The New York Times https://www.nytimes.com/2022/06/24/opinion/addiction-overdose-mental-health.html

OPINION

# Experts Say We Have the Tools to Fight Addiction. So Why Are More Americans Overdosing Than Ever?

**By Jeneen Interlandi**
Ms. Interlandi is a member of the editorial board.

Photographs by Kholood Eid

June 24, 2022

For most of his life, Harris Marquesano struggled to live inside his own skin. He was a sweet boy — affectionate with his parents, protective of his little sister and devoted to his friends. But he had more energy than he knew what to do with, and he worried almost constantly. In preschool, when his teacher had to have surgery, he was so distressed by her absence that he tried to take over his classroom, presiding over each playgroup like a tiny, anxious general. By junior high, he was acting out in earnest. Some of Harris's teachers suggested to his mother, Stephanie Marquesano, that he was just testing limits. But she knew it was more than that. "He was crawling out of his own skin half the time," she said. "Running around and acting out was the only way for him to manage that feeling."

In eighth grade, around the same time that he was diagnosed with A.D.H.D, Harris discovered marijuana. Substance use is especially dangerous for people with mental health conditions. They are much more likely to become addicted, and face a higher risk of overdose and other bad outcomes when they do. It's common for these disorders to occur together. Roughly half of those who have one also have the other. And it's crucial for them to be managed together, especially in teenagers whose brains are still developing, because they tend to amplify one another. But nobody explained that to Harris or his parents.

Harris was good looking and popular — a student council member and varsity soccer player — but high school was bumpy, in part because he could not seem to find the right kind of help. One psychologist discharged him shortly after he admitted to using marijuana, saying only that he was "too much" to handle. And in 11th grade, when his anxiety and drug use began to escalate, a psychiatrist refused to treat him. "He said he couldn't prescribe anything to someone using marijuana," Mrs. Marquesano said. "He told Harris to try Benadryl for his insomnia."

This advice struck Harris's parents as mighty thin gruel for a kid struggling with his mental health and veering into drug use. But before they could figure out what to do next, Harris was offered OxyContin at a party. In retrospect, his mother said, "that was really, basically, game over for us."

Harris Marquesano played varsity soccer at Ardsley High School in Westchester County, N.Y.

In the year and a half that followed, Mrs. Marquesano and her husband, Alan, shepherded their son through one inpatient psychiatric facility, two outpatient substance use programs and four inpatient rehabs. They also took him to psychiatrists and psychologists and 12-step meetings and the gym. None of it stuck.

Harris was trapped in a vortex: His anxiety and A.D.H.D. were driving his drug use, and his drug use was exacerbating his anxiety and A.D.H.D. None of the programs he attended seemed capable of addressing these problems together. His mental health providers would either ignore his substance abuse or use it as an excuse to refer him elsewhere, and his substance abuse counselors would do the same with his mental health issues. In rehab he would often be taken off prescription medications altogether, and instead of seeing a psychiatrist, he would be placed in "group therapy." Some of those programs flooded him with hollow aphorisms, others with tough love. But none addressed the internal struggle that was leading him to use in the first place.

"They keep telling me to remember life before substances," he told his mother during one of his inpatient stints. "But before substances, my brain went 1,000 miles an hour. Nobody is helping me figure out how to do things differently for when I get out." Less than a year later, in the fall of 2013, Harris died of an opioid overdose. He was 19 years old.

More people are dying of drug overdoses in the United States today than at any point in modern history. The number of yearly overdose fatalities surpassed 100,000 for the first time ever in 2021. Halfway through 2022, the rate appears to be rising even further (the latest numbers come out to about 300 people per day, or 12 people every hour, on average). It's tempting to see this crisis as the unavoidable byproduct of an unprecedented moment. Breathtaking drug industry malfeasance, soaring economic inequality and a world-shaking pandemic have conspired in ways that can make these kinds of deaths seem all but inevitable, and it's easy to imagine that such a wretched trifecta could not possibly have been anticipated, let alone prevented. But addiction itself is as enduring a part of the human experience as cancer, diabetes or Alzheimer's. In fact, it is at least as common as any of those. And our failure to treat it as consistently or as rigorously is not an accident. It is a choice.

In some ways, it's a choice we made decades back. By the time the American Medical Association recognized alcoholism as an illness in 1956, three deep fissures had already been carved between addiction, mental illness and virtually all other forms of sickness. Most health conditions were treated by medical doctors who were funded through health insurance, bound by a raft of regulations and held to strict professional standards. Mental illness was separate: accepted as a subset of mainstream medicine, but treated in separate facilities and not fully covered by insurance.

And addiction was something else entirely. Despite the A.M.A.'s pronouncements, most people continued to view it as a failure of morals or of willpower, a problem to be worked out with one's priest or probation officer. Addiction psychiatry became a distinct subspecialty only in 1993. Despite being one of the most common conditions listed in the Diagnostic and Statistical Manual of Mental Disorders (psychiatry's bible), few psychiatrists have been adequately trained to treat it. "It's been sort of orphaned," said Dr. Mishka Terplan, a psychiatrist and medical director of the nonprofit Friends Research Institute. "It still receives only a small fraction of the attention or resources that we devote to other common psychiatric disorders. And what it does get comes through completely different mechanisms."

Basic science and decades of failed policy have long since made clear that addiction is a legitimate medical condition — a chronic relapsing brain disorder, to be precise — and that it's often triggered (or exacerbated) by mental illness or by social forces like poverty and childhood trauma. But the systems by which this disorder is treated have yet to shift accordingly.

In June of 2012 — the year before Harris Marquesano died — the National Center on Addiction and Substance Abuse at Columbia University published a damning critique of the addiction treatment system. It was actually a "nonsystem," the authors wrote, as primitive and dysfunctional as the rest of health care had been in the 1900s. The risk factors for addiction were well understood by 2012, and some promising treatments had emerged. It was clear, for example, that anti-addiction medications could nudge people into long-term sobriety, especially when combined with talk therapy. But most doctors had not been trained to make use of that information, and a large majority of people who suffered from substance use disorders were still not receiving any care at all. For those who were, that care was haphazard at best, more likely to be ordered by a judge than by a doctor or therapist, not bound to any standards of quality or professionalism and rarely based on evidence about what worked and what didn't.

A decade later, critics say that very little has changed. "There is a substantial and very persistent implementation gap," said Dr. Sarah Wakeman, medical director for substance use disorder at Mass General Brigham. "We've known for a long time what works, but it looks nothing like what's actually happening."The causes of this gap are manifold and muddy. But the consequences are crystal clear: Lives that might otherwise be saved are instead being laid to waste.

In the days after Harris died, when Stephanie Marquesano was still raw and wild with grief, she found herself stepping directly into that void. What she really wanted was a do-over — a chance to go back in time to the very first signs of trouble with the benefit and burden of her own hindsight, so that she could save her son. Instead, she founded a nonprofit — the harris project — right at his funeral. She was adamant about avoiding what she describes as the clichés of the grieving parent turned advocate.

Stephanie Marquesano became an advocate for fixing the system that failed her son, Harris.

"I said, I'm not holding his picture up for the cameras," she explained one afternoon as we sat in her kitchen in Ardsley, N.Y. "I'm not using his story to shame or scare other kids who might be struggling." But she was determined to channel all the energy that she had devoted to Harris into fixing the system that had failed him.

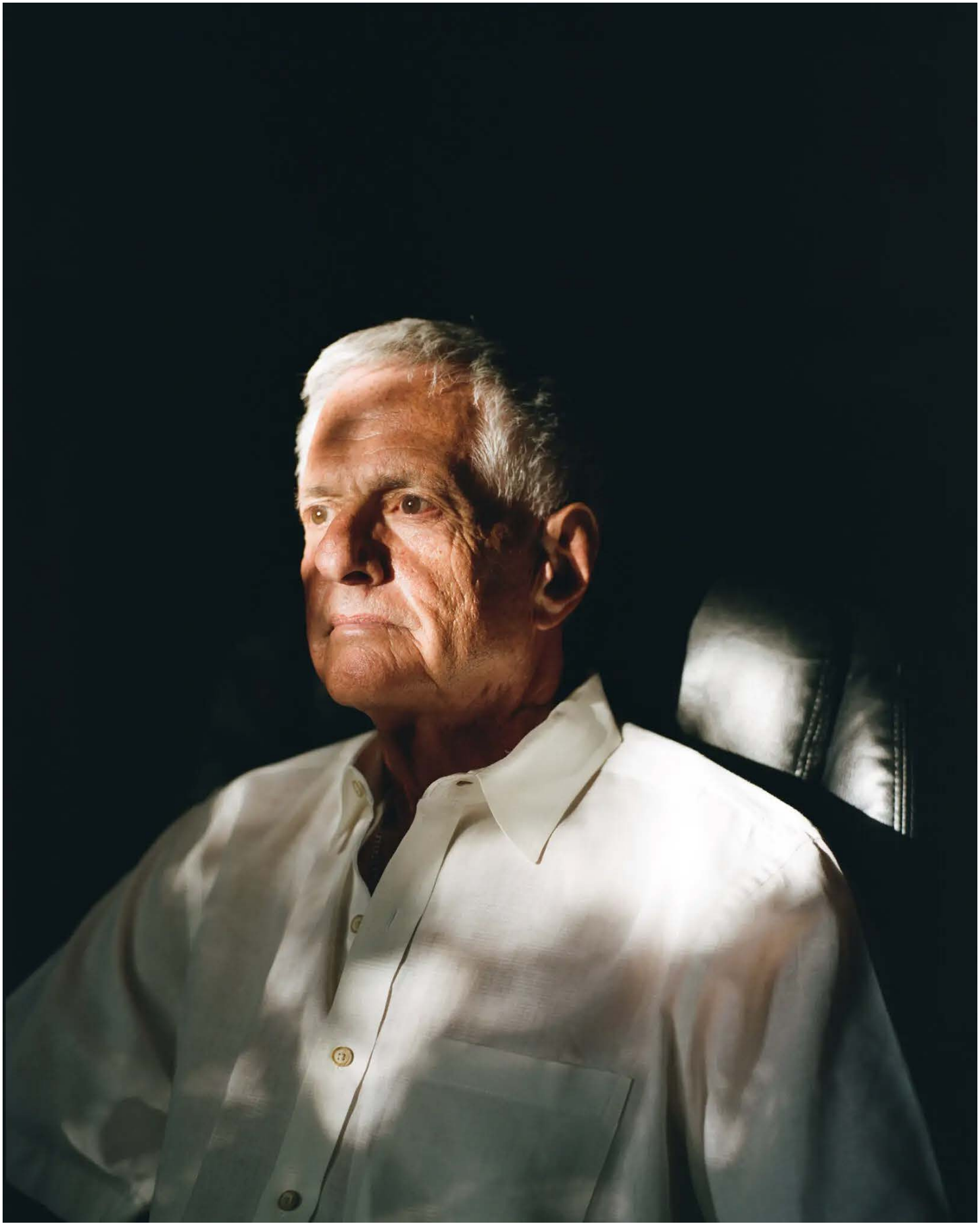
She started small, just the slide show Harris's friends had made for his funeral and a brief PowerPoint presentation that she'd take to school assemblies and mental health conferences. She found that giving even one such presentation — *This is what happened to my son, this is how the system failed, this is what we need to do differently* — could exhaust her for days. But she also discovered that people, kids especially, were interested in what she had to say. Eventually, the county mental health commissioner, Michael Orth, invited her to his teams' meetings to talk about the reforms she wanted to work on. Before long she was traveling regularly to Albany.

She met other parent-advocates there, who had weathered similar losses. She identified with their grief and their anger, but she couldn't help feeling that some of their aims were off base. "They were pushing to expand existing programs," she said. "I kept thinking, why would you push for more of something that doesn't work to begin with?" Despite ample resources and her own best efforts, Harris's care had remained haphazard — uncoordinated and disconnected from his actual needs — to the very end. Service expansion would not fix that. The whole system had to be changed, down to its bones.

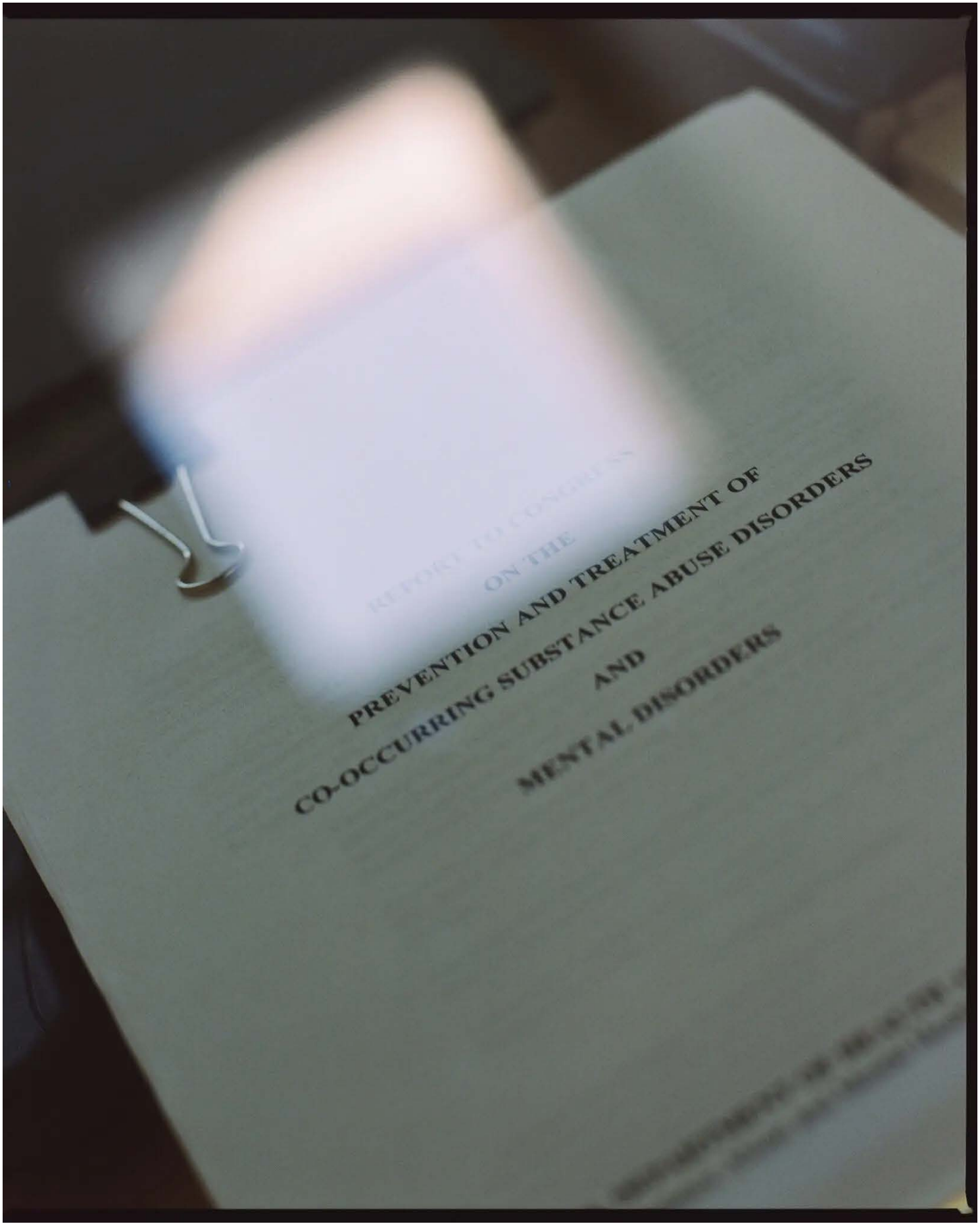
What struck me most about Mrs. Marquesano when we first met in January was how broadly she thought about problems at hand. Rather than latch onto any one project, she has made a mission of fixing addiction care in its entirety. She wanted to change everything from how agencies are structured to the way that clinicians treat their patients to what kids are taught in school. As a parent who took up advocacy in the wake of her son's death, she also represents a new and promising turn in the ongoing quest against addiction: For too long, families affected by substance use and addiction have been largely silent because of shame and stigma. In recent years, more of them have begun to speak out.

Mrs. Marquesano did not have a background in behavioral health, or in advocacy or in the special hell that was Albany politics. But she was a lawyer by training and an overachiever by nature, and she was certain that Harris would help her figure it out. She could still feel his presence, and it comforted her to think of them as a team: She would agitate for change on the ground, and he would light her path with signals from above. *Just tell me if I'm on the right track,* she would whisper to him whenever she felt nervous or uncertain.

Eventually, the mother of a boy who had been in rehab with Harris led her to Dr. Ken Minkoff, a psychiatrist who has spent the past few decades helping governments around the world reform their mental health systems. The problem, Dr. Minkoff said, is that too many systems treat people who suffer from both mental health and substance use disorders (what doctors refer to as co-occurring disorders) as the exception, when in fact they are the rule. They make up more than half of all people who seek treatment for one condition or the other. "You can't just create a few specialized programs for that many people," Dr. Minkoff said. "You need to structure your entire system with them in mind."



Dr. Ken Minkoff is a psychiatrist who has helped governments around the world to reform their behavioral health systems.




Dr. Minkoff has focused on the treatment of co-occurring disorders.

No one I spoke with disagreed with this premise. In fact, most policymakers, health officials and families described it as the gold standard: There should be "no wrong door" for a person like Harris. He should be able to walk into any mental health or substance use program, receive an assessment from trained professionals and be treated accordingly. If he suffered from more than one disorder — PTSD and alcoholism, say, or anxiety and opioid addiction — he should be able to address both of those in the same place, ideally with the same therapist.

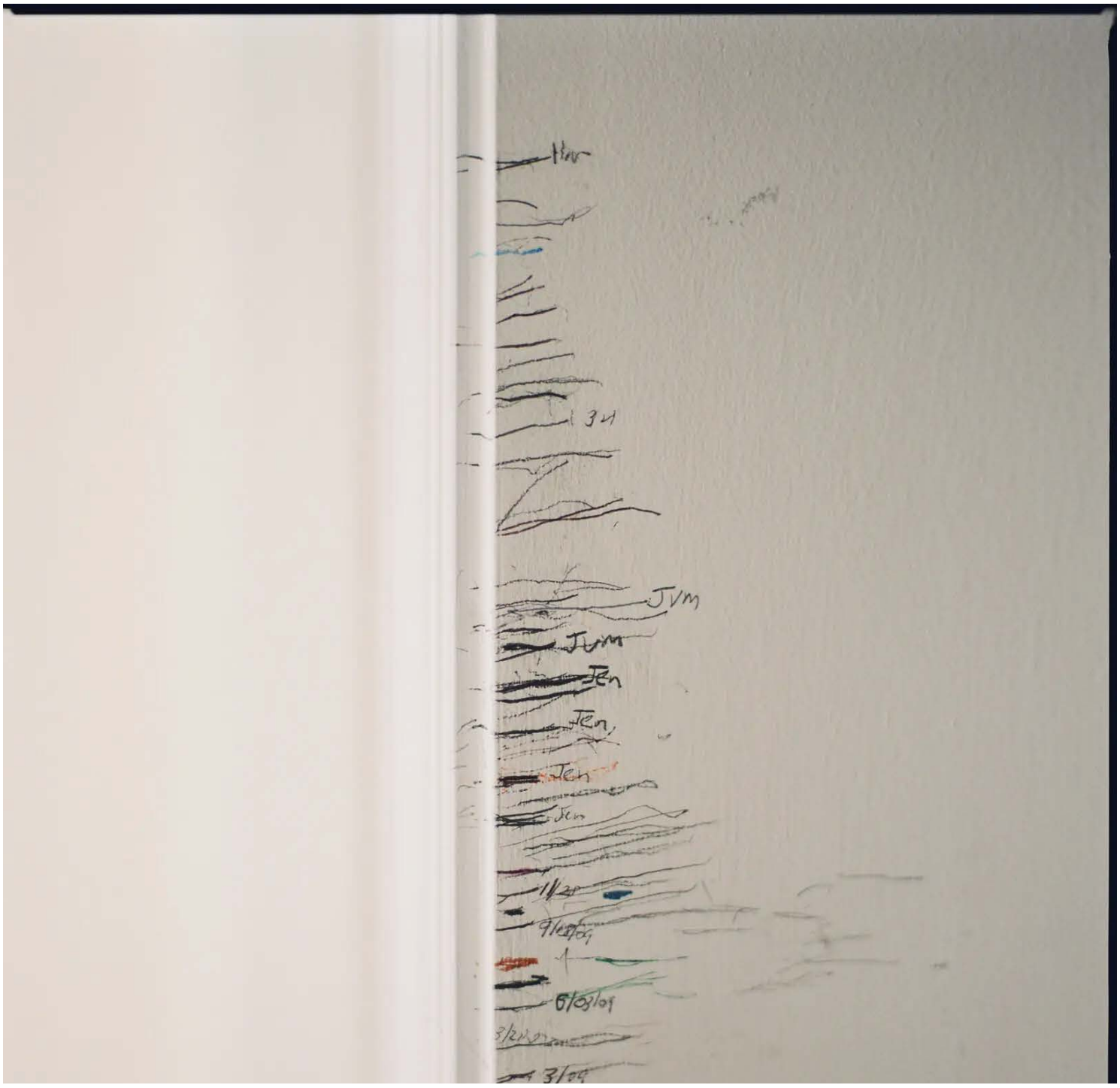
But a string of practical hurdles have made this philosophy almost impossible to put into practice. Addiction and mental health services are still effectively separate in many states. Clinicians accustomed to treating one are not necessarily comfortable with the other. And efforts to break these walls down have not yet come to much. The federal Substance Abuse and Mental Health Services Administration introduced several promising initiatives in the mid-2000s, Dr. Minkoff said. But those programs were terminated just a few years later.

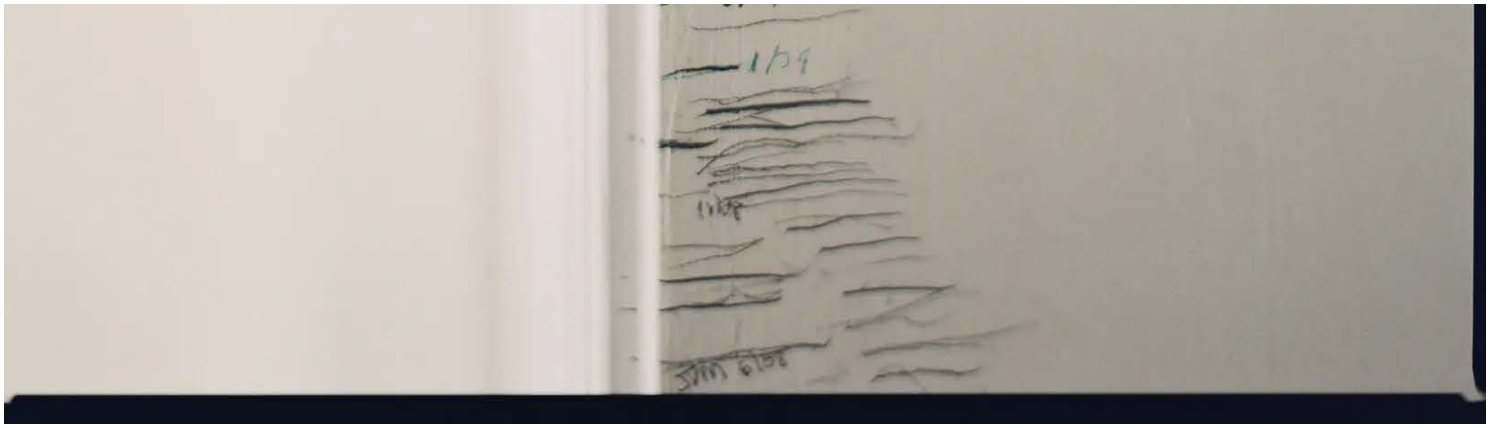
In New York, substance abuse and mental illness are still governed by two agencies — the Office of Addiction Services and Supports and the Office of Mental Health — each with its own licensing requirements, policies and funding streams. Clinics that are licensed by both agencies are expected to follow separate rules and meet a roster of separate regulatory requirements that can include separate financial records, separate medical records and separate physical spaces, depending on which condition they are treating in which patient. Most clinics find these strictures too time-consuming and expensive to deal with. As a result, most are licensed by only one agency or the other.

But clinics that have only one license face a different set of challenges. "We can only treat those patients whose primary diagnosis falls under our license," said William Mullane, clinical director of the Westchester Jewish Community Services, a nonprofit that runs several O.M.H.-licensed mental health clinics. Patients who are using substances but don't have a mental health diagnosis have to be referred elsewhere. If patients are using substances and do have a mental health diagnosis, Dr. Mullane's clinicians can treat them, but only if the mental health diagnosis is determined to be the main, or primary, cause of their symptoms. "It's a terrible policy," Dr. Mullane said. "It forces us to send people away who may be in crisis." When that happens, there's no telling where they will end up.

Patients who do manage to secure both forms of treatment must contend with repetitive evaluations that force them to recount the same traumatic stories over and over. They also face contradictory or incompatible treatment edicts, and logistical hurdles that can range from the inconvenient to the absurd. In one New York City clinic, for example, a former employee says that patients are allotted 20 minutes to discuss their substance use issues before being shepherded across the building to discuss their mental health in a separate room — sometimes with the same clinician, who has walked over with them. Other programs require patients with both mental health and substance use diagnoses to take each drug test twice, once for each agency. "You're taking the clients who already struggle the most and making everything twice as difficult for them," Dr. Mullane said. "They have a harder time making it to appointments and now you're asking them to go to two different places. They have a harder time doing the homework that treatment demands, and you are doubling that load."


Harris's bedroom at the family home in Ardsley.


JVM
JVM
Jen
Jen
Jen
Jen
6/03/04
3/04



Harris marked his and his sister's growth on the frame of a closet in his room.

In the worst-case scenarios, people with co-occuring disorders don't receive any treatment at all. "I have people trying to get help with their depression being told that they need six months of sobriety first," said Ashley Livingston, an advocate and a leader at the Friends of Recovery organization in Warren and Washington Counties. "And then I have some of those same people getting turned away from substance use programs because they have suicide ideation, even though that's actually a pretty common feature of opioid withdrawal."

New York's mental health and addiction offices have said that they work closely together and have pointed to a string of recent initiatives meant to improve the treatment of people with co-occurring disorders. These include overdose prevention in mental health clinics and a temporary waiver that enables some programs to provide care for all patients regardless of their primary diagnosis. But critics inside and outside the agencies say that those efforts have been too piecemeal to make a meaningful difference. "If you are not set up to serve literally half of the people you were created to serve, your model is broken," Mrs. Marquesano said. "A couple initiatives here and there are not going to fix it."

With Dr. Minkoff's guidance, Mrs. Marquesano, Commissioner Orth and their counterparts in several nearby counties began meeting regularly in 2017, to discuss potential reforms. Their goal was to figure out how to better integrate care at the county level, despite the broader system's limitations, but the list of needed fixes was daunting: Workforce shortages were profound, reimbursement rates abysmal, and state funding streams rigid. Generally speaking, mental health dollars could not be used to treat addiction, and vice versa. To Mrs. Marquesano's mind, the best way to fix all of that would be to combine the state offices of mental health and addiction services into a single new entity.

The idea wasn't new. Policymakers and advocates had pushed for something similar back in 2015, but that earlier effort had languished in the face of strong resistance. Now, Mrs. Marquesano and others picked up the baton and began rallying lawmakers and advocates to their cause. A merger was the essential first step to true service integration, they argued. By 2021, Gov. Andrew Cuomo was proposing an agency merger in his budget, and before long, State Senator Pete Harckham, chair of the Committee on Alcoholism and Substance Abuse, had introduced an actual bill in the State Senate.

Mrs. Marquesano knew that getting a bill introduced into one chamber of the State Legislature was only the beginning. Lawmakers in both chambers — and staffs at both agencies — would still have to be persuaded of the plan's virtues. And once they were, the work of actually merging would be muddy and difficult. But the prospect of real change filled her with hope. "It wouldn't solve everything," she told me. "But it would be such a massive step forward."

Before Harris's death, Mrs. Marquesano had been a member of the school board and a past P.T.A. president; she had sat on the committees that selected the programs that taught kids about the perils of drug abuse. She had taken pride in that work and had assumed that those programs did a good job. Only in retrospect did she recognize the problems with them.

Many antidrug curriculums still focused almost exclusively on resisting peer pressure, without paying any attention to other drivers of substance use. Most of them did not mention mental health at all. As a result, she thought, too many educators still treated substance use disorders and behavioral health issues as disciplinary problems, not medical ones. And too many students were still trapped in the same cycle that Mrs. Marquesano and her husband had fought to rescue Harris from — receiving help only after they were already addicted, or once they had been ensnared by the criminal justice system or not at all.

Mrs. Marquesano wanted desperately to break this pattern. And so, between trips to Albany and meetings at the county mental health office in Westchester, she continued to present her PowerPoint slides at schools across New York's Mid-Hudson region. The presentation had evolved into a prevention program — Co-Occurring Disorders Awareness, or CODA — and a few years in, was finally gaining traction. Students at dozens of schools had formed their own CODA clubs after hearing her speak, or had held CODA walks or dedicated various school events — football and soccer games, school spirit weeks — to CODA.

This past spring, I watched Mrs. Marquesano give several such talks. An event in Albany began in typical fashion, with Harris. If he were sitting there with them right now, she said, they would not necessarily peg him as a kid who was struggling with mental illness. But by the time he was their age — 13, 14, 15 — a vast chasm had opened up between his outward appearance and his inner turmoil. A slide show had been playing on the giant screen behind her — Harris playing soccer, Harris hugging his sister, Jensyn, Harris laughing with a group of friends. It segued now, almost abruptly, to a series of charts and bullet points. "I've been told that kids your age only have a 30-second attention span," she said. "I know that's not true. I think that you can follow what I am about to tell you, and I think that if you do, you'll see that it pertains to you, even if you start out thinking it doesn't."

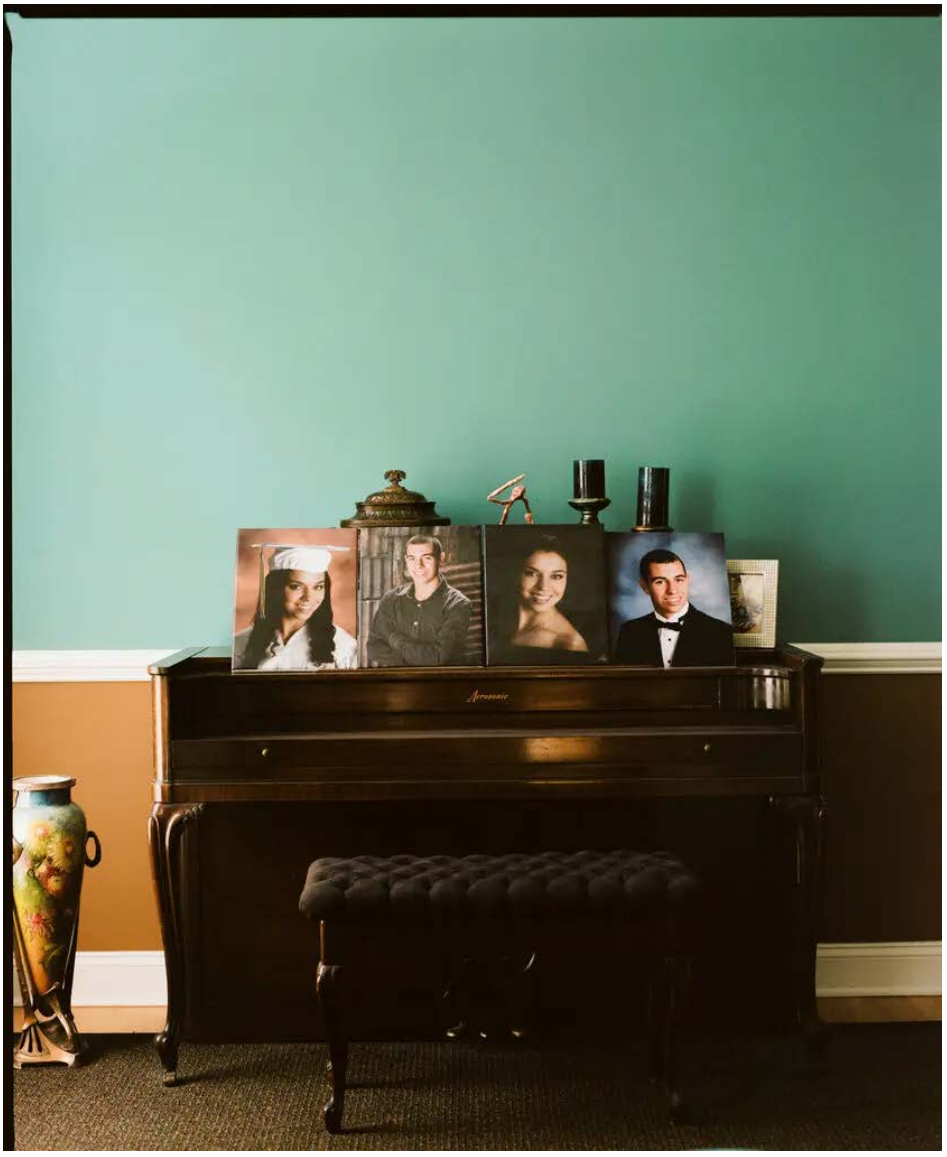

A student-run CODA event at Woodlands Middle/High School in Hartsdale, N.Y.


Stephanie Marquesano's CODA outreach stretches across New York's Mid-Hudson region.

She talked them through all the things she wished her own son had understood: how most kids start experimenting with drugs as teenagers; how a lot of people, adults included, consider it a pretty normal rite of passage; and why that was a potentially dangerous mistake. At their age, the human brain is a work in progress, she explained. It isn't considered fully developed until the age of 25. And most mental illnesses tend to emerge around the same time that experimentation with drugs begins. That confluence creates a dangerous undertow that can easily pull kids down before they even know what's happening.

The data was damning. "Twenty-two percent of 13- to 18-year-olds have a mental health disorder with severe impact," she said. "That means that somewhere between a fifth and a quarter of you are walking around feeling not quite right in your own skin. And data tells us that the vast majority of you who feel this way are not receiving any kind of treatment for it."

It was her own generation that had set this terrible precedent, she said. "We have lost the ability to feel what we feel, and to ask for help when we don't feel OK." Their generation, she said, had a chance to do things differently. She knew that most of them would not abstain from drug or alcohol use until adulthood. But she wanted them to at least stop and think about what they were doing and why. "Ask yourself," she said, "is it because you don't feel comfortable in your own skin? Is it to fill a void? Is it because you want to be less sexually inhibited? Start identifying the why, and then start talking about it."



Photos of Harris and his sister, Jensyn, in the family's living room.

Afterward, the line to her table stretched nearly across the room. Two girls wanted her to know that they had seen her present before and were fans. They'd been to lots of assemblies on mental health, they said, and lots on drug abuse. Hers was the only one to tie the two together. A few others asked about starting CODA clubs in their own schools.

More than anything else, though, the students wanted to share their own experiences. One girl had an older sibling who had been kicked out of the house. "He's doing drugs, so I get it," she told Mrs. Marquesano. "But also, he's manic! And I wish they would help him with that part, instead of just acting like it's all his fault." A boy who could not have been older than 13 waited until the others left to ask her about dealing with a loved one's death. "My father had mental health problems, and he drank and smoked pot, too," he told her shyly. "And then last year, he died while I was in the other room." Mrs. Marquesano did what she always does with the children who come to her: She encouraged him to find adults he trusted to talk with about how he was feeling, she urged him to be very careful with drugs and alcohol, and then she passed along her contact info, just in case.

In between talking to students in auditoriums and working to merge agencies in Albany, Mrs. Marquesano was thinking about one other area that seemed ripe for reform: the interactions between clinicians and clients. The idea of "no wrong door" made intuitive sense to her, but if clinicians weren't given the tools or training to treat mental health and substance use disorders together, then nothing would change. "We need to put something behind all these doors that actually works," she found herself saying over and over in meetings and conversations.

In late 2019, she crossed paths with Dr. Paula Riggs, a child, adolescent and addiction psychiatrist at the University of Colorado School of Medicine, who seemed to know exactly what that something was.

Dr. Riggs has spent her career mapping the intersection of mental illness and addiction in teenagers and young adults. At the start of her career, in the late 1990s, she said, psychiatry had yet to answer even basic questions like whether it was safe or effective to give anti-depressants to teenagers who were actively using drugs or alcohol. When Dr. Riggs set out to answer that question, her colleagues warned her that teenagers with substance use disorders were notoriously difficult to recruit for clinical studies. They would be unlikely to respond to her outreach, which included placing ads on public transit. In the end, however, her efforts paid off. "We couldn't stand to turn the phone off," she told me. "It kept ringing and we didn't want to miss anyone." She went on to conduct four trials for the National Institutes of Health, involving more than 500 adolescents.

By the time that work concluded, Dr. Riggs and her colleagues had identified a short list of medications that could be safely used to treat psychiatric disorders like depression and A.D.H.D. in teenagers struggling with substance use. They also had a new way to approach co-occurring disorders. That program, which Dr. Riggs named Encompass, is almost deceptively simple. It involves weekly talk therapy supplemented by psychiatric and anti-addiction medications when appropriate. Clinicians regularly assess mental health and substance use so that they can adjust treatment plans as needed. The goal, Dr. Riggs says, is to stop approaching addiction as an acute crisis and to start treating it like the chronic condition that it is.

"Nobody graduates from a diabetes clinic," she told me recently. "You just keep taking care of your health, and then if you need to intensify treatment because something is out of whack, you come back in until you've got it under control."

Encompass is being employed in some clinics — in Colorado, Washington, Kentucky and Indiana — and has been included on the federal government's list of evidence-based treatment options for teenagers and young adults with co-occurring disorders. But the program and others like it have been difficult to sustain, largely because there's no obvious way to pay for them. "There are huge barriers to billing for integrated treatment like this," Dr. Riggs said, including separate funding streams for substance use and mental health treatments, and low reimbursement rates for both.

One approach to treating co-occurring disorders involves weekly talk therapy, supplemented by psychiatric and addiction medications when appropriate.

Dr. Paula Riggs has spent her career mapping the intersection of mental illness and addiction in teenagers and young adults.

Mrs. Marquesano knew that Encompass would be a tough sell in New York, where staff shortages were legion and wait lists for treatment tended to run long. Clinicians would have to miss hours in the clinic to complete the trainings, and their bosses would then have to fight to get reimbursed for any of it. But when she cobbled together enough grant

money for a small pilot project — just enough to train 20 or so clinicians — she found twice as many takers as she could accommodate. “We’re taking 12 clinicians every week, an hour a week, out of direct billable activities, to learn this model,” said Dr. Mullane, whose clinics were among the first to sign up. “So we are losing revenue on it. But we have tried for years to move the ball forward without taxing this already very overtaxed system, and that has not worked either. So here we are.”

Mrs. Marquesano said that she receives requests just about every week from more clinics that want to participate in Dr. Riggs’s Encompass training. Funding is a continuing, uphill battle. “We’ve been doing all of this with duct tape and glue and whatever we can find to string things together,” she told me recently. But nearly a decade after her son’s death, she feels as if she’s finally making real progress.

In addition to bringing Encompass to New York, she has also managed to get terms like “integrated care” and “co-occurring disorders” into a small roster of bills that are now wending their way through the State Legislature. Her CODA program is set to go national through a partnership with Students Against Destructive Decisions, a much older advocacy organization that approached her after one of her talks this past spring. “She likes to say that she’s just the mom,” said Mr. Orth, the Westchester County mental health commissioner. “But she’s become one of our leading experts in co-occurring disorders, not only in the county, but in the whole state. She understands it at every level, and she is not afraid to challenge stakeholders or to push them.” Sometimes, he worries that she pushes too hard. But Mrs. Marquesano is OK with that. “I don’t care if people like me,” she said. “The system is broken and somebody needs to fix it.”

The debate over whether or not to merge two state agencies in New York is about as wonky and inside-baseball as it gets. It has not captured much attention at all, even as scores of public meetings have been held and overdose rates have ticked skyward — and it’s easy to see why. There’s a natural, collective tendency to distill wicked problems like addiction down into pat narratives with tidy fixes. In the face of so much preventable death, it’s almost comforting to assume that more money — or more attention or more data — is the solution instead of just the first step toward a solution. But addiction is about more than just people with use disorders and the stigma they face. It’s also about unions and funding streams, bureaucracies and politics. And it’s the outcome of these battles, as much as anything else, that will determine what the overdose rate looks like in another decade — or in two decades.

The New York State Senate passed Senator Harckham’s merge bill this spring, and Assemblywoman Anna Kelles has introduced the requisite companion bill in the Assembly. But to become law, that bill will have to clear a thicket of concerns and competing interests.

Some advocates and officials worry that a merger will be too messy and that it will not resolve the main problems plaguing both mental health and addiction treatment: low reimbursement rates and work force shortages. Others have expressed concerns about what will happen to funding and, by extension, to people’s jobs.

“Our bill makes clear that any savings the merger generates will be reinvested into the system,” Senator Harckham says. “But the unions, especially, have been battle-scarred, and it’s hard to blame them.” Governor Cuomo downsized the Office of Addiction Services and Supports, or OASAS, by some 150 positions during his tenure. Gov. Kathy Hochul has taken steps to reverse that damage — allocating some $402 million in new funding to the agency and appointing a new commissioner to head it. But even this welcome development presents a challenge to the merger movement. “It’s the first time in forever that OASAS is getting a boost instead of a cut,” Joelle Foskett, the legislative director to Senator Harckham, told me. “The instinct is going to be to hold on to that, not to risk it in a merger.”

There is also the matter of history: OASAS was established in 1992, when alcohol and substance abuse services were extracted from a different, larger agency and combined into a single new entity. Philip Steck, chair of the Assembly Committee on Alcohol and Drug Abuse, says that the whole point of that reconfiguration was to improve the state’s addiction treatment apparatus by separating it from everything else. “Substance abuse was neglected when it was part of a larger agency,” Mr. Steck told me. “The people who now want to merge addiction and mental health seem to be forgetting that.”

Mr. Steck agrees that the current setup — mental health in one agency, addiction in another — does not meet the needs of people who suffer from both. But he and others say that there are faster, more cost-effective ways to fix that than to try smushing two behemoth agencies together. For example, his own proposal is to simply "infuse" more mental health services into the 12 addiction treatment centers that OASAS already presided over. This move not only would lead to more integrated treatment for people with co-occurring disorders, he said, but also would help increase the work force, because state facilities pay more than the nonprofits. "The idea of a new behavioral health department sounds very progressive," Mr. Steck said. "And I am not saying it should never happen. But to remake the system like that could take 10 years, and we have people suffering right now."

Those are fair concerns, but to Mrs. Marquesano and the hundreds of advocates and officials who agree with her, the time for partial fixes is long past. "We have been begging for 21 years for these systems to integrate and coordinate more," said Paige Pierce, a parent-advocate and C.E.O. of the nonprofit Families Together. "Opponents keep insisting that a merger will not work. But what we have right now is really not working and has not been working for decades."

The federal government seems ready to acknowledge that, too. This spring, the Office of National Drug Control Policy unveiled a new, "whole-of-government approach to beat the overdose epidemic." The National Drug Control Strategy, as it's called, includes billions in new funding for evidence-based treatment initiatives, a renewed commitment to combating drug traffickers and a plan to "make better use of data to guide all these efforts." Those are welcome developments, but for the broader effort to succeed, officials at every level will have to grapple with a roster of deeper flaws in the nation's approach to addiction. Laws will have to change: Some drug-war-era statutes need to be repealed. Others, including those that focus on equal insurance coverage for behavioral health conditions, need to be better enforced. Agencies will have to be restructured so that false distinctions between addiction, mental illness and the rest of medicine are finally, fully erased. And funding streams will have to be reworked so that they support rather than impede evidence-based practices.

For any of that to happen, though, policymakers and advocates will have to overcome the same apathy and inertia that have thwarted decades' worth of previous reform efforts. And the rest of us will have to confront our enduring ambivalence about what addiction actually is and what the people who suffer from it need and deserve.

A few weeks before Harris died, when he and his mother were on the phone talking like old friends, he lamented having ever tried marijuana. It was the root of all that had gone wrong in their lives, he said. "What do you mean?" she asked. Marijuana was a fickle friend, he explained. It would either calm him down like nothing else could or make him more anxious than he had ever been. "I would have these panic attacks that I couldn't stop," he told her. He kept smoking anyway, desperate to win this game of roulette. And when he lost, he started looking for other substances to chase off the panic. "Before I knew it I was in way over my head," he said.

Stephanie Marquesano learned of her son's death here, by the dogwood outside her home.

The worst of the treatment programs Harris attended seemed intent on blaming him, and him alone, for this spiral. His mother still remembers how during family sessions, he and his fellow residents would be placed one-by-one in the center of a circle and verbally flogged. *Look at your mother*, the counselors had said to Harris. *Look at your sister and father. Can't you see how much you're hurting them? Why can't you just stop?* And then, as if to drive the point home, they called him an addict. To Mrs. Marquesano, this was a cop-out. You don't blame the cancer patient when chemotherapy fails, she thought. You adjust the treatment plan. But of all the messages Harris had been bombarded with in a year and a half of rehabilitation efforts, blame seemed to be the one he absorbed most fully. In a poem titled "mommy," he described himself as greedy, selfish and self-absorbed, even as he lamented all the hurt he had caused others. *I strayed and I strayed, until you almost lost sight,* he wrote. *But you never gave up.*

Harris had not given up either, though. His mother remembers how, just a few days before he died, the family was watching "Saturday Night Live" together over FaceTime. Harris was in a new treatment program in Central Florida linked to a local university, and he was excited about finally starting college. He also had a job interview lined up at a nearby mall for the following week. The police officers who went to his room afterward told her that his interview clothes were laid out perfectly on his bed.

"This all could have gone completely differently," she told me. "Harris just needed to know how not alone he was and that he could learn to manage these things in time."

*The Times is committed to publishing a diversity of letters to the editor. We'd like to hear what you think about this or any of our articles. Here are some tips. And here's our email: letters@nytimes.com.*

*Follow The New York Times Opinion section on Facebook, Twitter (@NYTopinion) and Instagram.*