, some will not, most will probably yield mixed results that will suggest new angles of study. The point is to try things and gather evidence, in an area full of gaps and uncertainties, and then use it to benefit society.

But sometimes even the clearest lessons are hard to implement. When Dr. Jarris served as health commissioner of Vermont he tried to expand methadone treatment into prisons, but was rebuffed by his counterpart in corrections. She told him, "We can't offer treatment in our prisons, because there's no treatment outside of prisons. If we offer it, people will be getting arrested to come into prison to get their treatment."

In talking to people for this story, I heard many funders and others in the field voice their wish that "getting treatment should be as easy as getting heroin." There's one kind of treatment that is.

The communal cure

It's a Thursday night in suburban Maryland, and the place to be is a church basement. Coffee and pamphlets stand at the ready in the corner. In the center

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of the room, votive candles flicker on a plastic cake tray, and the overhead fluorescents are dimmed for an intimate atmosphere. Strains of handbell choir practice drift down the stairs, creating a faint angelic soundtrack to the testimonies that are shared.

"Hi, I'm Dan, and I'm an addict," says the group discussion leader. "Hi Dan!" the crowd chimes in. Welcome to Narcotics Anonymous, or Never Alone, as some like to call it. (For confidentiality, names and identifying details have been changed.)

The theme this night is responsibility. A couple women speak of how they've slowly built up their lives again after years of stealing, hustling, going to prison, and burning bridges with everyone they knew. The ups and downs and stresses of life never go away, notes a participant, but being sober lowers the intensity of problems and makes them more surmountable. "As the quality of your life improves, the quality of your problems improves too." This resonates with other storytellers, who speak of slip-ups and setbacks and encouragements to get back on track.

A young guy shares his piercing regret that he didn't step up for his daughter while she was alive, and how it hurts him to the bone that he can never make it up to her. But knowing "there's another angel up there looking out for me" gives him the strength to go forward, get his life together, and try to be of service to others in her place.

The woman next to him hesitantly lifts her head. Her whole body is trembling, and she speaks barely above a whisper. "I'm Mary, and I'm an addict." ("Hi Mary!") She is three days clean. She has been detoxing alone at home, and this is the first time she's been out of bed since the last time she used. It took all of her determination just to get here tonight, and she's afraid, because she doesn't believe that the Twelve Steps can help her. But she has absolutely nowhere left to turn. She's lost her entire family, can't hold a job, and is about to be evicted from her home. "I don't know how to be anything other than an addict, and that scares me. I'm just tired of feeling so alone. I just can't do this anymore. But I think I'm more scared of not having that crutch in my life, and I don't know what to do with that, so… here I am."

She is not the only person crying. "We love you!" someone calls out. Other people share how they felt when they were in her shoes not so long ago: Coming to meetings "was really excruciatingly uncomfortable and scary and I wanted to f*****g die. Hearing, being around you guys, it was really, really bad. But alone? It was actually worse. So I would go to meetings." A resident of a nearby treatment center says there's an opening if Mary wants to come with her today, and explains how much the program there has done for her. At the end, several people come forward to embrace Mary. She looks blank and spent. I wonder if she'll ever be back.

Some version of this scene plays out in tens of thousands of locations across the country every day. Walk out your door and chances are there are meetings a few minutes away. A.A. (which is focused on but often not limited to alcoholics), N.A. (which welcomes all drug addicts), and other variations further broken down by drug or problem are a giant brother- and sisterhood hiding in plain sight.

There are so many forces pressing on us from above and below as we try to make our way through life. Economic swings, laws and policies, commercial incentives, social pressures—things that prime us for addiction and bring substances into our path. And deep inside us there are hidden influences of tiny molecules and genetic predispositions—things that, once the disease of addiction takes hold, seem to acquire an inexorable agency of their own. In between these forces out of our reach there are the personal choices that still give direction to our lives. The Twelve Steps help followers regain this power—ironically, by surrendering control (the first three steps). As the steps go on, they follow a moral arc from hopelessness and guilt to responsibility and grace.

Much modern discussion of addiction has run away from the idea of moral struggle. In efforts to make drug treatment more standard within science and medicine, or to nullify stigma, many health professionals and advocates recommend neutral terms like "substance use disorder," and warn against words like "addiction."

There's nothing wrong with making it as easy as possible for people to seek help without discouragement, but it is striking how far away that cool, clinical language is from what Twelve Steps participants say and think among themselves. People identify themselves every time they speak with the word "addict," and commonly refer to their life histories using words like "shame." From this vantage, being harmed by judgment from other individuals or institutions is often the least of their injuries, real though it may be. Their biggest burdens seem to be painful memories of their own actions they carry around inside, until they are able to dispatch them by working through a framework of admission, responsibility, and forgiveness.

This process of spiritual regeneration, not to mention the difficulty of gathering data on anonymous participants who come and go inconsistently, makes A.A. inherently elusive to scientific study. That hasn't stopped some researchers from trying, with their conclusions ranging anywhere from 5 to 90 percent effective. Millions of people fervently testify that these small mutual-support groups and their principles transformed their lives after nothing else had. Others, though, are never able to connect.

Twelve Steps programs sprout and grow regardless, ubiquitous and virtually free. Each chapter is self-directed and self-sufficient, passing a hat at the end of every meeting for a few dollars to meet its incidental costs. There are groups for teens and groups for seniors, groups

geared to professionals and groups of homeless people. Most groups, though, erase all such distinctions and focus on commonalities rather than differences.

A sticking point for many people is the quasi-religious character of A.A. Though often held in churches offering free space, the movement styles itself as "spiritual but not religious," and emphasizes that the Higher Power it references is wide open to interpretation. As one book on the principles of A.A. puts it, "Your Higher Power could be the unknown force that created the universe…. Maybe it's the beauty and wonder you see in nature, or the power of your A.A. group's love and acceptance. It can simply be something that is unknown, but has the opposite energy of what threw your life off track in the first place." The important thing is that "a person needs to gather strength from something outside himself in order to heal."

In her memoir *Lit*, Mary Karr writes of struggling to wrap her head around a Higher Power and how her sponsor made the same point about the wisdom of the group. Here, she told Karr, "are a bunch of people. They outnumber you, outearn you, outweigh you. They are, ergo—in some simplistic calculation—a power greater than you. They certainly know more about staying sober than you."

The twelfth and final step calls for those who reach balanced sobriety to give back, carrying the good news of healing to others. Sponsoring another member is a very common way to do this, and it is not just a formality, but a rigorous and intimate relationship involving frequent check-ins and close involvement, potentially at any time of day or night.

Other acts of service include taking on leadership roles within the group and going into hospitals and prisons to speak with addicts there. Many such missionaries describe these activities as the most meaningful of their entire lives. "With the exception of organized religion, Alcoholics Anonymous probably represents the largest program ever conducted to improve self-control," marvel John Tierney and Roy Baumeister in *Willpower*.

Characterized as it is by the intensive dedication of millions of people to each other's welfare and improvement, day after day and decade after decade, A.A. is one of the all-time greatest examples of micro-philanthropy. Yet even A.A., which is everywhere, isn't enough on its own. If it were, there wouldn't be an opioid crisis today.

The Minnesota meld

The Twelve Steps came to be the backbone not just of free-floating support groups but also of many institutional rehab programs. A little sanitarium for alcoholic priests sped this along. In 1947, the Catholic archdiocese of St. Paul and Minneapolis joined with local business leaders to provide seed funding for a treatment program for clergy and other professionals. Banker Richard Lilly became interested in the project after driving his car off a bridge and surviving the 120-foot fall. He purchased a farm called Hazelden north of the Twin Cities where alcoholics could get treated before reaching a point as dangerous as he had.

Hazelden's founders, sobered alcoholics, made A.A. central to the treatment program, adding professional counseling and health care to supplement the Twelve Steps. This multidisciplinary approach, combining spiritual and medical treatments, became known as the Minnesota Model, which the growth of Hazelden popularized across the rest of the country.

Today, Hazelden is the largest nonprofit treatment provider in the U.S., with 16 locations serving 19,000 patients every year. And its influence extends well beyond those who walk through its doors. Its publishing house is the largest dedicated to alcohol and drug use, indeed the largest self-help publisher of any kind. The nonprofit produces curricula for hospitals and schools. It runs a master's program in addiction clinical work. It has an education and policy arm (created recently with support from the Mary Christie Foundation) called the Institute for Recovery Advocacy. Because of its large patient population, it has advance data about drug problems gaining traction in different parts of the country long before they make the news (meth in the 1980s, opioids a few years ago), and can use that data to help other agencies respond more rapidly. Hazelden sets the tone for many other treatment programs.

Thus it was big news when, in 2012, the group announced a major change in policy: its centers would use medication to treat opioid addiction. Though its treatments had previously included medication during an initial detox, Hazelden had for many years espoused the "abstinence rule," prevalent in much of rehab, that sobriety achieved with the help of pills was problematic. But staff realized that their opioid-addicted patients were relapsing at high rates within a few days of getting out.

Getting out of treatment is the most dangerous time for an opioid addict. If he does relapse, he will likely give himself the same amount he had been taking before, yet his body's tolerance will have gone down, putting him at higher risk for overdose. Though the occasional relapse is now accepted as common on the road to recovery and not a sign of instant failure, these were happening very rapidly and with fatal consequences. So Hazelden changed course and allowed limited and temporary use of medications for opioid treatment.

Hazelden's $186 million annual budget is funded mostly through patient fees and publishing revenue, but it has an active donor base, many of them people who have been touched by the group's work in some way. While nine out of ten patients come in with insurance, donations provide scholarships for those who don't.

In 2014, Hazelden made headlines when it merged with another big name in addiction treatment, the Betty Ford Center. The former first lady had struggled

> Treatment is just the beginning. The real healing takes place when people get connected to others in long-term sobriety who have dealt with the same issues.

with pills and alcohol in secret until her family guided her into treatment. Addiction treatment became a hallmark of her later life, and she raised money for a rehab ranch in California. Founded in 1982, it turned around the life of one man who then helped drug and alcohol users across the American West.

The foundation of second chances

The work-hard, play-hard cable titan Bill Daniels seemed to be everywhere at once during much of his business career. Then one day, he was nowhere. A search party ultimately located him on a bender in the desert. Friends and family ushered him into rehab at the Betty Ford Center in 1985. Daniels would never take another drink.

Unlike common practice for public figures of the time, he was forthright about his struggles. He mentioned his recovery at every opportunity, and often paid for others to get treatment. "I enjoy giving people a second chance," he said. "I know a little about that."

The Denver-based Daniels Fund, his billion-dollar foundation, continues this tradition by granting second chances of all sorts: Turnaround scholarships for non-ace students. Job retraining for those whose careers came to a dead end. Supportive services for homeless, disabled, or otherwise disadvantaged people trying to achieve more independence. And funding for drug and alcohol users covering the whole gamut from prevention to treatment to recovery.

When rehab patients walk out the door after 30 days or so of treatment they can be vulnerable. Without ongoing support many will fail. "The recovery community is really where a lot of the healing takes place," says Owen McAleer, the Daniels Fund's program officer on drug and alcohol addiction. (Like other foundations with longstanding substance-issues portfolios, Daniels deals with all addiction but has seen a major uptick in opioids.) "When people are using drugs and alcohol to excess, a lot of times they are self-medicating because their life is painful. Treatment is just the beginning. The real healing takes place when people get connected to others in long-term sobriety who have dealt with the same issues, such as job loss, fractured families, trauma from childhood, and PTSD." He quotes the addiction psychologist Bruce Alexander: "The opposite of addiction is not sobriety—it's connection."

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The good news is that while there are 22 million people in America struggling with drug or alcohol addiction today, there are 23 million living in active long-term recovery. Connecting those two groups has great value.

The Daniels Fund supports Phoenix Multisport, an outdoor adventure and fitness program that brings together newly sober individuals to build relationships with each other while they achieve physical goals. The phoenix is a bird reborn from ashes, which is how many recovering individuals feel. In A.A., members commonly refer to the date of their sobriety as their "rebirthday."

The Daniels Fund has also helped start charter high schools in Colorado Springs and Denver specifically for teens in recovery. And in what McAleer calls its biggest move yet, the foundation is bringing to Colorado a program called Face It Together that does long-range addiction management. It helps patients navigate the early, bewildering stages of beginning treatment, then stays with them for years beyond that, assigning peer mentors and connecting them to resources in recovery. This includes supporting their employment. "Every person who has suffered from addiction needs strong, productive work in order to feel better and provide the financial base to address other life issues," says McAleer. "Work is central."

To this end, Face It Together engages the business community. It offers employers an addiction-services subscription that can save them money in the long run by reducing employee turnover and training costs, and increasing productivity. A lot of companies today can't find or keep enough workers able to pass drug tests, notes McAleer.

An epidemic that coincides with areas hit by heavy job loss has created a secondary effect that damages employability even when jobs are available. Princeton economist Alan Krueger recently suggested that as much as 20 percent of the decline in men's labor-force participation from 1999 to 2015 could be associated with the rise in prescription opioids during that time.

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The Daniels Fund also supports Step Denver, a residential program that brings men from homelessness through recovery, employment, and independent living. The foundation also supports the prevention program Rise Above Colorado, which brought the Meth Project (the campaign of public-service warnings started in Montana by donor Tom Siebel) to its own state; funds regional treatment centers; supports policy research at the Hudson Institute; and, along with Face It Together, is developing a toolkit for rural communities to assess their needs and make plans for addressing drug use.

A fresh start

Before it spread to Colorado, Face It Together debuted in Sioux Falls, South Dakota. It was created with support from donors like Ashoka, the Bush Foundation, Kevin Kirby, the United Way, and several local health systems, including the Sanford Health network.

Sanford Health, the largest nonprofit rural-health system in the country, was created with $1 billion in gifts from Denny Sanford. One of its interests these days is battling drug use across the northern Great Plains. At its location at Bemidji, Minnesota, it is hosting an experimental program called First Steps to Healthy Babies that is already being heralded as a model for other hospitals. In its pilot phase, with a grant from PrimeWest Health, it yielded a 10 percent decrease in referrals to foster care for newborns—at a time when foster care was rising exponentially in surrounding

areas. Opioid addiction, especially in areas like two nearby Indian reservations, is driving the foster-care problem.

A baby withdrawing from his mother's drug addiction while pregnant would ordinarily go straight into fostering, but at First Steps to Healthy Babies (which resembles similar programs supported by the Fairbanks and New Hampshire Charitable foundations and others) the mother receives simultaneous drug treatment and parenting support instead. As long as she complies, she gets to keep her child. Pregnant moms with an addiction are often afraid to seek treatment or even basic prenatal care for fear of losing custody. This program enables them to receive both. Many services wrap around to support them, including volunteers who help take care of the infants during withdrawal.

Gladys Nicol, a retired nurse and now great grandmother, has soothed her share of babies. She loves to talk and sing and snuggle with the newborn patients as they work through their painful symptoms, providing human comfort while their moms are healing and attending treatment nearby. Over her tenure, she's seen the number of drug-affected babies in the hospital nursery decline noticeably, occasionally to none at all.

One day, Nicol was running the front desk at a food bank when in came a mom and baby whom she recognized from their time in the hospital months before. The mom was glowing, and the baby looked very well cared for, but he was having a baby moment and "yelling his head off." As soon as Nicol spoke to him, he snapped to attention and looked straight into her eyes. "Then pretty soon here came a tiny little sort of a smile, and then it got big, and then finally a great big million-dollar smile." She is certain he remembered her from all those days of rocking, cooing, comforting, and what they had been through together. Out of that dark time, she was heartened to see that both he and his mother had been granted a fresh start.

The journey ahead

Back in the 1980s, before many of today's opioid casualties were even born, another scourge was starting to spread—confounding medical providers, rapidly killing off its victims, and leaping out of a particular subculture into public consciousness. The public did not know how to respond to this new threat, what came to be known as HIV/AIDS, until it had already reached epidemic proportions.

Irene Diamond was a donor who cut through the fog of panic and confusion with bold gifts that powered immediate action. She spent her husband's entire $220 million estate on research, and produced the world's earliest antiretroviral therapies as well as other clinical insights that helped turn around the AIDS crisis. From a peak of 43,000 deaths in 1995, 6,000 Americans died of the disease in 2014. While still a serious concern, HIV has become a treatable illness.

Government funding was eventually poured into HIV/AIDS, along the paths suggested by the Diamond Foundation's pioneering. Today, federal research spending for that malady totals $34 billion—$3,000 for each American living with HIV. By contrast, federal research on addiction today comes to around $70 for each American with a substance-use problem.

In the face of the opioid crisis, a handful of foundations are out there doing their best, but they can't conquer it alone. People are literally dying in the streets. Tens of thousands of children are growing up without their parents. It might seem like rock bottom, but it's still getting worse.

Addressing opioid addiction will be harder than AIDS, as it's more widespread and more driven by the complexities of behavior. This affliction doesn't have a single cause or a single solution. Any effort to combat it will bring many disappointments. Not for nothing is it called a disease of despair.

Leadership is needed. Philanthropy has often excelled in this kind of high-risk, high-innovation role. And every big effort has to start somewhere.

At the end of any Twelve Step meeting, chips are given out to mark sober anniversaries. First for those who have notched 30 days—often the most difficult month a person has ever been through. This achievement is appreciated with heartfelt applause. The ceremony continues—recognizing more months, then years. Each chip is a testament to acts of fortitude and moral transformation that were built up, as the program emphasizes, one day at a time.

Then at the end, each meeting recognizes what is described as the most important person in the room—the one who has just started the journey to a new life, and gone 24 hours clean. All that person has at that moment is a spark of hope. It can be snuffed out, or it can be fed.

Fostering and fueling such sparks, in many places and many ways, would be a grand charitable project. The best antidotes to despair, after all, are love, charity, and hope. P