


NASW SPECIALTY PRACTICE SECTIONS
SPRING/SUMMER ■ 2021

ATOD
ALCOHOL, TOBACCO & OTHER DRUGS

SECTION CONNECTION

Letter from the Chair

Thriving Through the Pandemic

I am so excited for the opportunity to serve as the chair for the ATOD specialty practice section, for several reasons: (1) I enjoy talking about and discussing critical issues within the work that we do, (2) I appreciate the ongoing opportunity to connect and work with other social workers in this practice area, and (3) I find ongoing joy at privilege to be able to do this work every day and walk alongside individuals looking to make positive changes in their lives. I use the words "walk alongside" because anyone who works in this space knows of the many challenges and opportunities that come with what we do. This can come in many forms, from supporting people engaging in mutual-aid groups to supporting individuals who are navigating other levels of care within the treatment continuum.

With that in mind, I wanted to focus on addressing some of the challenges and opportunities that occurred because of the COVID-19 pandemic. The uncertainty and constant changes of the treatment landscape have made it a difficult year for many of us. As a treatment provider, one issue that became apparent as states began to issue their various stay-at-home restrictions was how to continue to provide treatment services that provided ongoing access to existing and new consumers. This became an ongoing and evolving conversation with many providers, especially around the use of telehealth. One thing that I can say is that as a social worker working in this area, WE TOTALLY ROCK! The way that many of us were able to pivot and embrace the use of technology, adapt to rapidly changing policies and procedures, and navigate an everchanging treatment arena was awesome.

As social workers, being able to meet clients where they were using technology spoke to our overall commitment to ensuring accesses and continued treatment opportunities for people experiencing substance use challenges. I had the opportunity and pleasure to hear many stories of social workers going above and beyond to remove barriers such as lack of Internet or electronic devices, providing additional training for people who had technology challenges, and overall being flexible as we learned to adapt our treatment models to fit a virtual landscape. These acts may have seemed "just part of the job," but, they were much more. They provided people with the option to continue treatment and work on their recovery, and they offered individuals and families hope during challenging times. The work that we do is **ESSENTIAL!**

I want you all to take a moment and reflect on the past year. Think about all the moments that you made a difference in someone's life because of the great work that you do. Take pride in being a social worker and rising to the occasion during a global pandemic. I want to **THANK YOU** all for your hard work, perseverance, and dedication to the social work profession.

Anthony T. Estreet, PhD, MBA, LCSW-C, LCADC

NASW · SPS
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Anthony T. Estreet, PhD, LCSW-C, Chair
Nikki Fordey, LICSW, MLADC
Derrick Freeman, PhD, ACSW
Donald McDonald, MSW, LSAC
Jason Schwartz, LMSW, ACSW, MAC

MUTUAL AID and Informed Consent

DONALD MCDONALD, MSW, LCAS

I had eye surgery recently. The procedure was invasive enough that the disclosure of risk component of my ophthalmologist's informed consent included a startling percentage—20 percent to be exact. While the surgery likely would give me crystal clear vision, there was a 20 percent chance it could make my vision worse—much worse. Medical ethical practice dictates that my surgeon respects my rightful autonomy to choose my treatment after a discussion about the potential benefits—as well as the possible risks. I chose the surgery. It was touch-and-go for a couple of weeks, but I am happy to announce that my peepers are good to go.

From the NASW *Code of Ethics*, **Ethical Standard 1.03 Informed Consent directs** social workers to have similar conversations with our participants. We are directed to inform them of the potential benefits and possible risks involved with our services and provide them with an opportunity to ask questions. Informed consent is preceded by two exquisitely related and fundamental ethical standards: **1.01 Commitment to Clients** and **1.02 Self-Determination**. This is what we do! We wrote the book on person-centered practice. But do we fall short in our behavioral health practice, particularly when we are working with people experiencing substance use disorders (SUD)?

Many of us refer our participants to mutual aid meetings. Mutual aid organizations provide peer-based, nonclinical, nonprofessional support meetings to people in recovery from SUD. The meetings focus on socially supportive communication and the exchange of skills through shared experience. Mutual aid meetings based on the 12 steps, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), are some of the most widely available psychosocial supports for people seeking recovery from SUD. Numerous alternative mutual aid organizations have emerged over the years, yet none are as ubiquitous as NA and AA. If available, these alternative meetings provide choice for your participants who may want their mutual aid to have a specific flavor, for example, secular, gender-

specific, Native American, Christian, or harm reduction or moderation.

While the pandemic may continue to dominate the news cycle, we are still responding to the nation's overdose crisis. Social workers find themselves practicing in various settings where participants are prescribed medications for opioid use disorder (MOUD). Opioid agonist and partial agonist medications such as methadone and buprenorphine are the gold standard in OUD treatment. Despite 54 years of evidence supporting their efficacy, stigma surrounds these life-saving medications—particularly in 12-step culture. In fact, NA has made official statements relevant to the pharmacotherapeutic treatment of OUD. Bulletin #29, published in 1996 by the NA Board of Trustees, characterizes MOUD as "drug replacement therapy." It further expounds that people using MOUD may attend meetings and become members under Tradition 3, but they will not be considered "clean," the word NA uses to indicate abstinent. More recently, the NA World Board published a pamphlet entitled *Narcotics Anonymous and Persons Receiving Medication Assisted Treatment* (2016), in which they reaffirm that NA "treats" addiction with abstinence and spiritual principles and that treating addiction with MOUD is not considered abstinent. Conversely, AA considers pharmacotherapy an "outside issue." This language comes from Tradition 10, where 12-step groups eschew opinions on topics that may lead to public controversy. AA, however, is a mutual aid group focused primarily on people who identify as having a significant issue resolving problematic alcohol use, and discussions of drug use are generally not well received.

Many of the alternative mutual aid groups mentioned earlier have no stance on MOUD. Medication Assisted Recovery Anonymous (MARA) emerged to meet the specific needs of this population. Its attitude toward MOUD is summed up in its Preamble, which is read at the beginning of each meeting:

> *Medication-Assisted Recovery Anonymous is a support group of people who believe in the value of medication as a means to recovery. We understand that our individual needs may not be the same; our backgrounds may not be the same; our futures may not be the same. However, our desire to live a safe lifestyle joins us together. Non-judgement is our code.*

Additional mutual aid alternatives can be found in the surging digital mutual aid space. All 12-step and alternative groups—including MARA—have digital options (video or telephonic). The volume and variety of these digital meetings continues to grow in response to the pandemic. Many believe that this large digital presence is here to stay and ought to be maintained in your menu of resource referrals.

The potential benefits of 12-step mutual aid group participation are clear. Robust data strongly support the positive outcomes associated with prosocial engagement with a new, healthy peer group—replacing a culture of addiction with a culture of recovery. Good stuff. However, it is understood that with any medications, procedures, or referrals our treatment teams recommend to our participants, we have a responsibility to engage in balanced, informed consent—including disclosure of risk. So, what are the possible risks involved with 12-step meeting attendance? The following list I propose is not meant to be a blanket characterization of all 12-step meetings or disparaging to its members. It is also not intended to be comprehensive:

1. *Participants may encounter triggers such as graphic stories of drug use and trauma, people under the influence of drugs, or the presence of drugs or drug negotiations.*
2. *Participants may experience people seeking romantic and/or sexual relationships with vulnerable individuals. This act is prevalent enough to have its own moniker—13th stepping.*
3. *Participants will be exposed to language and concepts strongly rooted in Christian doctrine. This information may be relevant to the religion averse or participants practicing non-Christian religions.*
4. *Participants may encounter vestiges of 12-step's patriarchal origins. This information may be relevant to the healing/recovery of some women.*
5. *Participants may receive earnest and repeated medical advice from laypeople. They may be encouraged to discontinue medications for opioid use disorder as well as psychotropic medications for mental disorders.*

Once again, these are not guaranteed experiences. Neither was the 20 percent risk that my eye surgery might have gone south. I tread lightly here because the 12-step community is a nearly nine-decades-old culture—a splendid group of humans thriving in recovery and dedicated to sharing that experience and opportunity with others. These are my people. I am a person in sustained recovery from severe mental and substance use disorders since 2004, and mutual aid plays a role in my recovery. I am also a clinician. These are two distinctly different hats, and today I have no trouble distinguishing them. Social workers have volunteered for a challenging but rewarding journey—working with people with complex needs in systems seemingly designed for both provider and participants failure. We will seldom get lost when we remember our commitment to our participants, our vow to promote their self-determination, and our dedication to respect their autonomy and choice.
We got this.

Donald McDonald, MSW, LCAS, is the chief recovery officer at All Sober—a public benefit company whose mission it is to provide the millions of Americans suffering from substance use disorder and their loved ones with all the connections, information, and resources they need as they journey through recovery.

MEET THE COMMITTEE – Anthony T. Estreet, PhD, LCSW-C

Anthony Estreet, PhD, LCSW-C, is a tenured associate professor in the School of Social Work at Morgan State University. He is the director of the Health and Addiction Research Training Lab and is responsible for the development and implementation of the Social Work Addictions Training (SWAT) ASP within the Master of Social Work program. Anthony's main area of research for the past eight years has focused on program implementation and behavioral health treatment-related outcomes. He is the immediate past president for NASW-MD chapter and the immediate past and founding president for the Baltimore Legacy Chapter of the Association for Black Social Workers.

Anthony is also the CEO/executive director of Next Step Treatment, a behavioral health consulting and treatment center. Fueled by his strong desire to address health disparities through policy and practice efforts, Anthony has developed key partnerships with various community-based organizations, hospitals, and universities to provide ongoing training and technical assistance focused on improving treatment-related outcomes. He has been a practicing clinician for over 15 years in the area of behavioral health and is licensed in the state of Maryland for social work and addictions counseling. Anthony has significant experience in training and technical assistance related to addressing mental health and substance use disorders. He is a national trainer for SAMHSA's Central East Addiction Technology Transfer Center with a specialized training focus on behavioral health interventions. Anthony is also the addiction co-track chair for CSWE's annual program meeting.

WHAT DO YOU ENJOY ABOUT YOUR WORK?

I enjoy the day-to-day opportunities to work with students and community stakeholders addressing issues related to behavioral health with a specific focus on substance use. Being able to integrate the goal of practice-informed research and research-informed practice has led to a variety of enhanced training opportunities for both the students and community members. Students get experiential training outside of the classroom and community stakeholders get to engage with students in grassroots efforts that inform policy, practice, and research.

CHALLENGES FOR SOCIAL WORKERS IN MY PRACTICE AREA:

One of the biggest challenges that I see for social workers within the practice area is language. As social workers enter the space of working with people impacted by alcohol, tobacco, and other drugs, it is imperative that we be mindful of the language that we use and be intentional about removing any stigmatizing words. This takes deliberate effort to keep up with the current terms within the practice area and to always check in with ourselves about any biases we may have doing this work.

ADDICTION AND RECOVERY WORK in the Pandemic

JASON SCHWARTZ, LMSW, ACSW, MAC

The year 2020 brought challenges few of us imagined. In late 2019, after 25 years in a community-based addiction and recovery program, I joined a community hospital in metro Detroit as the director of behavioral medicine. The first COVID -19 wave was devastating in our community and overwhelmed the hospital's bed capacity. We had to create additional ICU capacity and repurpose many existing beds. We made the difficult decision to suspend our inpatient chemical dependence program and use those beds to create a comfort care unit for dying COVID patients. (Behavioral health services continued in our inpatient psychiatric unit, our outpatient Substance use disorder, (SUD) services, and the emergency department.) By May 2020, deaths had slowed dramatically but our community's mortality rate of 17.4 percent (Tankersley, 2020) was among the highest in the nation.

It is becoming an overused expression, but our hospital's staff were undeniably heroic, and many were now confronting the effects of chronic stress and trauma. Our parent hospital system made the decision to implement "resiliency rounds" on staff in high-stress units, and I was asked to lead this effort at our hospital. The task included checking in with staff about their self-care and restorative activities. This project made me more aware that I had also been emptied by the experience and needed to model the restorative activities we were encouraging. Writing about addiction treatment and recovery had been a rewarding activity in the past, but I felt completely drained and uninspired. It occurred to me that interviews would not require any creativity on my part and would provide an opportunity to connect with peers, so I recruited a few colleagues to do a series of interviews with addiction professionals about how the pandemic was affecting their work and their clients.

We interviewed 12 professionals representing six states and two countries. There were six social workers, plus the six subjects from allied disciplines including a physician, certified SUD counselors, public health educators, and masters level counselors. Their areas of practice spanned residential treatment, outpatient services, harm reduction, advocacy, peer coaching, crisis response, corrections, and medication-assisted treatment. Here is what we heard from them.

Loss: The two Detroit professionals reported losing colleagues to the pandemic and one reported losing at least 33 members of their local recovering community. In addition, both colleagues and clients experienced losses in their personal lives. This means these workers were having to navigate losses in their own personal spheres while also supporting clients who were dealing with losses in their personal spheres as well as within their shared spheres (program staff and members of the recovering community). To make matters worse, the pandemic disrupted rituals of mourning, like homegoings, remembrances, and funerals. These professionals were still living this experience and didn't profess to have solutions, but they did discuss their coping strategies, which included good nutrition, physical activity, and finding ways to stay connected to their personal systems of support.

Social Distance: "Social distancing" is a phrase we've all heard countless times since the beginning of this pandemic, and we have probably become numb to it. Despite this, social distance was an especially salient theme in these interviews. Isolation is often central to the experience of addiction, and connection to growth-fostering relationships and communities are often central to treatment and recovery support. Social distance functions as a countervailing force to our use of groups and emphasis on community, resulting in an experience of disconnection and loss for several of the workers and their clients. Multiple professionals described this loss in multisensory ways, including loss of touch, no longer sensing the physical presence (or energy) of clients and colleagues, no longer smelling others (noting that he was not previously aware of other's scents), and the brief incidental interactions that occur throughout a day in an agency or community. There was considerable concern about patient isolation, particularly among those who may not have consistent access to broadband or the technology to video conference. Despite their best efforts, these professionals have lost contact with many of their most vulnerable clients.

Totality of the Disruption: Another underlying theme is the totality of the disruption—that there does not seem to be anything that is unaffected. Clients' lives are disrupted. Workers' lives are disrupted. Agency life is disrupted. Community life is disrupted. Within each of these, there are multiple layers of disruption. Within family life disruptions include the isolation of elders, the loss of opportunities for children to play, tension between parents and teens about safety precautions, and

adjustment to home schooling, which includes countless considerations from supervision to space to technology to strategy. Other disruptions, each with multiple layers of their own, include financial, public transportation, food security, social networks, and spiritual practice. None of this addresses service delivery, which has its own layers of disruption that include closed offices, reduced capacity, new infection prevention protocols, staffing shortages, reduced referral options, implementation of new technologies, new expenses, reduced revenue, and a workforce that's dealing with all of the disruptions mentioned above.

Parallel Process: This pandemic can accurately be described as a disaster, and it is important to recognize that this is not a disaster that has happened (past tense), and social workers are now coming in to support clients who were affected it. This is an ongoing disaster that is experienced by the social workers, the organization, the community, and the clients. The losses and stressors that clients experience are simultaneously being experienced by the social workers and the agencies.

It is important to place this in the context of an addiction treatment infrastructure and workforce that has long been recognized as under-resourced and unstable (Garner & Hunter, 2014; McLellan et al., 2003). Bloom (2010) studied and described the effects of chronic stress in helping systems as follows: "These workplaces tend to have problems that parallel or mirror the problems of their clients, including organizations that are chronically crisis-driven and hyperaroused, having lost the capacity to manage emotions institutionally."

The professionals I interviewed did not describe their organizations in these terms, but they did recognize that these dynamics are common in human services and that substance use services are at elevated risk for them.

If we accept that the pandemic approximates a disaster, we can consider it a potential source of collective trauma. Bloom (2010) cited Kai Erikson's (1994) description of collective trauma as "a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality. The collective trauma works its way slowly and even insidiously into the awareness of those who suffer from it, so it does not have the quality of suddenness normally associated with 'trauma'. But it is a form of shock all the same, a gradual realization that the community no longer exists as an effective source of support and that an important part of the self has disappeared. . .. 'I' continue to exist, though damaged and maybe even permanently changed. 'You' continue to exist, though distant and hard to relate to. But 'we' no longer exist as a connected pair or as linked cells in a larger communal body."

Again, it is important to note that most professionals did not describe themselves or their organization as traumatized in this way, but they did see their communities as traumatized or at risk for trauma. It is also important to note that Erikson characterized collective trauma as a gradual realization, and most of the professionals interviewed expressed concern about the well-being of their staff and organization.

Opportunity: Finally, other themes that were heard in every interview were commitment to this population, perseverance through these difficult circumstances, and innovation in processes and use of technology. Nearly all believed that the field would see long-term benefits from the expansion of telehealth and videoconferencing. Benefits included lowered thresholds for engagement and retention of patients with transportation or geographic barriers, easier professional networking and support, easier professional supervision, more accessible continuing education, and opportunities for family engagement. Others saw opportunities to revisit policies and practices around medications for opioid use disorder, including take-home doses and initiation requirements. Others saw the pandemic as forcing a helpful reevaluation of nearly everything—including our values, our relationships with patients and each other, and our place in society as essential workers.

Most of these interviews were conducted during the summer and early fall, before these regions were hit with second and third waves of COVID. In hindsight, I wish I had explored what they were learning about self-care in the context of a sustained crisis. It was touched upon in several interviews but was not an area of focus. The comments we did hear from the professionals we interviewed were congruent with recent comments from Blair Braverman (Swisher, 2021), an adventurer and Iditarod competitor. She reflected on the lessons her sled dog experience has taught her about enduring the pandemic (emphasis mine):

> *"So the similarity between the pandemic and mushing is that you don't know how far you're going, and* ***you don't know how much it will take to get there.*** *Every time I harness up my dogs, and they're barking and they run out of the yard and onto the trail, they don't know if they're going two miles or if they're going 200 miles. They do not know. They're just going to run, and they'll tire themselves out if I don't slow them down because they aren't able to see ahead. So, in order to get my team to endure something of an incredible distance, I need to force them to rest before they want to. And that's actually the hardest thing. People ask us how we teach sled dogs to run. And the answer is, you literally put a harness on them, and they run. You don't have to teach anything, but you do have to teach them to rest, and that is a challenge. It is a lot easier to prevent fatigue than to recover from it. Just to bring that back to the pandemic, what I would just say is, people are pushing themselves really hard. And you need to make sure that you're acting as if it could go forever. You need to be*

resting, taking care of yourself, getting enough sleep, connecting with your friends. All these things are things we feel like we can push to later. But if you get too isolated or scared or any of these things, it's just going to be so hard to undo."

These lessons are undoubtedly true for everyone, but they seem especially important for those of us whose life's work is serving our most vulnerable neighbors.

Jason Schwartz, LMSW, ACSW, MAC, is the director of behavioral health at St. Mary Mercy Hospital in Livonia, Michigan. He can be reached at jfschwartz@gmail.com.

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MEET THE COMMITTEE – Derrick Freeman, PhD, ACSW

Derrick Freeman, PhD, ACSW, helped transform a broken New Orleans Juvenile Court into a model for the nation's inner-city juvenile justice systems. Through his innovative ideas and support of mental health/behavioral health, health care, social services, education, and mentoring of young people and families, Derrick continues developing, supporting, and transforming systems to their prominence. Derrick is a member of the National Association Social Workers, Council on Social Work Education, Kappa Alpha Psi Fraternity, Inc., 100 Black Men of Metro New Orleans, and a host of other associations; he is an associate professor of social work in the Millie M. Charles School of Social Work at Southern University at New Orleans; and he continues to practice, develop, and implement programs, and advocate for a united Greater New Orleans, addressing the ever-changing needs.

WHAT IS YOUR AREA OF EXPERTISE?

Chemical dependency, behavioral health and health care policies, and their impact on urban communities. I have lead agencies, organizations, and advisory boards, where I impact policy in behavioral health, health care for the aging, family systems, the environment, crime prevention, juvenile justice, housing, jobs, and recreation.

WHAT DO YOU ENJOY ABOUT YOUR WORK?

My primary mission as a social worker is to enhance human well-being and help meet basic and complex needs for all people, focusing on individuals/groups that are vulnerable, oppressed, and living in poverty.

CHALLENGES FOR SOCIAL WORKERS IN MY PRACTICE AREA:

People go untreated for various reasons (lack of understanding, lack of resources such as detox facilities/centers, living arrangement/location, etc.). I find that many people in need of treatment may be reluctant to seek help because they hold certain beliefs about it, they may not have insurance to cover the costs, or they may live in an area where treatment is not available.

NASW PRACTICE PERSPECTIVE

Alcohol Screening, Brief Intervention, and Referral to Treatment (SBIRT): Best Practices for the Prevention and Treatment of Risky Drinking in Girls/Women of Childbearing Age

Women are the fastest growing group of alcohol users in the United States.

High-risk drinking among women, defined as more than three drinks a day or more than seven drinks per week, increased by 58 percent over the last 10 years, while alcohol use disorders (AUDs) rose by 84 percent. Read more visit:

https://naswinstitute.inreachce.com/Details/Information/5b231b2b-3358-420d-b4bf-8a5af181bbdd

UPCOMING LIVE SPS WEBINAR

FRIDAY, JUNE 4, 2021 (1-2:30 EDT)

Taking a Look at Guardianship: Important factors for Social Workers

Presenter: Jennifer Crumlish, PhD, ABPP and Malika Moore, MSW, LICSW, LCSW-C
CE Category: 1.5 Social Work contact hours
Cost: SPS Members: Free

Guardianship is a legal intervention used to protect incapacitated adults through the appointment of surrogate decision makers, typically social workers and psychologists, who assist the court in their decision-making on these matters. Social workers should certainly be particularly concerned about guardianship as more people live into older ages with some degree of impairment. This workshop presents an overview of the guardianship decision-making process and of the roles social workers and psychologists play in promoting social justice and care through their assessment process. We look at factors that are critical to social workers in our decision-making process when making a determination for or against guardianship of an incapacitated adult.

To register visit: The SPS Webinar Catalog

MEET THE COMMITTEE – Nikki Fordey, LICSW, MLADC

Nikki Fordey, LICSW, MLADC, holds a BA in English from Northeastern University, an MSW from Simmons University, and a MA in public policy from New England College. She is a licensed independent clinical social worker in Massachusetts and New Hampshire and a Masters Licensed Alcohol and other Drug Counselor in New Hampshire. Currently, she provides mental health and substance use disorder counseling and case management to people recently released from federal prison. Nikki is also active in local and state politics, as she is currently vice chair of her town's budget committee and was a candidate for NH State Representative in 2020. Nikki lives in Litchfield, NH, with her partner, Patrick, and their two rescue dogs, Grumbles the pug and Tex the bulldog mix.

WHAT IS YOUR AREA OF EXPERTISE?

I hesitate to call myself an expert because I am always learning new things, but since graduating with my MSW in 2014 I have consistently specialized in co-occurring disorder treatment and integrating medication-assisted treatment where appropriate and available.

WHAT DO YOU ENJOY ABOUT YOUR WORK?

I enjoy helping people realize their full potential and setting the goals they want for themselves, not what others believe or have told them they should be doing. I am passionate about harm reduction work and meeting people where they are without judgment. It is my clinical work that informs my efforts to influence and change public policy; (with permission) I bring my clients' voices to elected officials and advocate for policies that will benefit our shared society.

CHALLENGES FOR SOCIAL WORKERS IN MY PRACTICE AREA:

Unfortunately, there are a lot of myths, misinformation, and stigma out there about substance use, substance use disorders, and harm reduction efforts. I am passionate about pushing for evidence-based reforms that will help people live fulfilling and complete lives on their own terms. I believe that even within the social work profession there is a lack of education and understanding of what it means to do the work I do, and especially what I am doing currently in assisting people to reintegrate into society after incarceration. My hope is that more social workers will reread the Code of Ethics and realize that ALL people are worthy of dignity and compassion.

MEET THE COMMITTEE – Donald McDonald, MSW, LCAS

Donald McDonald, MSW, LCAS, is a person thriving in sustained recovery from severe mental and substance use disorders since 2004. Donald calls himself a recovery activist because he understands that people experiencing mental and substance use disorders face discriminatory barriers to freedom and wellness—and that the recovery movement is a social justice movement. He leverages his privilege and recovery status along with his clinical knowledge about substance use disorders, policy advocacy, and systems change to help rural and underserved communities create innovative programs, address stigma, and embrace many pathways of recovery.

His background includes being a consumer of services, a provider of clinical services in multiple settings, a health policy advocate, and a recovery community leader. Previously, Donald served as the national field director of Faces & Voices of Recovery, SAMHSA STR-TA Recovery Consultant for North Carolina, executive director of Addiction Professionals of North Carolina, and director of advocacy and education for Recovery Communities of North Carolina.

Donald currently works as a technical expert lead with JBS International, directing technical assistance for Health Resources and Services Administration Rural Community Opioid Response Program (RCORP) grantees across the country. He is a war veteran, former preschool teacher, husband, father, grandfather, and social worker. He holds a Bachelor of Education from North Carolina State University and an MSW from University of North Carolina Chapel Hill. For fun, he hikes with his wife, plays his flugelhorn, and enjoys visiting recovery community centers and pie shops throughout the country.

WHAT IS YOUR AREA OF EXPERTISE?

Mental and substance use disorders recovery, rural health, community mobilizing, and addressing stigma.

WHAT DO YOU ENJOY ABOUT YOUR WORK?

When we empower people through deliberate education and vigilant advocacy, more lives are saved, more people find wellness, and more communities prosper. That's what I enjoy most about my work.

CHALLENGES FOR SOCIAL WORKERS IN MY PRACTICE AREA:

Progress within behavioral health policy and practice is a marathon—not a sprint—and many of us are ill-prepared for the levels of compromise and self-care required to sustain this fight long enough to experience forward motion.

MEET THE COMMITTEE –

Jason Schwartz, LMSW, ACSW, CAADC, MAC

Jason Schwartz, LMSW, ACSW, CAADC, MAC, is the director of behavioral health at St. Mary Mercy Hospital in Livonia, Michigan. Prior to St. Mary's, Jason spent 25 years at Dawn Farm, most of that time as clinical director. Jason's experience includes inpatient and outpatient psychiatric services, long- and short-term residential substance use disorder treatment, social detox, a community outreach center, adult and adolescent outpatient services, corrections outreach, and transitional housing.

Most of his work has focused on developing, embedding, and extending recovery support in the client's community. For decades, these strong connections to the community had been a protective factor from burnout. In recent years, the opioid overdose crisis turned this community engagement into a risk factor for secondary trauma. This experience focused Jason's attention on preventing overdose among clients while also preventing secondary trauma among the staff.

Jason blogs at Recovery Review. Blog and is a lecturer at Eastern Michigan University's School of Social Work.

WHAT IS YOUR AREA OF EXPERTISE?

Addiction, substance use disorders, and mental health care.

WHAT DO YOU ENJOY ABOUT YOUR WORK?

Mentoring new professionals, recovering community engagement, and witnessing dramatic transformations in clients. The addiction and recovery landscape is constantly changing at the community, academic, and professional levels. I enjoy the continuous learning that this area of practice demands.

CHALLENGES FOR SOCIAL WORKERS IN MY PRACTICE AREA:

Lack of access to treatment of adequate quality, intensity, and duration. This leads to poor outcomes, which leads to lowered expectations of systems, workers, communities, and patients.

Call for Social Work Practitioner Submissions

NASW invites current social work practitioners to submit brief articles for our specialty practice publications. Topics must be relevant to one or more of the following specialized areas:

- Administration/Supervision
- Aging
- Alcohol, Tobacco, and Other Drugs
- Child Welfare
- Children, Adolescents, and Young Adults
- Health
- Mental Health
- Private Practice
- School Social Work
- Social and Economic Justice & Peace
- Social Work and the Courts

For submission details and author guidelines, go to SocialWorkers.org/Sections. If you need more information, email sections@naswdc.org.

Did You Know?

There is a growing emphasis in the professional fields working with clients with SUDs on using short-term and limited interventions. However, many clients who are dependent on substances require long-term intervention.

For more information, visit SocialWorkers.org/Sections

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750 FIRST STREET NE, SUITE 800
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