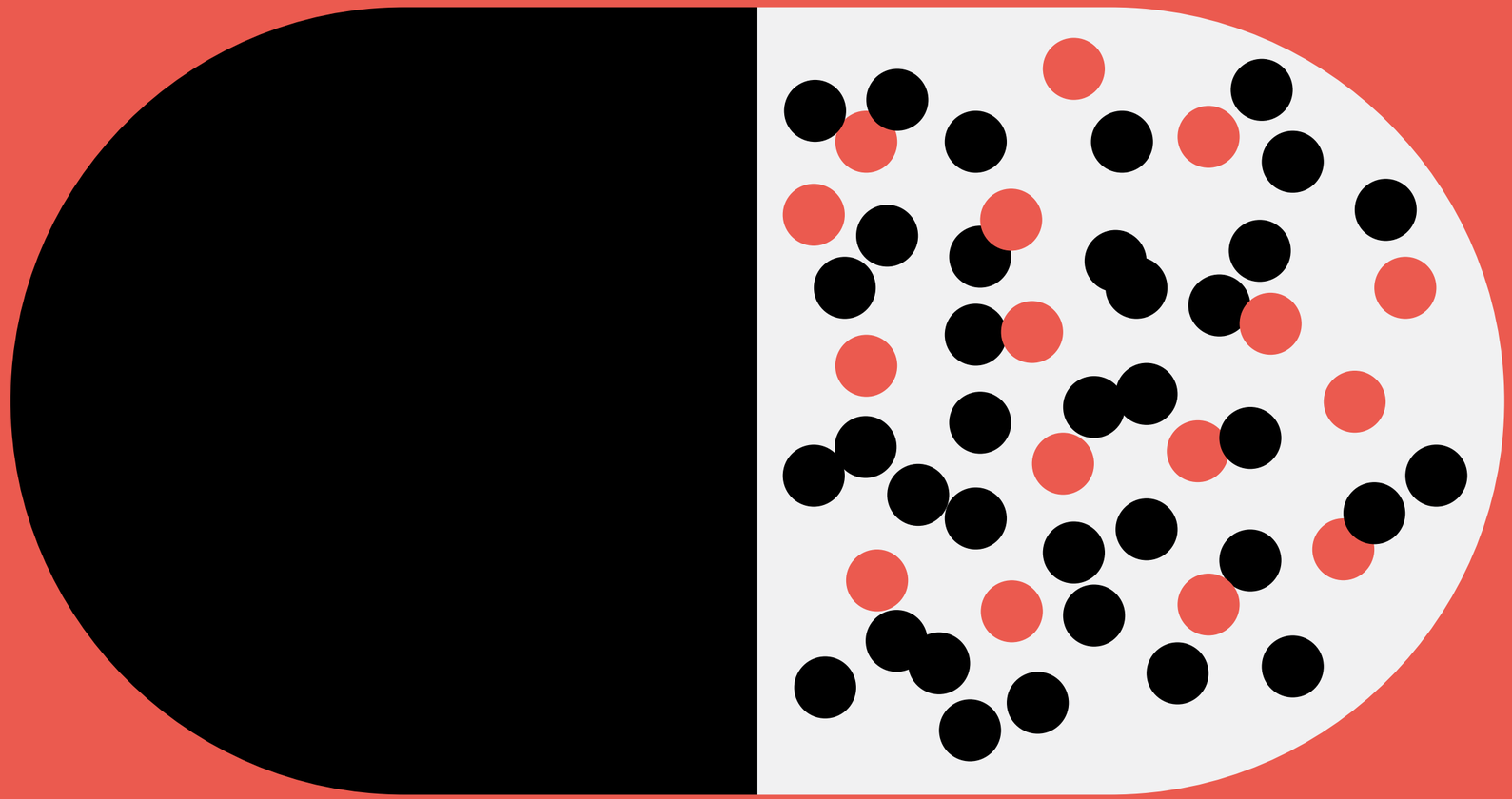
Miracle Drug?

Suboxone—a controversial drug for treating heroin and opioid addiction—gets its due.
By Mary Stone



Ryan Moore

Janet had a lot going on in her life when she became addicted to pain meds 14 years ago. She and her husband had just bought a new house; they were busy building a business together. She had their kids to care for, a sick mother across town, plus her own health problems.

It was 2003. Janet was struggling with painful cysts from endometriosis. After a series of surgeries, she asked for a hysterectomy to eliminate the problem. But at age 40, Janet was considered too young for the procedure and sent to a pain specialist instead. Days later, Janet walked out of his office with a prescription for a large bottle of Vicodin, and refills for many more.

"It didn't take long," Janet recalls. "I understand when people say, 'I tried something once, and that was it,' because it changes the way you see the world. Boy, things are a whole lot easier. At the time of my life when I was prescribed those, I was super busy. I was still doing some part-time bookkeeping for a real estate company I had worked for for years. I was involved in the kids' schools, I was in PTO, I was the treasurer of that; I was on the school board."

At first, Janet took the Vicodin as prescribed: two every six hours. And it worked. "All of a sudden, all of those things I was doing got a whole lot easier," she explains. "So, if I woke up in the morning, and I just didn't know how to get through the day, I would think, 'Well, I'll just take three instead of two,'" she says. "It just sort of sneaks up on you."

Because of the stigma that goes along with substance misuse, Janet asked that we not reveal her last name or where she lives. (Janet lives in a suburb of Rochester that could be any American suburb today, given the magnitude of the opioid crisis.) The shame and stigma she deals with have affected her throughout the course of her recovery, not just from society at large or the opioid addiction itself, but from the treatment she uses to help control her addiction: Suboxone.

Suboxone is the brand name for buprenorphine, a medication that can stop withdrawal symptoms and cravings as soon as the first dose. Scientifically, Suboxone is well-regarded for its efficacy as part of a medication-assisted treatment (MAT) plan, which is recommended to supplement ongoing counseling and therapy. Yet some in the recovery community, Janet says, wrongly think that using Suboxone means you're not truly "clean."

In Narcotics Anonymous, 'clean' means abstaining from anything that is mind altering, Janet says. Suboxone is not mind altering. People who have been through addiction (and therefore have an elevated tolerance) say they do not feel Suboxone. In fact there are fairly few common side effects. But it is a partial agonist, meaning it partially binds to opioid receptors. So, for some people who believe recovery requires total abstinence, Suboxone falls into a gray area.

"The stigma does remain in some of those help groups," says Jennifer Faringer, director of the National Council on Alcoholism and Drug Dependence for the Rochester area. But some groups are more open, she adds. "Now, in Monroe County, we have not one but three HA groups, that's Heroin Anonymous groups. Those groups are going to be much more informed and aware that Suboxone and methadone and Vivitrol (a once-monthly injection of naltrexone)—are medically assisted treatments that help people to sustain recovery."

"My husband really didn't like (Suboxone). He felt like I wasn't clean if I was taking it. He feels differently now," Janet says, referring to an especially painful relapse she endured when she tried to wean off Suboxone too quickly. They both realize now that she relies on this medication to help continue her recovery. In addition, Suboxone can help alleviate pain for patients like Janet who cannot use painkillers. Recently, her dentist consulted with Janet's addiction psychiatrist to prescribe a higher dose of Suboxone that helped inhibit pain from a recent procedure. Between ibuprofen and Suboxone, Janet says, she was able to stay almost pain free.

Suboxone doesn't work as well in isolation, Janet says. It has to go along with attending regular counseling, Narcotics Anonymous meetings and daily measures to keep her on her path. She just wishes she could be more open at her meetings when it comes to discussing her treatment. "(Narcotics Anonymous) isn't very fond of Suboxone," Janet says. At meetings, she chooses not to discuss medication-assisted treatment.

"A lot of people say it's an outside matter, so just don't talk about it. But then in the meetings people do talk about it," Janet says. "There's a part of you that's not really comfortable, but I look at it differently now. (Suboxone) has been a life saver. I'm able to live my life. I got over that stigma. I've recommended it to other people. I've been in therapy for three years and worked through some issues that I've had since childhood. I'll never say anything bad about this medication."

"We used to tell clients, 'If you find that problem, go to another (NA meeting),'" Faringer says. "Now, I don't even tell them that. I say, 'Go to a Heroin Anonymous group.' You're much likely going to get the level of support that you need with people that have been in your shoes and probably have or continue to take medically assisted treatment, and they'll understand."

"So many physicians and alcohol and drug counselors and family members and 12-step communities, like NA and AA, make people feel ashamed for actually doing gold standard treatment of care," says Patricia Halligan M.D., a Pittsford-based addiction psychiatrist. "If you ask the American Academy of Addiction Psychiatry, 'What is the gold standard treatment of choice for opiate addiction?' they're going to say medically assisted treatment. That is methadone, Suboxone, or Vivitrol shots."

Since 2000, physicians have been able to prescribe Suboxone from their offices—moving medication-assisted addiction treatment outside the clinic setting. Combined with cognitive therapy, regular Narcotics Anonymous meetings and medication, Halligan's patients have a far better chance at sticking with their recovery than they have without medication, she says. Halligan notes research showing the relapse rate with Suboxone at the three- to six-month mark, for example, is 50 percent compared with a 90 to 95 percent relapse rate without medication to quell cravings and stop withdrawal.

As promising as those figures seem, however, connecting substance users with long-term Suboxone treatment is exceedingly difficult. It's a topic people with opioid use disorders should be able to talk about with their family doctor, but most primary care physicians, Janet and others say, haven't got the first clue about addiction and treatment.

Suboxone treatment can be offered only by health care providers with special waivers. Physicians apply for the waivers from the Substance Abuse and Mental Health Services Administration, a branch of the U.S. Department of Health and Human Services. They take a mandatory eight-hour training, online or in person. In the Rochester area, too few of these qualified physicians have openings to treat the growing number of substance abusers who would benefit from Suboxone, Halligan says.

To expand the reach of medication-assisted treatment, President Obama in 2016 signed into law the Comprehensive Addiction and Recovery Act, which allows nurse practitioners and physician assistants access to the waiver, following 24 hours of training. But there is a mandated cap on the number of patients these caregivers can treat with Suboxone at the same time.

"People feel like nobody knows what to do (about the opioid crisis), and those of us that do know what to do are too busy saving one heroin addict at a time. I feel like I'm on a life raft with limited spots, and people are clamoring to get in, and the ship is going to sink if I let too many people on," Halligan says.

To Halligan, improving access to long-term Suboxone treatment is essential in dealing with the opioid crisis. That starts with qualified physicians. She wishes more doctors would seek the training, so more could benefit from the improvements she is seeing in her patients' lives.

"I have 85 people on Suboxone," Halligan says. "These are men and women that are professionals; they have jobs. They have kids; they coach their kids' extracurricular activities; they go to family functions; they go to AA meetings; they go to NA meetings. They have sponsors. They have hobbies, and they feel normal again. They don't drink, they don't smoke weed, and they don't take abusable drugs." All of those requirements need to be met in order for her to prescribe Suboxone, and it works, she says.

But the treatment has to be long enough to

move patients out of danger. This is the third problem, as Halligan sees it: The tendency of certified physicians and treatment centers to wean their patients off the medication too early. Sometimes due to clinic protocols or because insurance has reached its limit or because caregivers wrongly think they should, Suboxone is stopped too early—before people have a chance to get out the woods. For some, she says, that can take years or a lifetime.

Suboxone may be extremely effective at stopping withdrawals and cravings, but if patients discontinue treatment too quickly, the likelihood of relapse jumps to 95 percent.

Weaning, if it is done, must happen very gradually over the course of many months. Even then and under the best conditions, people struggle to stop Suboxone—as much as they do heroin or pain pills, Halligan says. But, advocates for Suboxone say, so would diabetics if they were trying to wean themselves off insulin. Diabetes and addiction both are chronic, long-term diseases that require long-term treatment. There is no reason, she says, that people in recovery cannot continue to take Suboxone for the rest of their lives—if that is what works for them.

"It's not just me that believes this," Halligan says. "The American Academy of Addiction Psychiatry, the American Medical Association, we all believe the same thing, that an opiate addiction is a chronic, relapsing illness, the same as diabetes, high blood pressure, asthma. So would we say to, for example, a diabetic: 'Well, you've been a whole year on insulin, and your blood sugars have been well-maintained. It's time to taper you off the insulin'?"

The changes to the brain in someone who has misused opioids can last years, or they can last a lifetime and permanently depress dopamine levels in the body. The structure and function of the brain changes. As an ongoing condition, continued medication-assisted treatment should be a foregone conclusion.

Halligan says some caregivers stop treatment too soon because of its stigma or their ignorance. It is especially frustrating, she says, that many physicians do not step up to deal with a problem that in no small part originated with over-prescribing painkillers in the first place.

More than 900,000 U.S. physicians can write prescriptions for painkillers such as OxyContin, Percocet and Vicodin, the Pew Charitable Trusts reports. But fewer than 40,000, or less than 5 percent, have the waivers authorizing them to prescribe Suboxone to patients who become addicted to those and other opioids, according to November data from the Substance Abuse and Mental Health Services Administration.

"Physicians created the pain pill surplus in this country, and if you take a look at heroin addicts, most of them started with pain pills," Halligan says. "Fifty-five percent of heroin addicts who started with pain pills, the pain pills came from friends' and families' medicine cabinets. So this isn't news; you've already heard these stats before. So we as doctors have created the problem. It's up to us to step up."

Moving addiction treatment to the doctor's office could be, and many say should be, part of a major shift toward treating addiction with the long-term attention it requires. The problem, experts say, is the stigma that physicians have about treating addicts and how much time and effort those patients require. Holly Ann Russell M.D., says that view is wrong: Working with this group of patients is exceptionally rewarding.

"I think (Suboxone) is a miracle in medicine for some people. I have spoken to so many people who have said, 'I didn't think I was going to be alive to this age. I didn't think I was going to make it past 24.' It brings tears to my eyes when I think about how transformative it can be," Russell says. "There are very few things we can do in primary care that can make such a difference for people and so immediately. We have so many patients who have been reunited with their children who were taken away when they were actively using."

Russell is an assistant professor in the University of Rochester Medical Center Department of Family Medicine and co-director of the Medication Assisted Treatment Program at Highland Family Medicine. She teaches Suboxone treatment and is part of a grant to educate other primary care doctors on how to prescribe Suboxone for opioid use disorders.

As a result of this treatment, her patients are going back to school; they are going to college, she says. Some are studying to become addiction counselors.

"It's transformative, and from a primary care doctor's perspective, it is one of the few things we do where I know I am really making a difference for patients in a major way," she adds. "Yes, maybe (with an average patient) we can be preventing a stroke in 10 years, but when I'm writing a script for Suboxone I'm potentially saving a life that day. It's a completely more immediate feeling of service to the community."

In general, however, the curriculum at medical schools does not include addiction treatment. "We still have so much stigma around addiction," Faringer says. "It's not understood, it's not part of their training. In medical school, if you get six hours on addiction, that's a lot."

Slowly, that is changing, Russell says. "I think it's happening in a handful of family residencies now, but it's certainly not universal by any stretch," she says. The University of Rochester offered Suboxone training as an elective three-and-a-half years ago. No one signed up for it, in part because residents are extremely busy, she explains. But the school considered the training important enough to make it mandatory.

The training includes working in an office with professors and doctors in the community treating patients with Suboxone. Feedback from students has been universally positive. A lot of them, Russell explains, had the wrong idea about treating these patients, in part because their exposure to addiction is in the hospital when people have overdosed and are at their worst.

"Many of the residents—and I think this is true for a lot of primary doctors too, not just residents—they have a lot of preconceived notions about what treating patients with substance abuse disorders looks like and how complicated that might be or challenging that can be. They don't want to treat 'those patients' or have them in their offices," Russell says.

Russell's patients come to her after they have graduated from a chemical dependency program and need a place to land for their long-term medication maintenance. This is called a warm handoff, and it's essential to keep people, fresh from treatment, on track. Unfortunately, there are too few physician offices where people can go for their long-term treatment, Halligan says, and most of those practices that are qualified to treat them are not accepting new patients.

Russell believes that primary care physicians absolutely should treat addiction. Old school doctors, she says, might not agree, but younger ones generally do.

"We are experts at managing chronic disease, and if you believe that addiction is a chronic disease—which you should—then the long-term maintenance should be managed by primary care physicians, I feel very strongly," Russell says.

Critics of Suboxone say that some patients might try to use it to get high, or turn around and sell their pills on the street. But Suboxone contains naloxone, an opioid antagonist that not only prevents a high, it induces immediate withdrawal. The naloxone is inactive if the medication is used as prescribed. If it is crushed up, for example, and injected, the naloxone is activated.

On the street, there is a market for Suboxone, Russell says, but that is because there aren't enough channels for people to obtain it legitimately.

"People sell their Suboxone oftentimes to get money to buy other drugs, so I think that is one thing that people are worried about," Russell says. "Suboxone that is sold on the street is to help people who don't want to get high and want to prevent withdrawal. So there are people in the addiction world who think that even if Suboxone is being diverted to the street, it's still helping somebody. It's not that I'm promoting that in any way, but there is very low risk to someone who is taking Suboxone without a prescription. In fact, I much prefer they do that than take heroin or any other opioids. It's extremely safe and nearly impossible to overdose on Suboxone."

"Mandating Suboxone training can lead to a shift in how addiction is treated in years to come."

Mandating Suboxone training, Russell says, can lead to a shift in how addiction is treated in years to come. But she says it is up to medical educators, in primary care residencies and in medical school, to integrate addiction treatment into the curriculum. Physicians who have been in practice for many years may find it difficult to fold medication-assisted treatment into their existing routines. But by making it a part of a practice from Day 1, Russell argues, it may someday be common to find addiction treatment in primary care practices.

"Certainly, in Rochester, the family medicine residency, we are the major supplier of new primary care doctors in Rochester, and all of our residents are now required to at least take the course to get their waiver. We can't force them to get their waiver, but we can require them to take the course by graduation," Russell says.

"Through the exposure of our program and the really positive feedback that we've gotten, I'm confident that within a few years we will have many more primary care doctors who will be prescribing (Suboxone) as part of the primary care practice."

Janet was lucky enough to find an addiction psychiatrist willing to treat her long term. In addition, she has a daily routine designed to help support her recovery. She has reduced her responsibilities. She learned to say 'No,' even to her kids. She has learned to take the time she needs and to put herself first.

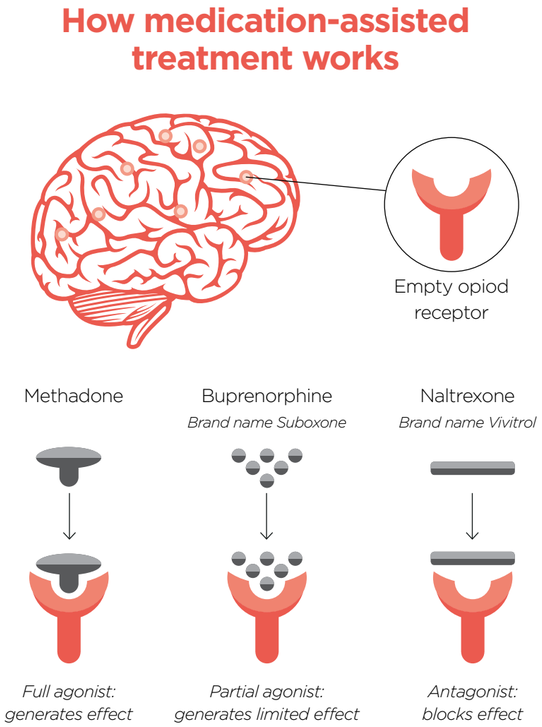
"Now, I go to a meeting, or I need 15 minutes every morning with my book. I take my time in the morning. Everybody knows," Janet says. "I think (my family) likes that I'm different, and they give me the space I need to do what I need to do."

The struggles and suffering addiction caused for her have actually served to make her stronger and wiser, she adds. "Addiction has given me gifts. I am a better person now. I'm way healthier now, emotionally, mentally, and even physically, than I was. A lot of that is due to my therapist and things I have been trying to do and even working the NA steps, taking time every day to see where I am in the world, which I need. I don't know that I would want to do it over. It was hard, but would I change anything? No, I don't think I would."

To find local providers of medication-assisted treatment, go to https://ncadd-ra.org and click on Resources.

Heroin Addiction

A Treatable Disease



For some people in recovery, Suboxone is considered a miracle drug, a lifesaver that can stop opioid withdrawals in their tracks and eliminate cravings within an hour of taking it. For others, it's just another drug to be dependent on.

Like methadone, Suboxone elicits a very divided reaction in the recovery community. Yet, unlike methadone, Suboxone is not a full opioid agonist; it cannot produce a high in addicts the way methadone does if it is misused. Still, some people in 12-step support groups such as Narcotics Anonymous believe people who use these medications to support their recovery are not completely clean.

That's what Joe used to think. A resident of Greece, Joe suffered an overdose in the 1990s that miraculously allowed him to kick heroin cold turkey with no cravings and no withdrawal. It was by the grace of God, he says. He has no other explanation. He was so grateful, the experience kept him from using again for more than three decades.

When his son became addicted to heroin a few years ago, Joe thought he should be able to stop using without the help of a partial opiate like Suboxone—until Joe himself relapsed two years ago and began the treatment too.

It was a back injury requiring painkiller prescriptions that drove him back to using. He was retired from his job by this time and buying Percocet on the street. He had a high tolerance, he says, and needed a lot to get high. Anyone who is addicted to heroin goes into withdrawal 24 hours after the last fix, Joe explains. For him, that last withdrawal started after a plane trip back from Miami Beach, where he had spent three days playing golf with buddies.

He was out of Percocet, so his wife seized the moment and made an appointment with a new psychiatrist the day after his return. By the time Joe got to her office, withdrawal was setting in.

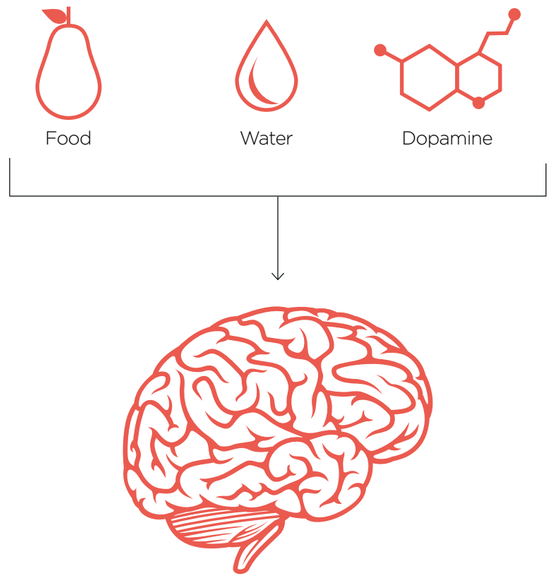
"How do I describe withdrawal? It's hard to describe other than the worst sickness you're ever going to have. You get stuff coming out of every orifice on your body. It's just a beast. It's as tough as anything I've ever felt, and it just doesn't go away until you get an opioid in your system. I don't know how else to describe it. It's just the absolute worst. The closest to hell as I ever want to be," Joe says.

That day the psychiatrist prescribed Suboxone, and Joe's wife drove to the pharmacy to fill it.

"I put it under my tongue, and within, I want to say it was within close to a half an hour, I was back to semi-normal," Joe says. "It's like—it's just like a magic wand, you know. If you can picture it, just have somebody just sick as a dog, you put it under your tongue, and within half an hour you're back to functioning."

Science

Neurobiology 101: Addiction and the Brain



"We need three things to survive [besides oxygen]: food, water and dopamine—and dopamine is the most important. If you deprive study subjects of water for three days, then put them in a functional MRI and place water on their lips, the relative size of the craving is like a baseball. Do the same with food, and it is like a basketball. Then take someone with an addiction to opioids, up to one year after their last use, and talk about OxyContin while they are in a functional MRI, and the relative size of that craving is the size of a baseball field.

"Why? Because dopamine is the chemical behind our drive to live and survive. It rewards us with feelings of pleasure, satisfaction and well-being when we pursue things that are good for survival. It punishes us with feelings of desperation, illness and hopelessness when we pursue things that are bad for survival. Our limbic system is fine-tuned to keep our dopamine levels between 40 ng/dL (a terrible day—when you can't get out of bed and can't get anything done) and 100 ng/dL (the best day ever—when you feel invincible).

"Long-term opioid use changes the system—sometimes permanently. The first hit of heroin brings dopamine levels up to 1,000. However, our brain is designed to keep us in balance—excess dopamine over time causes our brain to ramp up systems to get back to normal: less dopamine gets released each time, the number of dopamine receptors goes down, and the 'anti-dopamine' inhibition system ramps up and works in overdrive. Over time, the same dose of heroin or OxyContin causes less and less dopamine release, until the point where the brain can't get beyond 10 to 20 ng/dL without help. Daily pills or daily heroin is required just to feel normal. Functional MRI studies have shown that these brain changes take one to two years to recover, and in many people, after long enough use, the brain never recovers.

"This is why people are 14 times more likely to die if they don't use buprenorphine (brand name: Suboxone) or methadone for treatment. These meds stabilize the dopamine system and bring it back to normal, and since they are long-acting, they take people out of the cycle of withdrawal and craving.

"If our goal is to punish people and make them feel terrible, then we require abstinence, consign them to lives at 10 to 20 ng/dL dopamine levels, and judge them for not being able to get their lives together. If we follow science, data and math, we will use the treatments that work and save lives."

—Excerpt from a 2015 presentation for the California Health Care Foundation by addiction specialist R. Corey Waller M.D., medical director of the Center for Integrative Medicine at Spectrum Health Medical Group in Michigan

Opportunity

A Broken System

Due to desperate demand for addiction treatment and a system frantically trying to assemble itself in response, procedures, policies and deadlines aren't always efficient or even logical. And the time spent wading through them, waiting for a slot in treatment, can cost people their lives.

"That's been the call from the community: 'I can't get my loved one into treatment,'" says Jennifer Faringer, director of the National Council on Alcoholism and Drug Dependence–Rochester Area. "You know, they were hearing things in the past like, 'Sorry, there's nothing now. You'll have to wait three weeks' or 'You'll have to wait a month.' That's not acceptable. You wouldn't tell a cardiac patient, 'Yeah, hold what you got and come back in a month.' So we can't certainly do that with the disease of addiction.

"Especially one that's of this crisis level and proportion, because if someone doesn't get immediate treatment, their likelihood is very high that they go out and use again. They are way past the point of, 'Gee, I think I'll use today.' It's totally hijacked their brain," Faringer explains. "They have to use until they get help, and they might at that point have likely already substituted heroin. And then if they get a hold of a heroin bash where fentanyl has been added, that next use could be their last, and that's where there's been fatalities."

When people do overdose, if emergency responders arrive in time to administer naloxone (a medication used to block the effects of opioids, more commonly known by its brand name Narcan), they are put into acute withdrawal, explains Lori Drescher, a Rochester-based addiction recovery coach. She helps people dealing with opioid use disorders navigate the system and derive the most help they can. But in the emergency room, they don't get the help they could, she says. They are stabilized and within a couple of hours released in a state of severe withdrawal focused only on their next hit.

"What I think should happen is a peer should be called to come in and meet them where they are who can show them compassion and talk to them in the language that they know because they have walked in their shoes," Drescher says. "I'd like to see them get the opportunity to medically detox or at least begin to medically detox while they're in the ER. The thing that people with addiction fear more than anything is getting sick because the withdrawal is so horrible.

Such a scenario can't be forced, but if given the opportunity, they may say yes. "To me, that's just a huge hole, and it's low-hanging fruit," Drescher says. "Is it going to solve the crisis? No. Is it going to save lives? Absolutely."

Drescher and Faringer are members of the Monroe County Opioid Task Force. Caregivers, family members, local officials and others come together to develop solutions for the crisis. Improving immediate access to care has been the top priority. To that end, Open Access was developed. Located at 1350 University Ave., the center is in a building that houses several service providers, including a detox facility. It will be open 24/7 to direct people to addiction treatment services.

The state Office of Alcoholism and Substance Abuse Services provided $500,000 for renovations and operational costs for the center, which officials say is the first of its kind in the state. There, staff will assess people in need of treatment and refer them to the right level of care.

"Not everyone is able to seek treatment during normal business hours. This center will ensure that help is available at any time of day or night for people in need," OASAS commissioner Arlene González-Sánchez said in a recent statement.

Another improvement to the system in Rochester are walk-in evaluations. Three local treatment providers have stepped up to offer people with opioid use disorders days and times to come in for assessments, giving them a place in line for the first treatment slot that becomes available.

To help people with addiction cope long term, a recovery community and culture is forming for people to support each other beyond the four walls of an NA meeting. People need things to do, to feel passionate about, outside of drugs and alcohol, recovery coaches explain.

"In treatment … you essentially have to change everything: people, places and things, and people don't know how to do that post-treatment. It's really key that they do," says Sean Smith, co-founder of ROCovery Fitness. "For me, I know that hanging out in a church basement wasn't enough. I certainly appreciate the 12 steps. They certainly helped me in my recovery, but I needed more. You move a muscle, you change a thought."

ROCovery Fitness is a big part of the new culture emerging to support people in recovery. The nonprofit organization offers weight lifting, cycling, hiking, yoga, mediation and other sporting events for people looking to live sober, whether they're recovering from an addiction or not. People who participate can be at any level of fitness, but they must be sober for 48 hours before participating at ROCovery. The idea is to show people they have options, that they can still have fun and enjoy life sober.

"Sober doesn't mean it's the end of life, and you're no longer going to have fun," Smith says. But society at large would have people think otherwise. Alcohol, for example, is intertwined with sports. "You watch a boxing match, and Budweiser is right in the middle of the ring. You finish your marathon, you get a free beer at the end," Smith says. ROCovery wants to make sports accessible and safe without these temptations and pressures.

But for the opioid crisis to change, society must change as well, Smith says. "Until the community mobilizes more efficiently, we're not going to see any success. There needs to be more effort from schools, and at the state (level) to get the funding so we can get more people into treatment and provide more education to prevent it and help the kids out there who are suffering," Smith says.

To the average person, drug abuse is just an abstraction. If we don't have any direct or even indirect experience with heroin or opioid addiction, we have little more than an ill-informed concept of an emaciated figure on the edge of death, in the throes of withdrawal, unwilling to listen, cooperate or change. This is not always the reality, experts say, and more and more people are learning that first-hand when a loved one becomes addicted.

For these people, a complex reality emerges, one in which people with substance use disorders who do want help often don't get it fast enough because treatment facilities here are full, because there are too few qualified physicians to treat them, because insurance doesn't cover care, or because it's all too complicated to navigate when your pre-frontal cortex is paralyzed by addiction.

The good news is that there are medical treatments for people with heroin or opioid addictions; options exist, and attitudes about addiction are starting to change, Faringer says.

"If there's any hope around this particular addiction, the opioid crisis, if there's any hope at all, for the first time, I'm starting to see in people's faces an 'aha' moment," says Faringer, who frequently gives community presentations about addiction. "Almost everyone knows someone that's been affected by this: It crosses all demographic lines; it crosses all racial lines, economic lines, urban, suburban, rural.

"It's the kind of things we've been saying in addiction for decades. It's sort of hitting people now because it's crossed so many boundaries, and the likelihood of a fatality with this one is so immediate that it's gotten people's attention."