gave him the contact information for a man I knew who specialized in helping people with substance use disorders. At the least, he would have listened to Garrett and been able to direct him to the expert help I could not.

But like others around him, I didn't insist he make the call. It's not possible to say with certainty what would have worked for Garrett, but there are courses of treatment for adults addicted to heroin. Garrett didn't try them.

Medication-assisted treatment — such as methadone and buprenorphine (Suboxone) — paired with comprehensive counseling and behavioral therapy is currently the most proven treatment for adults with an opioid use disorder. It's backed by decades of research showing it can decrease drug use and reduce criminal activity.

People receiving medication and therapy, as opposed to just therapy or no help at all, are significantly more likely to live. As one study published in the journal Health Affairs concluded, "Mortality rates were similar for buprenorphine and methadone. By contrast, mortality rates were 75 percent higher among those receiving drug-free treatment [such as therapy], and more than twice as high among those receiving no treatment."

While no single approach is desired or successful for all patients, "if somebody has a heroin dependence and they did not have the possibility to be offered methadone or Suboxone, then I think it's a fairly tall order to try and get any success," Dr. Bankole Johnson, professor and chairman of the Department of Psychiatry at the University of Maryland School of Medicine, told the Huffington Post. "There have been so many papers on this — the impact of methadone and Suboxone. It's not even controversial. It's just a fact that this is the best way to wean people off an opioid addiction. It's the standard of care."

Yet only about one in 10 people with an addiction involving alcohol or drugs receives any form of treatment. Of those who do, few get any treatment backed by research, according to a five-year study by the National Center on Addiction and Substance Abuse, which questioned whether "the low levels of care that addiction patients usually do receive constitutes a form of medical malpractice."

Garrett's experience not being connected to treatment that worked for him is "the norm, not the exception," said Dr. Mark Publicker, an addiction specialist in Maine. "We know what works, and here's an example of a young man who never stood a chance of getting what would work," he said. "I can't imagine how fortune would have led him to get effective treatment."

Because of privacy laws, I know what Garrett's mom told me — that no one referred him to medication-assisted treatment.

If Garrett had been on medication, "in a good program, he would have been less likely to reoffend. Without any access to medication, without any evidence-based, science-based treatment, there was no way he was going to end well. His addiction could only progress. It wasn't like he was going to have a spontaneous recovery," Publicker said.

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What is not controversial in the medical community can be among the public. Even Garrett and his friends had their doubts about medication-assisted therapy, and held the common perception that taking something such as methadone was just replacing one drug with another. Their opposition seemed rooted in something more, too: a basic lack of faith in the systems set up to help.

Perhaps someone could have compassionately explained to Garrett that an opioid use disorder is a chronic disease like diabetes or asthma, requiring long-term treatment. Maybe that person could have clarified for him that, while medication and counseling were certainly inconvenient, they potentially could save his life. But when it really came down to it, could someone have encouraged him to trust the type of professionals who belonged to a system of care that had only let him down before and has legitimate struggles of its own?

Methadone maintenance therapy has been the standard of care for decades, but its delivery is less than ideal. Because it's a highly regulated Schedule II drug, it must be dispensed daily at special clinics, though some clients who show good progress can take home doses for several days. (Methadone used for addiction treatment is different than the methadone dispensed as pain medication.)

Some patients must travel long distances to get to the clinics; others don't pursue the medication because of stigma. Meanwhile, residents often oppose the clinics in their area. Even those in the medical and health community — many of whom were trained in abstinence-only treatments — may oppose using medication to help treat someone's substance use disorder.

What's more, many have misconceptions about the length of time a patient should be on methadone. The National Institute on Drug Abuse considers 12 months the minimum amount of time, with some patients receiving the treatment for years.

In Maine, methadone clinics have struggled. The state cut the clinics' Medicaid reimbursement rate in 2010 and again in 2012. At $60 per week per patient, they must provide medication, individual and group counseling, drug screenings, and educational and vocational assessments. The National Institute on Drug Abuse has determined it should cost an average of $143 per week to deliver quality services. Maine's reimbursement rate is among the lowest in the country.

To stay open, the state has allowed clinics to scale back on the level and frequency of therapy they provide. They once were required to have no less than one counselor for every 50 patients. Now they're permitted to have one for every 150 patients.

Publicker, who previously worked for Kaiser Permanente in Washington D.C., said he has seen patients manage their opioid addiction successfully with both medication and consistent therapy addressing the underlying issues in their lives. But in Maine, because methadone clinics get a "bundled-rate" reimbursement, Medicaid does not pay for both methadone and therapy obtained outside the clinic, effectively forcing patients to get counseling at the overburdened clinics that often struggle to provide enough therapy.

Daniel Pease, substance abuse program manager at Crisis & Counseling, based in Augusta, said he does not tend to refer patients to methadone clinics in part because it means they can't come back for outpatient counseling. Garrett, who told me he attended therapy at Crisis & Counseling, was therefore less likely to get a referral for methadone. Pease couldn't confirm or deny whether he was a patient because of privacy law.

Some also criticize methadone because they may see patients continuing to use other substances while on the treatment. But "the issue isn't that the methadone isn't working. The issue is they're not being provided with an adequate spectrum of care," Publicker said.

Suboxone is one alternative to methadone and can be taken at home — though it has to be prescribed by specially trained doctors who are allowed to treat a restricted number of patients. It's a lifesaver for many, but there is concern about its potential for diversion — where people with a prescription give or sell the drug to others for illicit use or to stave off withdrawal from other drugs.