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# SUBSTANCE ABUSE

## STORIES FROM THE PROFESSION

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I still remember her laugh and the way she liked to joke about my driving. Sarah[1] was my first interaction with someone diagnosed with comorbid mental health and substance misuse disorders. She helped to form me as a social worker, a field that was not in my original career plans. My initial goal throughout high school was to become an investigator. I majored in criminal justice for my undergrad program, with an ultimate dream to work for the Federal Bureau of Investigation (FBI). During my coursework I became drawn to structural theories for crime and deviance. While my classmates discussed the need to increase penalties and the benefits to a tough-on-crime approach, I discussed the need to consider the surrounding context and understand economic, structural, and educational barriers associated with crimes within communities. An experience as a summer camp counselor with inner-city youth was my first exposure to social work. It was this experience that made me consider social work as an alternative career option. My senior honor's thesis, a documentary about females experiencing homelessness and service provision within local shelters, solidified my decision to pursue social work, rather than law enforcement, as a career.

My first position after graduating from my undergraduate program was as a community mental health case manager. I had a Medicaid-funded caseload of 40 individuals with an array of diagnoses and differing treatment needs.

[1]Name changed

It was a difficult job with high demands of certain billable hours of client contact every month and paperwork deadlines requiring overtime, despite a lack of overtime pay. The position was stressful and the pay was minimal. After interacting with case managers who had been working there for 20 years, it was obvious that burnout was a possibility. Despite the negative aspects, I loved my interactions with those I had the privilege of serving as a case manager. I always knew that it would be a temporary position, as I did not have the qualifications to move into more management or leadership roles. Although I knew the position was temporary, I was determined to learn as much as I could during this time period.

Sarah was transferred to my caseload within the first few months. As I interacted with and learned from her, she provided a foundation for me as a beginning social worker and helped to shape perspectives that I hold today. Although Sarah presented challenges to someone new to the field, I appreciated identifying and working toward her strengths. She was diagnosed with bipolar disorder and cocaine use disorder. Her cocaine use disorder escalated in intensity and began to affect her mental and physical health. After becoming heartbroken by the burn marks on her fingers caused by the crack pipe, and her worsening cough due to her prolonged crack cocaine use, I found what appeared to be a perfect treatment setting and helped her to get enrolled – only to face utter disappointment when she left after 2 weeks. I dealt with negative comments from my coworkers. "You can't trust people who are addicted. They are manipulative. We just can't help them." Despite all of the negative comments from social work coworkers and all of the self-doubt, I persisted and adapted, eventually learning to put her needs first. She did not want treatment. I wanted treatment for her and she acquiesced, as she felt it would ease my concerns. It was during this time I learned the important lesson of meeting individuals where they are and respecting the right to self-determination. I was not aware of harm reduction as a concept at the time, but in retrospect I took this type of approach in my future interactions to meet Sarah's goals while planning for her safety.

As the years passed, I became frustrated at structural barriers that impacted insurance coverage for medication, the fact that insurance payment time periods dictated when individuals were released from psychiatric units even if they could have benefited from additional time, and the overall stigma directed toward those on my caseload when we were in the community together. I also felt powerless in my role at times. The tipping point happened after I became aware that one individual on my caseload was obtaining multiple prescriptions from

different pharmacies. She mentioned paying one doctor in cash and divulged that she was receiving prescriptions for multiple opioids, including Vicodin, Percocet, and OxyContin. I approached her psychiatrist with my concerns over the potential for interaction with her psych medications. The psychiatrist informed me that the individual in question suffered from back pain and needed the prescriptions. Despite my elaboration on the suspect nature of how the individual obtained the prescription pain pills, the psychiatrist effectively shut down any other dialogue on the topic. This was in 2008, during the early stages of the opioid epidemic, and the issue had not reached the level of national dialogue. After being informed that my concerns were baseless, I became discouraged at the lack of communication between mental and physical health providers. Further, I felt a power imbalance due to my age and inexperience, and I believed that questioning the psychiatrist would be futile. It was at this point that I realized that I needed to pursue my master's degree in social work (MSW), so that I could address changes on a macro level.

During my MSW program internship, I became involved in community organizing and policy advocacy work related to human trafficking, with a focus on domestic minor sex trafficking (DMST). At this time Ohio was one of the last states that did not designate human trafficking as a stand-alone felony. On the federal level, the Trafficking Victims Protection Act established that anyone under the age of 18 was a victim without the need for proof of force, fraud, or coercion. Although the federal legislation could be used to prosecute traffickers, the state felony distinction was needed to address gaps in prosecution and allow the trafficker to face maximum penalties. At this time youth were still being labeled as juvenile prostitutes by law enforcement and social service providers, and the language had not yet shifted to DMST victims. Service providers characterized the DMST victims as "bad kids" and focused on the secondary behaviors related to trafficking, such as runaway behavior. Victims often faced injustice in court proceedings. For example, a 13-year-old victim was charged with prostitution whereas the adult male who purchased services received no charges. It was evident that additional policy was needed, but the state legislators would need to be convinced. One of my major intern projects was contributing to a state report that was used by legislators to make human trafficking a felony. I also became active on the community level and assisted in founding a local coalition uniting multiple stakeholders to establish policies and procedures related to trafficking while increasing awareness and education. The coalition had a diverse membership ranging from community members, health and social service providers, researchers, FBI agents, nuns, and even

empowered sex workers. I served as secretary for the coalition, before later being elected to cochair the coalition.

Following my graduation I pieced together multiple micro- and macro-level grant-funded positions, including research assistant, regional epidemiologist, women's group leader, and visiting lecturer. On the mezzo level I continued to volunteer my time with the trafficking coalition, the annual international human trafficking conference, and provided free trainings around the state. I also became active with state and federal policy makers, later receiving a certification of recognition for my community work related to trafficking from the county commissioners and special recognition from the Ohio House of Representatives, 45th House District of Ohio. One of the highlights of my macro policy advocacy efforts during this time was providing testimony to the Ohio Legislature in support of policy targeting the demand side of human trafficking. Human trafficking has three components: supply (victims), distribution (traffickers), and demand (customers). Policy initiatives have started to focus more on demand, so that customers are held accountable, whereas in the past customers often testified against the trafficker to escape penalties, despite their participation in sexual victimization. As I listened to the primarily male lawmakers discuss questions over whether increased protections for victims might increase false accusations, I became more aware of the need for empowered female voices in political advocacy to stand against the status quo.

Although my mezzo and macro work began with a focus on human trafficking, my position as regional epidemiologist began to attract my intellectual interest. Through this position I contracted with the state of Ohio conducting research related to drug trends. During this time the prescription opioid and heroin epidemic was beginning to take hold throughout the country, and Ohio was especially impacted. As I conducted focus groups with those in substance abuse treatment, treatment providers, and law enforcement, the same themes arose. Individuals were prescribed large amounts of prescription pain medications and would find themselves physically dependent on the pills. Legislation was introduced to curb prescribing patterns and individuals began transitioning to heroin, which was cheaper and more potent than the pills.

Seeing the epidemic grow and overdose rates steadily increasing, I knew that I wanted to contribute more, and that change through research and policy advocacy was where I belonged. I decided to pursue a PhD in social work with a focus on opiate use transitions and trajectories. When I first started my

program, I had practically no knowledge of harm reduction. My home state had one harm reduction center when I left for my PhD program, and although I had heard of syringe exchange programs, I was not educated on how they operated. During my first and second year in my program, I engaged in volunteer work at a harm reduction center to learn more about this public health philosophy. Harm reduction takes an approach of meeting clients where they are, and focuses on minimizing adverse consequences associated with drug use such as overdose, HIV and hepatitis C transmission, and incarceration. Services can include syringe exchange programs, naloxone overdose prevention training, wound care, psychosocial groups, and supervised consumption facilities. As I worked with the staff and clients of the harm reduction center, I thought back to my first experiences working with Sarah. I remember how I tried to encourage her to pursue an abstinence-based approach to treatment and met with failure. It was only when I began to meet her where she was, and employ a "safety first" planning approach, that we made strides in meeting her treatment goals.

I am now an advocate for harm reduction approaches, with a particular focus on supervised consumption facilities. Although my participation in community organizing and policy advocacy is currently limited due to my dissertation obligations, I am finding ways to support and advocate for harm reduction approaches. My current papers and projects have a harm reduction bent to them, and I include some discussion over harm reduction in my presentations at conferences. I discuss harm reduction with my former colleagues engaged in micro-level work and provide materials so that they can become further educated. I retained my connections to community organizers in Ohio and provided suggestions and materials as they implemented a syringe exchange program in my former town. Although I am currently not as engaged as I would like to be, I have been able to bring my micro-level harm reduction volunteer work experience and my new macro-level skills to assist in protocol development. I feel fortunate to continue to find fulfillment in merging the different levels of social work practice.

Despite the ability for the different levels of social work to complement each other, I have noticed a divide between micro and macro practice within my different social work roles. As a micro social worker, I have experienced the impact of policies and protocols created without the knowledge of how those receiving services, and the social workers providing services, would be impacted. One policy change in particular stands out. While I was a case manager, the agency transitioned to treatment planning based on diagnosis. This severely

limited the ability for the individual to be active in his or her own treatment goals. The diagnosis-based treatment planning only lasted a few months, but resentment toward the change lingered. Conversely, as a macro social worker involved in policy advocacy, I have also been on the other side. I advocated for policy changes that did not consider how the agency would be affected. When human trafficking legislation was passed in Ohio, the Children's Services Agency was mandated to provide care for victims. This caused a change in their internal policy, as the original responsibility was to provide care for individuals abused by family members or guardians. Under the new legislation, the agency would need to care for the DMST victims, even if the family or guardian was not involved in the trafficking. The new mandate to Children's Services was unfunded, so the agency would need to increase its scope of care, without an increase in funding. Unfortunately, in our zealous advocacy for the policy change, we had not considered the impact of the mandate, and the implementation process would have been much smoother had the front-line staff been involved in policy conversations.

Moving into a role within academia, I have also noticed the divide in the classroom among students. Micro-oriented students have initially expressed less interest in the policy and research classes that I have taught, while macro-oriented students often neglect to incorporate an understanding of the social worker in the field and experiences of clients. As I continue to grow as a social worker, and into a role of training other social workers, the need to blend micro, mezzo, and macro together to make effective change becomes more evident. This is one reason I am drawn to qualitative research. Although quantitative analysis provides an understanding of prevalence and gives policy makers impetus for change, the numbers are meaningless without an understanding of the lived experience. For me, qualitative research is the best practice, as it allows me to engage with the population I am passionate about, while involving them in developing the most effective approaches for prevention and intervention.

My journey from micro- to mezzo- to macro-level work has not been a lin-ear process, and I currently do not define myself as a micro, mezzo, or macro social worker. Rather, I see myself operating within a continuum, where I can use research and policy advocacy to make changes, but one in which I need to remain aware of what is happening on the micro and mezzo level. I am a multi-level social worker blending all of the practice levels in order to effect the most change. Without such integration the individuals, agencies, communities and systems of care will face a disservice from a profession created to make a difference.

# JOB DESCRIPTIONS FROM THE FIELD OF SUBSTANCE ABUSE ADVOCACY

**Substance Abuse, Legislative Advocacy Coordinator, Baltimore Harm Reduction Coordinator**

**Job source:** www.indeed.com

**Salary:** No salary listed in job posting

**Education and Experience:**

- A successful candidate for this position will be highly organized, detail oriented, and comfortable working independently. They must be skilled at collaboration with a variety of stakeholders and collective decision-making. Additionally, they must be outgoing and feel comfortable convening a coalition of diverse individuals (including people who have been targeted by the war on drugs and anti-sex work policy, law enforcement, family advocates, treatment providers, etc.) about potentially sensitive issues (drug use, overdose, sex work, etc.).
- Candidates should have knowledge of and commitment to harm reduction and racial justice as well as demonstrated knowledge of the Maryland legislative process.

**Responsibilities:**

- Identify and contact new coalition members, focusing on groups and individuals directly impacted by the war on drugs and anti-sex worker policies.
- Provide leadership to the statewide coalition, including scheduling regular calls, planning agendas, and documenting meeting action items.
- Interpret, analyze, and draft statutory language and legislation based on coalition consensus.
- Track progress of relevant legislation in the MD General Assembly, and communicate this progress and advocacy opportunities with coalition members.

- Coordinate with the BRIDGES Coalition (https://www.facebook.com/Bridges-Coalition-1760625273964186/about) and other stakeholders to develop harm reduction advocacy/educational strategy (including materials) for legislators and other advocates.
- Work collaboratively with and assist in providing a meaningful learning experience to a Peer Advocacy Intern.
- Coordinate an advocacy training in Baltimore for BHRC members.
- Coordinate an advocacy event in Annapolis with coalition members.
- Participate in regular meetings with supervisor (Executive Director) and other project leadership (BHRC Advisory Board and BHRC Policy Committee Chair).
- Prepare reports to fulfill grant requirements.

**Substance Abuse Prevention Specialist**

**Job source:** http://www.d19csb.com

**Location:** Petersburg, Virginia

**Salary**: $32,000–$45,000

**Education:** Bachelor's degree in Human Services Field and considerable experience working with families and children, teaching and/or public speaking and experience in the substance abuse field

**Responsibilities:**

- Delivery and promotion of prevention services (school and community based) for nine localities in District 19 Community Services Board
- Implementation of prevention strategies that include needs assessment and recommendation for prevention strategies
- Program development
- Strong presentation skills
- Working with children and families in a community based setting to reduce prevalence of substance abuse and related problems based upon sound research based principles and processes

**Project Coordinator/Teen Advocacy Coalition – Willapa Behavioral Health**

**Location:** Raymond, Washington

**Education:** Bachelor's degree in related field

**Salary:** No salary information provided

**Responsibilities:**

- Manage a Drug Free Community initiative devoted to help youth succeed. This role is the liaison between the Teen Advocacy Coalition and three local high school districts, community organizations and volunteers.
- Must be passionate about substance abuse prevention, supportive mental health services and willing to encourage teen leadership and community involvement.

**Program Administrator, Community Services Board**

**Job source:** www.governmentjobs.com

**Salary:** $47,822.70–$77,977.98

**Location:** Norfolk, Virginia

**Education:** Bachelor's degree plus 3 years' experience in program management or related field. Two years' experience in treatment of persons with substance abuse and mental health issues in a correctional setting with 2 years supervisory experience.

**Responsibilities:**

- Work closely with local hospital emergency rooms, emergency services, and crisis stabilization staff to provide client perspective on a comprehensive assessment to determine individualized treatment preferences.
- Assist peer recovery specialist in helping clients in developing recovery plan by identifying client's strengths, goals, and steps toward recovery to include needed supports.
- Assist peer recovery specialists as they help clients with general problem solving and development of skills in obtaining services and supports through coaching toward an increased sense of responsibility.

- Ensure that clients learn about available community resources and that peer recovery specialists advocate for services on behalf of clients as needed.
- Support peer recovery specialists as they act as liaisons between clients and other service providers to ensure that client preferences expressed in recovery plans are included in individual service plans.
- Ensure that peer recover specialists maintain accurate data collection and documentation consistent with agency guidelines, grant requirements, and licensure standards.
- Collaborate with multiple programs as part of a treatment team, community services providers and significant others as necessary.
- Facilitate staff meetings, case review meetings and staff training activities as required.
- Utilize SAMSHSA's crisis prevention and other recovery oriented peer support programs.
- Encourage peer recovery specialists as they help clients develop skills and strategies to prevent relapse of substance addiction and possible mental health symptoms, reconnecting them with their recovery goals.

**Drug and Alcohol Prevention Coordinator, State of Maryland**

**Job source:** www.jobaps.com/MD

An Alcohol and Other Drug Abuse Prevention Coordinator is the full performance level of work in a single person program, assessing, designing, coordinating and implementing alcohol and drug abuse prevention programs within a local health department. Employees in this class do not have supervisory responsibilities.

Employees receive general supervision from a higher-level healthcare administrator in the Department of Health and Mental Hygiene's headquarters office.

Positions in this classification are evaluated using the classification job evaluation methodology. The use of this method involves comparing the assigned duties and responsibilities of a position to the job criteria found in the Nature of Work and Examples of Work sections of the class specification.

The Alcohol and Other Drug Abuse Prevention Specialist is differentiated from the Alcohol and Other Drug Abuse Prevention Coordinator in that the Alcohol and Other Drug Abuse Prevention Specialist performs the full

range of staff duties under general supervision in a multi-person program. The Alcohol and Other Drug Abuse Prevention Coordinator is responsible for administering a single person program, performing the full range of duties under general supervision of a headquarters healthcare administrator. The Alcohol and Other Drug Abuse Prevention Coordinator is differentiated from the Alcohol and Other Drug Abuse Prevention Supervisor in that the Alcohol and Other Drug Abuse Prevention Supervisor has full supervisory responsibility for Alcohol and Other Drug Abuse Prevention Specialists. The Alcohol and Other Drug Abuse Prevention Coordinator does not supervise but works a single person program.

**Examples of Work:**

- Monitors data collection to identify the problem areas specific to the community in order to develop, in the assigned local health department, addictions prevention plans and increase community awareness;
- Develops, coordinates and implements prevention educational programs and alternative youth activities to decrease and prevent drug and alcohol involvement and related risk behavior;
- Maintains and distributes alcohol and drug abuse prevention educational materials;
- Assists community groups, other agencies and organizations in developing, organizing and conducting programs to prevent and resolve conditions and problems related to alcohol and drug abuse;
- Plans, organizes and conducts training for staff of other State and local agencies, schools, local businesses, industries and community groups involved in alcohol and drug abuse programs;
- Prepares and maintains reports, records and documents pertaining to funding sources, program evaluation and reference information on chemical dependency;
- Develops and implements the alcohol and drug abuse prevention policies and procedures;
- Prepares grant proposals for addictions prevention projects;
- Evaluates the alcohol and drug abuse prevention program activities of the local health department to determine effectiveness and efficiency;

- Confers with the local health officers and program directors to recommend remedial or corrective actions to prevent alcohol and drug abuse problems;
- Develops and maintains a wide variety of alcohol and drug abuse educational services for use by program directors, school personnel, private and public organizations and the general public;
- Performs administrative functions related to the overall direction of the addictions prevention components within the local health departments;
- Performs other related duties.

**Knowledge, Skills and Abilities:**

- Knowledge of disease concepts of alcoholism and drug abuse dependency;
- Knowledge of principles and practices involved in the development and implementation of alcohol and drug abuse education and intervention programs;
- Ability to stimulate community action in the development of effective alcohol and drug prevention programs;
- Ability to compose promotional and educational literature relating to alcohol and drug abuse prevention;
- Ability to provide consultation in the areas of occupational alcoholism and/or drug abuse for employee assistance programs;
- Ability to effectively present topics on substance abuse;
- Ability to establish and maintain working relationships with other professionals and agencies.

**Minimum Qualifications:**

- Education: Possession of a bachelor's degree from an accredited college or university with thirty credits in behavioral science, health services, human services or education.
- Experience: Two years of experience in counseling alcohol or drug dependent clients; in providing therapeutic education services to alcohol

or drug dependent persons and their families; or in directing school or community health education.

**Notes:**

1. Sixty credit hours from an accredited college or university to include l8 credit hours in the behavioral sciences, health services, human services or education and an additional two years of experience as specified above may be substituted for the required education.
2. Additional experience as specified above may be substituted for the required education on a year-for-year basis.
3. Graduate level education in behavioral sciences, health services, human services or education may be substituted for the required experience on a year-for-year basis.
4. Candidates may substitute U.S. Armed Forces military service experience as a commissioned officer in Drug and Alcohol Counseling or Health Care Administration classifications or Mental/Behavioral Health and Drug and Alcohol Counseling or Health Services Administration specialty codes in the health related field of work on a year-for-year basis for the required education.

**Licenses, Registrations and Certifications:**
Employees in this classification may be assigned duties which require the operation of a motor vehicle. Employees assigned such duties will be required to possess a motor vehicle operator's license valid in the State of Maryland.

**Rehabilitation Specialist – Alpine Special Treatment Center, Alpine, CA**

**Job source:** www.indeed.com

**Salary:** $14.55–$19.05 an hour

**Mission:** Alpine Special Treatment Center Inc.'s (ASTCI) mission is to provide an environment where adults with mental illness and co-occurring disorders transition from acute crisis to stabilization. Clients' safety and well-being is maintained while encouraging and promoting individuals' highest level of independence through an integrated, individualized and comprehensive therapeutic program. ASTCI provides a welcoming environment and goal oriented program that gives the mentally disabled and dually diagnosed individual the

tools necessary to transition back into the community while maintaining a more independent lifestyle.

**Facility Information:** ASTCI is a secure, 113-bed mental health rehabilitation facility located 28 miles east of downtown San Diego. ASTCI has been providing services to the County of San Diego for 40 years. Our facility is CARF accredited, and recognized for excellence in providing treatment to clients, most of whom are conserved due to severe disability. We are proud to announce that Alpine Special Treatment Center has been selected as the 24-hour Program of the Year by the Mental Health Recognition Committee of San Diego. This is validation of our excellent program and dedication to our clients. ASTCI is open 365 days a year, 24 hours a day. You can learn more about Alpine Special Treatment Center Inc. by visiting: http://astci.com.

**Job Description:** Alpine Special Treatment Center, Inc. is currently seeking dynamic, caring, Masters-level clinicians to work closely with clients in a direct-care, team-based environment within an inpatient treatment setting. In addition, Alpine Special Treatment Center, Inc. is seeking individuals with an interest in leadership, and the ability to manage and provide support to a team of direct care staff during their shift. The position is fast-paced, team oriented and provides the opportunity for clinicians to gain experience in the treatment of clients struggling with severe and persistent mental illness while also gaining skills in leadership, compliance, and therapeutic interventions.

**Duties:** The Psychosocial Rehabilitation Specialist (PSRS) position works closely with clients in a direct-care, team-based environment on the secure dual-diagnosis units, to provide daily care to clients residing at the facility. Initially, entry level Psychosocial Rehabilitation Specialists learn the facility's policies and model of care and complete duties in line with the facility policies and model of care. Duties include the facilitation of groups and activities that support the psychosocial rehabilitation model, monitoring and observation of clients, activity of daily living support, documentation, crisis prevention/intervention, contraband searches, inventory checks, admission and discharge preparation with clients, and medication/meal monitoring. This position is offered under direct supervision at all times. Additionally, this position must demonstrate strong professionalism skills, dependability and adherence to HIPAA, client rights, safety and other pertinent regulations associated with client care. Advancement on the career ladder to Psychosocial Rehabilitation Specialists level II, III or IV is possible with demonstrated competency against the benchmarks outlined in the job description with related increases in the

pay rate. The ability to make a difference in clients' lives, increase knowledge of mental illness, enhance leadership, interpersonal and communication skills is limitless in this fast-paced and supportive environment.

**Work Schedule(s):** Full-Time (40 hrs per week)

**Working Days:** Mon, Tue, Wed, Thu, Fri, Sat, Sun; 1st Shift 7:00 am to 3:30 pm; 2nd Shift 10:00 am to 6:30 pm; 3rd Shift 3:00 pm to 11:30 pm

**NOTE:** Shifts may vary depending on client care needs, days off may not include standard weekend days or holidays. Flexibility in scheduling is favored.

**Salary/Benefits:** Competitive hourly rates commensurate with experience and the Psychosocial Rehabilitation Specialist role, from $14.55–$19.05/hour.

Night and weekend shift differentials are available, along with holiday premium pay. Comprehensive training to include crisis de-escalation certification (provided by the facility within first 90 days of employment). Company-paid health insurance within 60 days includes: Medical, Dental, Vision, Life/AD&D, and Long-Term Disability.

Paid time off (PTO), 401(k) retirement program. All Psychosocial Rehabilitation Specialists are eligible for ASTCI's quarterly incentive bonus program and additional career advancement opportunities during his/her tenure at ASTCI.

**Key Requirements:**

- Must pass pre-employment physical examination
- Must be proficient in written and spoken English
- Designated drug testing required
- Able to successfully pass a criminal background investigation (DOJ/FBI)
- Verification of educational credentials through a certified transcript
- Crisis intervention experience
- Team player
- Excellent communication and observation skills

**Qualifications Education or Training**: B.A. or B.S. in Psychology, Social Work, Counseling, or related field (or graduating within 3 months)

**Experience:** 2 years' experience working in a mental health setting may be substituted for the educational requirement.

**Certification:** Current/Valid CPR certification (AHA AED/BLS/Healthcare Provider)

**Physical Requirements:** This position requires walking, standing, and sitting for long periods of time. Incumbent will be climbing stairs, lifting up to 50 pounds, use dexterity of the hand and wrist and arm strength to perform various reoccurring tasks. As a component of the crisis prevention/intervention duties, the position may require a "hands on" component of the job associated with working with individuals that at times may present as aggressive or threatening due to their mental health symptoms.

**Preferred Qualifications:** Successful Psychosocial Rehabilitation Specialist practical experience in a psychiatric and/or substance abuse treatment setting is highly preferred.

**Job Type:** Full-time

## ADVOCACY FOR SUBSTANCE ABUSE – POLICY EXAMPLES

An interesting thing happens when you type "substance abuse policy" into the Google search engine. All of a sudden you are directed away from advocacy websites and news articles and instead you encounter examples of "policies" that businesses can use to enforce drug-free workplace policies. Addiction is a complicated issue. In the United States we have legal and illegal drugs that are often used to the point of addiction. On the federal level, the Substance Abuse and Mental Health Services Administration (SAMHSA) administers funding to states in order to address addiction.

The Overdose Prevention and Patient Safety Act (H.R. 3545, Rep. Tim Murphy [R-Pennsylvania]) would place all substance use disorder (SUD) patient records under the much looser protections of the Health Insurance Portability and Accountability Act (HIPAA) (Knopf, 2017). This would eliminate the confidentiality laws that lead to many people seeking treatment.

## REFERENCE

Knopf, A. (2017, October 2). Patient confidentiality campaign launched in 42 CFR Part 2 battle. *Alcoholism and Drug Abuse Weekly, 29*(38), 1–5.