FROM THE FIELD

The Peer Recovery Workforce and Illicit Drug Use: Reductio Ad Absurdum

By Bill Stauffer

In recent years, our field has undergone significant challenges to accommodate drug use within the framework of addiction recovery. It has occurred in our private sector and within government. Perhaps the clearest example being in Government. In its 2022-2026 strategic plan, the National Institute on Drug Abuse (NIDA) defined recovery as *"different things to different people. Broadly speaking, it is a process of change through which people improve their health and well-being while abstaining from or lessening their substance use or by switching to less risky drug use. For some, this may mean complete abstinence; for others, recovery could be ceasing problematic drug use, developing effective coping strategies, improving physical and mental health, or experiencing some combination of those or other outcomes."*

As in any broad statement, there are elements of truth here. People with more mild forms of substance use conditions can resolve their challenges in ways that do not require radical changes in how they live in the ways that people with severe substance use conditions typically do. From a treatment perspective practically and conceptually, this is not new. Decades ago in the field as a young counselor, I often worked with people who used problematically who resolved those challenges with a few life style changes after which they lived normal lives. Few would consider themselves in recovery.

In that same era, groups across the nation began to talk about addiction recovery in a new way, a way that highlighted recovery in ways perhaps best captured in the first attempt to define recovery from addiction as a "voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship" through a consensus panel convened by the Betty Ford Institute, which is now the Hazelden Betty Ford Foundation. This recovery movement improved our care systems and elevated the dignity and worth of millions of Americans who had changed their lives in profound ways.

A lot has changed since those days and definitions of recovery are now so accommodating that they are effectively devoid of meaning. To highlight this, a person who uses drugs with a clean needle would be defined as in recovery under the NIDA definition above. To be clear, clean needles have broad public health benefits. The practice reduces the spread of contagions like HIV and Hepatitis. Engaging people who are using drugs in this way makes sense and save lives. It should not be controversial to help people stay alive. Likewise addiction treatment and recovery efforts are vitally important. Finally, there many examples of our drug laws causing huge problems in our society, Yet lumping the interests in respect to less harmful drug use, drug use normalization, treatment and recovery from addiction under the same conceptual framework of recovery has caused a lot of profound challenges. These challenges have been compounded by "Reductio Ad Absurdum" messaging strategies that stifle meaningful dialogue around these highly complex issues.

A fairly clear example of this is a recent statement that the National Peer Recovery Alliance (NPRA) who represent peer support workers. NPRA asserted they "firmly believed that individuals working in the field of substance use disorder recovery should not participate in illicit drug use." Once it was posted they faced the ire of drug use advocates. The dialogue quickly reduced itself to the level of absurdity. So much so that NPRA removed their statement. Before it was removed, there was a lot of rhetoric falsely claiming that the stance meant NPRA only supported abstinence recovery, was against harm reduction and hated people who use drugs. The points they made about peer workers using illegal drugs undermining public trust and compromising the integrity of the services were largely ignored. It was unfortunate.

NPRA posted via Facebook on February 11th they are rewriting their statement for clarity. Based on the vitriol they experienced, they may decide to simply stay silent. What I read the initial post; it was clear to me they were not talking about a reoccurrence of use; simply that the peer workforce should not use illegal drugs.

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It is also worth noting that any public funding would rightly bar staff from using illegal drugs. There is not a certifying body in the country that would condone professionals using illegal drugs. As an example of how extreme dialogue can get, I mentioned these facts on the post thread. I was asked by a drug use advocate if I was also in favor of slavery, consistent with the concept that illicit drug use is an innate human freedom. It was another example of an absurd assertion. For the record, I do not think drug use is an innate right, and I am against slavery. It is also beyond the point that peer workers should not use illegal drugs. Somehow, we must rise above absurdity in our dialogue to move efforts forward and avoid harm in the name of help.

It is true with respect to these topics, as most in our field are quite nuanced and complex. Drug use is on a spectrum. There are no one size that fits all solutions. We must have a lot of compassion when coworkers are found to be misusing drugs. It is also true that scorched earth, shaming strategies against groups who raise concerns like NPRA will not further our efforts. If the recovery field, which rose up out of the desire to help people recover from the most severe forms of addiction, goes down the rabbit hole of accommodating illicit drug use as the norm we will lose public support and credibility. We cannot allow this to occur. We must find a way to embrace recovery in the sense we did historically in ways that include ethical conduct in our workforce even as we ensure space for compassion and understanding in respect to complex issues like this one. The first step may be to cease the absurd rhetoric and assert the obvious: Our peer workers should not be using illicit drugs. •

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Court forestalls NIH cuts – for now

The Trump Administration lowered the indirect cost rate research institutions can charge the National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), and other National Institutes of Health (NIH) research funders to 15%. This is much lower than the 60% allowed in the past and recently. As a result, some academic medical centers immediately cut back on travel and other spending for their researchers.

Indirect costs are used for heating, air conditioning, and other overhead costs in running research experiments. Last year, the NIH made $35 billion in research grants, $9 billion of which was for overhead.

A judge stopped the cuts temporarily. In an interesting but expected twist, the red states where governors, legislators, and the voters support President Trump and his agenda are opposed to the NIH cuts. In Alabama, for example, the state overhead that the university medical school gets in NIH grants for research goes into the economy. It happens in blue states too. But now the red states are in a bind because they do not support the cuts.

A devastating side effect, of course, is that needed research may not be able to be done. Researchers may not be able to travel to conferences to share their information, and to bring back new information to their institutions. The leaders at NIDA and NIAAA have long been important sources for *ADAW*, but they have not responded to queries since President Trump was inaugurated January 20. We hope to hear from them soon. Now that Robert F. Kennedy Jr. has been installed as Secretary of the Department of Health and Human Services – the parent of the NIH – the dust may settle soon.

Meanwhile, the question of the NIH overhead cuts has not been resolved. And medical institutions are being cautious as a result. •

Organizations worry about DEI ban

It took less than 24 hours for some organizations to absorb the hold the federal government has over them, if they take federal funds. Those groups which were outspoken in favor of diversity, equity, and inclusion (DEI) programs immediately put out notice that they would no longer pass on federal funds to any partner or subcontractor espousing DEI.

Here is what the Opioid Response Network (ORN), a vital organization providing needing training on how to treat opioid use disorder (OUD), posted on its website:

"As a federally funded program, pursuant to President Trump's executive order signed on January 20, 2025, ORN is no longer funding programs specific to Diversity, Equity, and Inclusion (DEI). Our understanding of new executive orders is that federal funds can no longer be used to conduct DEI-related activities on any technical assistance (TA) request or funded

