I Received Some Profoundly Bad News this Week

It is the kind of news that does not remain contained within a single organization or a small circle of friends. It ripples outward. And this news has rippled through much of our local addiction treatment community because the man at the center of it was someone many of us knew. We worked alongside him. We laughed with him. We argued with him. We watched him help people. Many individuals who are now alumni of treatment programs knew him as someone who played a meaningful role in their recovery.

And now he has fallen. Hard.

Drew was someone I knew personally and worked alongside for approximately three years, has reportedly relapsed profoundly and now stands accused of selling cocaine to undercover detectives, driving a BMW toward a detective, ramming an unmarked police vehicle, fleeing at speeds reportedly approaching 100 miles per hour, and later hiding in an attic during a SWAT operation before falling through the ceiling into the bedroom below.

The allegations are extraordinarily serious. Accountability matters. Drew is responsible for the choices he made. And at 31 years old, he now faces consequences that may alter the course of his entire life. I am not a lawyer, and I will not speculate about precisely what sentence he may receive. But clearly, this is not a minor stumble. It is a catastrophic fall from grace.

It would be easy to shake our heads and say, "How terribly sad." It would be easy to ask what happened to Drew. How could he do this? How could someone who worked in addiction

treatment, someone who had helped others struggling with substance use, end up selling drugs and running from the police?

But I think those are the easier questions.

What about us? What did we miss? And what did I miss?

Before I Ask About Us, I Have to Ask About Me

I served as clinical director during much of the three years that Drew and I crossed paths and worked alongside one another. I knew him. I saw his remarkable strengths, and I saw his struggles. I raised concerns at times that he was in over his head and carrying responsibilities that may have exceeded his training, experience, and capacity at that point in his recovery.

But perhaps I did not raise those concerns loudly enough. Perhaps I did not try hard enough to understand what was happening beneath the behavior. Perhaps there were moments when I saw the anger but did not look deeply enough for the pain underneath it. And truth be told, Drew activated me too.

Internal Family Systems, or IFS, gives us a remarkably compassionate way of understanding what happens inside all of us. Rather than viewing the human personality as a single, unified voice, IFS recognizes that we have different parts, each attempting in its own way to protect us.

Some parts function as managers. They work hard to keep life under control, help us succeed, prevent failure, and protect vulnerable places within us from being exposed. Other parts carry deeper wounds. IFS calls these exiles. They may carry shame, fear, rejection, grief, abandonment, inadequacy, or the painful belief that we are simply not enough.

And then there are firefighters. Firefighters emerge when those deeper wounds are threatened or exposed and the pain becomes too much. They do not calmly analyze the situation. They act quickly to put out the emotional fire. They may rage, attack, withdraw, numb, use substances, run, blame, control, or do whatever they have learned to do to make unbearable feelings stop.

I saw that firefighter in Drew. But if I am going to be honest, I must also acknowledge that at times his firefighter activated mine.

There were moments when his anger, intensity, and volatility triggered something defensive in me. At times, I felt attacked, undermined, or unfairly blamed. And while I would like to believe that I always responded from my calmest, wisest, most grounded Self, that would not be entirely true. At times, I probably was not at my best.

That is difficult to write, but it matters. It is always easier to identify someone else's firefighter than to recognize our own. It is easier to analyze another person's defenses than to ask what those defenses stirred up inside us. And perhaps one of the greatest dangers in behavioral health is believing that because we are the professionals, we somehow stand outside the human systems we are trying to understand.

We do not. We bring our own histories into the room. We bring our own wounds, our own managers, our own firefighters, and our own need to be right, respected, understood, valued, and safe.

And so, when I ask what happened to Drew, I cannot limit the question to Drew. I have to ask myself what I could have done differently. Could I have listened more deeply? Could I have seen more clearly what was underneath his anger? Could I have raised my concerns more forcefully? Could I have been less activated myself in moments of conflict? Could I have reached him differently?

I do not ask those questions to punish myself, nor do I believe that I caused what ultimately happened. Drew made his own choices, and those choices carry responsibility and consequences.

But there is an enormous difference between taking blame and taking responsibility. Blame asks, "Whose fault is this?" Responsibility asks, "What was mine to see, mine to do, mine to say, mine to learn, and mine to change?" That is the question I am asking of myself now.

Are We Really Helping as Much as We Think We Are?

Once I ask that question of myself, I believe I have the right, and perhaps the responsibility, to ask it more broadly of the addiction treatment industry.

We want to believe that addiction treatment works. Of course we do. We want to believe that when we take someone off the streets, place them in residential treatment, surround them with counselors, groups, structure, and support, we are changing a life.

And sometimes we are. I have witnessed extraordinary transformations. I have watched people come back from places that seemed impossibly dark. I have seen families restored, relationships repaired, dignity rediscovered, and human beings begin to believe that perhaps their lives were worth living after all. Good treatment can save lives.

But the harder question is whether we are helping nearly as much as we claim we are.

Dr. Judith Grisel, the behavioral neuroscientist and author of Never Enough, has raised a deeply uncomfortable challenge to the field: despite decades of enormous investment, expanding treatment systems, and increasingly sophisticated language about addiction, our overall outcomes have not improved nearly as dramatically as we would like to believe over the past 50 years.

That should trouble us.

For decades, the addiction treatment industry has struggled with a fundamental problem: measuring its own effectiveness honestly. Treatment centers may advertise impressive recovery rates, but what exactly does "success" mean? Does it mean completing 30 days of treatment? Being abstinent at discharge? Answering a telephone call six months later? Being sober for the previous 30 days?

Does the calculation include everyone who entered treatment, or only those who completed the program? What happened to the people who left early? What about those who could not be located? What about the person who died? Who gets counted, and perhaps more importantly, who disappears from the denominator?

We want the numbers to look good because we desperately want to believe we are doing good. But hope is not data, and marketing is not science.

Outcome research in addiction treatment is notoriously difficult. Long-term follow-up is hard. People disappear. Self-report is often unavoidable but inherently limited. Definitions of recovery vary enormously. Studies may follow people for months when the real question is what happens over years. Programs may report only those who completed treatment or those who could be successfully contacted, potentially excluding the very people most likely to have relapsed, deteriorated, become incarcerated, or died.

The more rigorous the question becomes, the less impressive many of our claims begin to look. That does not mean treatment is worthless. Far from it. But it does mean we must stop confusing what we hope is happening with what we can actually demonstrate.

Stabilization Is Not Transformation

The same honesty must be applied to the therapies we deliver.

CBT and DBT are invaluable components of addiction treatment. They help people build resilience, manage immediate crises, tolerate distress, recognize destructive patterns, and make better choices when their lives are most unstable. These skills can be lifesaving, and they belong in good treatment.

But they are not enough.

There is robust evidence for the short-term benefits of cognitive and skills-based therapies. The evidence for durable, long-term transformation is far less impressive. Gains often diminish over time, relapse remains common, and the ability to manage symptoms should not be confused with healing the deeper processes that gave rise to addiction in the first place.

Crisis stabilization must be accompanied by deep, transformational care that reaches the core wounds beneath addiction: trauma, shame, attachment injuries, autonomic dysregulation, fractured identity, unresolved grief, and the protective defense systems that developed to keep unbearable pain at bay.

A person can learn to challenge a distorted thought and still carry profound shame. A person can master a distress-tolerance skill and still have a nervous system organized around danger. A person can identify every trigger on a worksheet and still have no understanding of why those triggers carry such enormous emotional power. And a person can become remarkably skilled at helping someone else through a crisis while remaining profoundly vulnerable when his own deepest wounds are activated.

I saw that in Drew.

He was bright. Very bright, actually. He had never graduated from high school, but his intelligence could not be measured by a diploma. He wanted desperately to do well. He wanted to succeed. He wanted to matter.

And in certain situations, particularly when a struggling patient was threatening to leave treatment against medical advice, Drew could be remarkable. He could connect. He could engage. He could reach someone who was walking toward the door and somehow help that person reconsider.

I saw that Drew. I also saw what happened when he became overwhelmed, criticized, exposed, or afraid of failing. Something inside him could shift dramatically. His firefighter could emerge with extraordinary force.

Teaching someone how to survive a crisis is essential. But we must also help transform the internal system that keeps creating the crisis. We need both: skills for resilience and stabilization, and deep transformational work that reaches the wounds beneath the behavior. Anything less risks helping people become better at managing their pain without ever truly helping them heal it.

Three Minutes Out of Recovery

There is another uncomfortable reality in the addiction treatment industry that deserves far more attention.

We sometimes take people who are barely out of their own recovery crisis and rapidly place them in positions of enormous responsibility.

Their lived experience is valuable. Sometimes extraordinarily so. A person who has walked through addiction may possess a credibility, intuition, and capacity for connection that no textbook can teach. Some of the finest people I have ever worked alongside in addiction treatment came from lived experience.

But lived experience is not the same thing as professional preparation, emotional consolidation, clinical training, or autonomic stability. Recovery has begun. That does not mean it has consolidated. And then we give that person a title. We give them patients. We give them crises. We give them responsibility. Sometimes we give them staff to manage. We expose them to suicidality, relapse, anger, manipulation, family chaos, organizational politics, grief, and death. Then we are surprised when they become overwhelmed.

Perhaps we should not be.

Sometimes the addiction treatment industry risks confusing someone's ability to help another person in crisis with their ability to withstand chronic professional stress. Those are profoundly different capacities.

And I think we need to ask an even harder question: At what point does opportunity become exploitation? The response that "everybody in the industry does it" is not an answer. Widespread practice does not automatically make a practice wise, ethical, or safe.

I came from a hospital system where professional privileges were taken extraordinarily seriously. You did not simply say that you knew how to perform a treatment and begin doing it. Your education was verified. Your license was verified. Your training was documented. Your competence was evaluated. Specific clinical privileges were reviewed by a professional board, periodically renewed, and if you fell below professional standards, you could lose those privileges and potentially face action against your license.

That level of accountability was not considered excessive. It was considered patient safety.

Yet in parts of the addiction treatment industry, we place some of our most vulnerable patients into the hands of some of our least trained and sometimes most vulnerable staff members. Then we call them the backbone of the organization.

And they are.

The behavioral health technicians, recovery coaches, peer-support specialists, and frontline workers are often the worker bees, the backbone, and the unsung heroes of addiction treatment. They spend more time with patients than many clinicians ever will. They sit with them through the night. They talk them down from leaving. They absorb their anger. They witness their despair. They celebrate their victories.

But what are we doing to protect the backbone from breaking?

Who Is Taking Care of the People Who Take Care of Everyone Else?

Perhaps one of the greatest blind spots in addiction treatment is that we focus almost entirely on the health of patients while failing to ask serious questions about the health of the people treating them.

Who is caring for the staff? Who is watching for burnout? Who notices when someone's anger is escalating? Who recognizes when a staff member's own trauma is being activated? Who sees the manager desperately trying to prove himself, or the firefighter beginning to emerge? And who is willing to say, "This person may be talented, but right now this position is too much for them"? More importantly, who listens when someone raises that concern?

An organization is only as healthy as the people who inhabit it. You cannot create a culture of regulation with a chronically dysregulated staff. You cannot teach emotional safety in an emotionally unsafe organization. You cannot preach vulnerability in a culture where people are terrified of making mistakes. And you cannot help patients heal their protective systems while ignoring the raging firefighters, exhausted managers, and wounded exiles walking the halls wearing employee badges.

Staff health is not separate from patient care. Staff health is patient care.

We need to take care of these people. Not sentimentally. Not with an employee appreciation lunch once a year. Not with a motivational email about self-care.

We need real training, real supervision, real attention to emotional health, and real opportunities for staff to address their own wounds without shame or fear of losing their jobs. We need to recognize that a person in recovery who works in addiction treatment is not magically immune to relapse simply because he now wears a staff badge. In fact, the work itself may expose him repeatedly to the very wounds, substances, environments, and relational dynamics from which he is trying to heal.

What Did We Miss?

I think about Drew. I think about the young man I knew before the mugshot and the SWAT team, the bright young man who wanted desperately to do well, the man who could be remarkable when someone was walking out the door and needed another human being to reach him. I also remember the anger, the volatility, the firefighter, and the signs that he was overwhelmed. And I remember my own firefighter too. That matters to me now.

I cannot know exactly what happened inside Drew or everything that led from the person I knew to the allegations now being reported. None of us can. His choices are his own, and accountability must remain part of the story. But it should not be the only part of the story.

Because if a man can work inside the addiction treatment industry, help others in moments of crisis, carry his own unresolved pain, become increasingly overwhelmed, and eventually end up accused of the very behaviors the industry exists to treat, then perhaps we should have the courage to ask a harder question: What did we miss? Not only in Drew, but in ourselves, our organizations, our treatment models, our research, and the stories we tell ourselves about how well we are doing.

I still believe deeply in healing. I still believe people can change. I have witnessed too much transformation to believe otherwise. But believing in healing should never require us to exaggerate our success. In fact, perhaps the opposite is true.

If we genuinely want to save lives, we must be brave enough to tell the truth about how often we fail, how much we still do not understand, how inadequately some of our staff are prepared, and how desperately we need to care for the people who spend their lives caring for others.

I come back to Drew, and I come back to myself. Could I have listened more deeply? Could I have seen more clearly? Could I have raised my concerns more forcefully? Could I have managed my own firefighter better when his firefighter collided with mine? I do not know. And perhaps that uncertainty is precisely why these questions need to be asked.

This is not about assigning blame. It is not about flagellating an organization, an industry, or myself. It is about taking responsibility seriously enough to look honestly at what happened and ask what we might learn from it.

Because there will be another Drew: another bright young man or woman with extraordinary gifts, a powerful desire to help others, and wounds that have not yet fully healed. Someone will see the talent and offer a title. Someone will see the passion and add responsibility. Someone will mistake being gifted in a crisis for being ready to carry the chronic weight of other people's crises. And perhaps the most important question is whether, next time, we will see more clearly.

The measure of a treatment center should never be the beauty of its website, the confidence of its marketing, or the success rate it places in bold print. The measure should be much harder and much more human: What happens to the people who walk through our doors?

And that question must include everyone: the patients, the families, and the staff. Especially the staff.

Because perhaps the real hope in asking these hard questions is not to assign blame for what has already happened, but to help us see more clearly the next time. To recognize the overwhelmed young man before his firefighter takes over. To notice the gifted staff member who is carrying more than he can bear. To listen when someone raises a concern. To care for the people who spend their lives caring for others with the same compassion, depth, and commitment we promise to those who come to us for treatment.

We cannot change what has already happened to Drew. But perhaps we can allow his story to change us.

And perhaps that is where healing begins.