


NASW SPECIALTY PRACTICE SECTIONS
FALL/WINTER ■ 2018

# ATOD
ALCOHOL, TOBACCO & OTHER DRUGS

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# Letter From the Chair

### CULTURAL HUMILITY: A PARADIGM SHIFT

Although the concept of cultural humility was introduced approximately 20 years ago (Tervalon & Murray-Garcia, 1998), the helping professions only recently embraced it. The delay may be due, in part, to the fact that it requires the dominant culture to be accountable, to take responsibility, and to act. The traditional concept of cultural competence assumes that if we simply know enough about a specific group's characteristics, norms, traditions, values, and beliefs, we will be able to provide effective interventions and successfully treat this group. Often this cultural knowledge is erroneously superimposed onto an existing evidence-based intervention that was developed and tested on a group of participants from the dominant culture; incorrectly, this still places the onus of responsibility on clients who are a part of a minority culture. The unspoken expectation is that because the practitioner has now learned all there is to know about a particular culture, the client should now adapt to a treatment model developed for the dominant culture.

Cultural humility, however, places the onus of responsibility on the practitioner. Three core concepts define cultural humility: lifelong learning, self-reflective practice, and positive action that challenges unequal power structures.

Cultural competence and cultural humility are also distinguished by how knowledge is acquired: With cultural humility, knowledge comes to the practitioner from the client, not just from a textbook or a scholarly publication. The practitioner honors the inherent wisdom of the persons served and views them as the experts of their own lives.

Self-reflective practice requires the practitioner to constantly check his or her own biases, and the practitioner who views practice through the lens of cultural humility understands that we all have biases and that the only way to overcome them is through acknowledgment and challenge—and a regular practice of honest, self-reflection.

The final, and perhaps defining, feature of the construct is positive action. Practicing within the framework of cultural humility compels us to challenge unequal power dynamics: institutional racism, homophobia, sexism, ageism, ableism, xenophobia, and unjust social policies. In short, cultural humility commands us to practice what we preach, and to live the core social work value of social justice.

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### REFERENCES

Tervalon, M., & Murray-Garcia. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Healthcare for the Poor and Underserved, 9*(2), 117-125. doi: org/10.1353/hpu.2010.0233. Cultural humility video resource: www.youtube.com/watch?v=SaSHLbS1V4w

# ATOD Committee Members





# STAFF SAFETY

JASON SCHWARTZ, LMSW, ACSW, MAC

*"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet. This sort of denial is no small matter. The way we deal with loss shapes our capacity to be present to life more than anything else… .We burn out not because we don't care but because we don't grieve. We burn out because we've allowed our hearts to become so filled with loss that we have no room left to care." (p. 52)*

Rachel Naomi Remen (1996)

By now, many of us unfortunately may have become numb to the near daily stories about the opioid crisis. The scale and persistence of the crisis is staggering. The crisis is eclipsing every other issue in ATOD services. Many angles have been covered, including the scale of the overdose crisis, the role of race in the public policy response, the impact on child welfare, the suffering of bereaved mothers and their advocacy activities, the role of harm reduction, and on and on.

An important, but neglected aspect of the crisis has been its effect on those in the field of substance use and prevention.

**What kind of toll do these deaths take on social workers and other addiction professionals?**

**How can workers protect themselves from burnout and vicarious trauma?**

**How can agencies protect and support their workforce?**

With so little written on the subject, workers and agencies are left to find their own way to maintain professional wellness while serving people with opioid use disorders, (OUD), their families and their communities.

As the clinical director of a community-based addiction treatment and recovery support program, these questions became important. While our staff had some knowledge of burnout, vicarious trauma, and self-care, these matters became salient in new ways. This article shares some of our experiences in the face of the crisis.

Our program primarily serves people with high severity, substance use disorders (SUDs) and services are organized around long-term engagement and facilitating involvement in the recovering community. It is common for us to stay engaged with clients for 18 months and

many of them provide support to current clients for years and decades. We also have dozens of members of the recovering community visiting facilities every day. Historically, this had been a powerful protective factor against burnout—every day, staff see living proof that their work is important and effective.

As the crisis escalated, we found ourselves convening increasingly frequent sentinel event meetings (A meeting to identify the root causes of an unanticipated event involving serious injury or death) for overdoses. Of course, we spent considerable time seeking better ways to meeting the needs of our clients and prevent overdoses. At the same time, we found ourselves increasingly concerned about the effect these losses were having on our staff. We reached out to other programs to hear about what they were seeing and how they were supporting their staff. To our surprise, they were aware and concerned about overdoses as a national issue, but they were not directly affected to the degree that we have been. This led to a surprising realization—that our long-term engagement with clients, their families and our connections in the recovering community (our historical protective factors) are risk factors for burnout and vicarious trauma in this crisis. It seems we hear about every overdose, while other programs often don't learn about overdoses that occur once patients leave their programs. Further, our deep involvement in the community means that we become a source of support for people throughout the recovering community, many of whom have never been clients. (e.g., volunteers, family members, attendees of education events, community members that support and sponsor clients, etc.)

It took some reflection to notice this and consider how to respond, and it was not always a planned, purposeful process. We eventually gravitated toward framing it as a safety issue for staff, as described by Bloom (2013). An expert on trauma-informed care, Bloom describes a "safety culture" as an essential element of any trauma-informed system. A safety culture addresses four interacting safety domains: physical, psychological, social and moral. Attention to parallel process, as systems in sustained close contact tend to develop similar patterns of thoughts, feelings and behaviors (2010). This means it is not possible to maintain a safety culture for clients without also maintaining a safety culture for staff.

Moral safety is probably the least concrete of these domains but it was one of the first domains on our radar. We were concerned about the moral distress that staff might be experiencing, including:

- a gnawing sense that they've failed their clients, client's families, colleagues, community and organization;
- a vague sense that they could have and should have done more;
- wondering if we were living up to our organizational and personal values;
- a sense (real or imagined) that interrogation of our practices would not be accepted.

We sought to ensure moral safety by making a concerted effort to ensure open dialogue in sentinel event meetings. We developed a preamble to the meetings, stating and restating that the purpose of the meeting was to learn and improve, not to assign blame. We also tried to convey a desire to discuss anything that seemed relevant to anyone at the table—that nothing is taboo.

Administration took the lead by asking challenging questions about agency policy and whether the problems we face demand new practices and an evolution in organizational philosophy.

It didn't take long for social and psychological safety issues to emerge. Many of these questions were unspoken, but just beneath the surface:

- I'm a professional, should I be feeling this grief?
- What if I cry? How will others respond? What will they think of me?
- I want to reach out to the family. Is that about my needs, or theirs? If I share that thought, will others see?
- I'm angry at the client. If I share that feeling, will others judge me?
- I'm noticing some things I think I failed to do. What will others think? Will they blame me?
- I don't know if I can keep doing this work. Will others think I'm weak or not committed?
- Do I know what I'm doing? Do we know what we're doing?

We addressed these safety issues by expanding the sentinel event preamble to create an expectation of grief and inviting everyone to share their thoughts and feelings as addiction professionals and as human beings who have experienced a loss. It also reminds us that this experience of loss is not a problem to be solved. As such, our response should be to listen generously and care for each other, rather than attempt to fix it.

Again, it was important that organizational leaders modeled sharing their thoughts and feelings, even if it made them feel vulnerable. This made it possible for others to do the same. Many of us imagined that this might open floodgates and consume considerable time and resources. This has not been the case. It appears the most important element is creating space for staff to share their reactions and support each other. The result is actually the opposite of what we feared. Staff spend less time ruminating, they are less anxious, and are more connected to each other in ways that support each other's wellness and growth.

This has not just been about protecting the wellbeing of our staff. As a result, we've been able to work together to adapt policies, develop new practices and improve existing practices to prevent overdoses, improve recovery monitoring and follow-up, improve collaboration with other providers, improve informed-consent, and identify and provide support for others affected by the overdose.

We don't profess to have all the answers and are very interested in hearing how other agencies are weathering this crisis. Please consider sharing your experience with me at jschwartz@dawnfarm.org. If we get enough responses, we'll publish a follow-up.

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## REFERENCES

Bloom, S.L. (2010). *Organizational stress as a barrier to trauma informed service delivery.* In Becker, M. and Levin, B. A Public health perspective of women's mental health, New York: Springer (pp.295–311).

Bloom, S.L., & Farragher, B.J. (2013). *Restoring sanctuary: A new operating system for trauma-informed systems of care.* Oxford: Oxford University Press.

Remen, R.N. (1996). Kitchen table wisdom: Stories that heal. New York: Riverhead Books.

## RESOURCES

Blau M. (2017). STAT forecast: Opioids could kill nearly 500,000 in U.S. in next decade. STAT. Retrieved from www.statnews.com/2017/06/27/opioid-deaths-forecast/

Felter C. (2018). The U.S. opioid epidemic. Council on Foreign Relations. Retrieved from www.cfr.org/backgrounder/us-opioid-epidemic

# LANGUAGE MATTERS

DONALD MCDONALD, MSW, LCAS

I was honored recently to address a room of journalists on harm reduction and treatment access issues. Naturally, I discussed the terrible influence of our most recent epidemic: North Carolina lost 1,726 citizens to accidental drug overdose in 2016, twice the number lost just six years earlier. I reminded folks that there is "nothing new under the sun." Although the current opioid epidemic is measured in a staggering loss of life, we as a society are no strangers to the negative outcomes that result from inappropriately responding to addiction—overflowing prisons and jails have been the metric of our failure for decades. Additionally, I was asked to offer a potential new angle for our audience: What stories haven't been told? What stories haven't been told enough? I struggled with this task in the back of my mind even while I grew outraged sharing such information as:

- We lose two loaded school buses per month in North Carolina to accidental drug overdose—and that number continues to rise;
- One in 7 people have a substance use disorder, and we know what causes it, and we know how to prevent it, and we know how to treat it, and we know that people have the potential to get better than well;
- Only one in 10 people have access to specialized treatment, and what we have been considering appropriate treatment for decades is not;
- Funding and resources for treatment and recovery continue to decline despite our growing knowledge and the rising loss of life; and
- People continue to be denied systems of compassion and care as we transfer them to systems of control and punishment.

**Epiphany.** I found the story that has not been told. I asked, "Where is the outrage?!" Whether this audience of journalists chooses to run with my suggestion, I don't know. Collective outrage may get us out of this crisis, but how did we get here? We have five decades of research proving that addiction is a chronic brain disorder, not a moral failing. We know how to prevent it. We know what causes it. We know how to treat it. We know recovery is a reality. Yet we have been responding to alcohol and other drug problems with the acute care model of addiction treatment and incarceration. How did we get here? Discrimination and the language we use is a big part of the problem—and the solution.

Everybody knows somebody in recovery from substance use disorder, but they may not realize it. The reason is that folks are reluctant to speak openly about their recovery status. Reasons range from shame to fear of retaliation, to concerns about anonymity within 12-step recovery affiliations. Estimates indicate that more than 20 million people are in recovery and that a similar number need treatment. In the absence of recovery stories, the public, policymakers, and systems of care and punishment have been able to maintain tremendously negative and inaccurate stereotypes about the people who develop substance use issues.The recovery community must own its measure of blame for the discriminatory structures that create obstacles to people initiating and maintaining recovery.

Many folks don't initiate recovery because of stigma. Many people can't maintain recovery because stigma creates barriers to employment, safe housing, higher education, and so on. Stigma becomes discrimination when negative public perception evolves into negative public health policy. According to the 2015 International Conference on Stigma at Howard University, in Washington, DC, stigma is defined as "a degrading and debasing attitude of the society that discredits a person or a group because of an attribute.… "Stigma destroys a person's dignity; marginalizes affected individuals; violates basic human rights; markedly diminishes the chances of a stigmatized person of achieving full potential; and seriously hampers pursuit of happiness and contentment." (International Conference on Stigma, 2018) When an oppressed population endures the stress of stigma, members can develop *internalized stigma*. One study shared that an insidious variant of shame occurs when a person cognitively or emotionally absorbs stigmatizing assumptions and stereotypes … and comes to believe and apply them to him- or herself (Drapalski et al., 2013). The study authors go on to state that persons suffering from internalized stigma develop still worse health outcomes, such as depression, feeling helpless, worsening symptoms, and a decreased likelihood to seek treatment or self-advocate. In summary, the presence of stigma inhibits help-seeking behaviors and limits one's healing capacity even when help is sought.

Don Coyhis, leader of the White Bison Wellbriety movement, is often quoted as saying, "Words are important. If you want to care for something, you call it a *flower*; if you want to kill something, you call it a weed." White Bison Wellbriety supports sober lifestyles and advocates for Native American Recovery and Wellness. The language we use to describe persons with substance use disorders has an impact on public perception, public policy, and the

development of internalized stigma or shame; for many the term *substance abuse* is a particularly heinous offender in this regard. In one randomized study, health care workers at two conferences (n = 728) completed a survey with case studies describing the subject as either a substance abuser or as *having a substance use disorder*. In the case study, the subject was having difficulty complying with court orders. The study asked the health care workers to recommend options ranging from the therapeutic to the punitive. Those workers with the *substance abuser* case studies were significantly more likely to recommend punitive measures (Kelly & Dow, 2009; Kelly & Westerhoff, 2009). The very presence of this pernicious label affects the quality of care we offer the vulnerable populations whom we serve. This study is "smoking gun" evidence we need to convince systems of care and practitioners to stop using outdated, inaccurate, and stigmatizing labels.

"The *lapse/relapse* terms are rooted in morality and religion, not health and medicine, and come with considerable historical baggage," wrote White and Sade (2010). They cited such examples as: *lapse of faith, lapse in grace, lapse in judgment, lapse into bad habits, lapse in payments,* and so on. The authors go on to state that these terms regarding addiction entered the medical profession during the temperance movement, when it was still widely believed that uncontrolled substance use was an issue of weak will and low morals. But this terminology never left, even after science proved that addiction is a chronic brain disorder. White and Ali (2010) suggested a move toward more morally neutral language, which more accurately describes a return of symptomology, such as *recurrence* or *return* to use. When our programmatic activity is geared toward sustaining remission post-treatment, wouldn't it be more accurate to call it *recovery management* over *relapse prevention*? The former focuses on promoting an overall healthy lifestyle to sustain remission from chronic illness; the latter focuses on not engaging in a singular behavioral manifestation of illness. The term *relapse prevention* propagates the self-inflicted myth of substance use disorder and denies the complex nature of social determinants of health and the need for robust recovery support services.

The national advocacy organization Faces and Voices of Recovery offers a solution, Recovery Community Messaging Training (RCMT). This language transformation curriculum is based on research into the power of language. Peter D. Hart & Associates and Robert M. Teeter's Coldwater Corporation (2004) conducted a survey of the recovery community and the public, with eight focus groups in four cities. The survey addressed issues of anonymity, language, stigma, and discrimination. One finding concerns a long-standing norm within 12-step communities. The study measured public perception such expressions as, "I'm a recovering alcoholic." Only 22 percent of respondents understood that the speaker is free from addiction and no longer uses alcohol or other drugs. A stunning 62 percent believed that the speaker is still trying to quit using alcohol or drugs. Research shows that even when folks do "come out," if they use traditional 12-step language, most people assume they are still sick. When allies and helpers refer to people living with substance use disorder as *alcoholics* and *addicts*, they often feed a negative and inaccurate stereotype.

Michael Botticelli is the former director of the White House Office of National Drug Control Policy, the first "drug czar" openly in recovery. He was openly in long-term recovery from a substance use disorder. Upon his departure from office, he circulated a memo, hoping to continue our transition from the "war on drugs" to building compassionate and competent systems of care for people touched by addiction. He writes, "By using accurate, non-stigmatizing language, we can help break the stigma surrounding this disease, so people can more easily access treatment, reach recovery, and live healthier lives." We are experiencing the deadliest public health emergency in American history, and we are working within underfunded, understaffed, fractured, and siloed systems to contain it. The solution is undoubtedly complex, but one element is well within our capacity, and we can begin implementing it today: language matters.

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## REFERENCES

Drapalski, A.L., Lucksted, A., Perrin, P.B., Aakre, J.M., Brown, C.H., DeForge, B.R., & Boyd, J.E. (2013). A model of internalized stigma and its effects on people with mental illness. *Psychiatric Services, 64*(3), 264–269. doi:10.1176/appi.ps.001322012

International Conference on Stigma. Retrieved from www.whocanyoutell.org

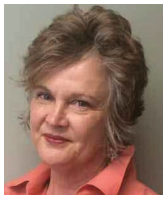
Kelly, J.F., & Dow, S. (2009). Stigma in addiction: Does it matter how we refer to individuals with substance-related conditions? *Alcoholism: Clinical Experimental Research, 33* (Supplemental), 129A.

Kelly, J.F., & Westerhoff, C.M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy, 21*(3), 202-207. doi:10.1016/j.drugpo.2009.10.010

Peter D. Hart Research Associates, Inc. (2004). *Faces and voices of recovery public survey*. [Online.] Retrieved from www.favor.org.za/new_pdf/2004_hart_survey_analysis.pdf.

White, W. & Ali, S. (2010). *Lapse and relapse: Is it time for a new language?* [Online.] Retrieved from www.facesandvoicesofrecovery.org.

# WOMEN AND RISKY DRINKING: Prevalence, Risks, and Preventing Alcohol-Exposed Pregnancy



ANITA PREWETT, MS, MA
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**"Americans are drinking more, but why?"** asked the headline in *Huffington Post*, one of several media outlets to report on findings published last summer in *JAMA Psychiatry* (Grant et al., 2017). The researchers analyzed data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC-III, 2012–2013), and what they found is indeed newsworthy: high-risk drinking—particularly among women, minorities, and older Americans—rose significantly over the decade since the previous survey (NESARC, 2001–2002). Not only are more women drinking (69 percent reported past year alcohol use, a 16 percent increase since 2002), but also high-risk drinking and alcohol use disorders are on the rise. High-risk drinking — defined in NESARC as, for women, four or more drinks on any day at least weekly—was reported by 9 percent of female respondents, compared with about 6 percent in the previous survey. Further, 13 percent of women reporting past year alcohol use are drinking at levels that meet criteria for DSM–IV alcohol use disorders, compared with 8 percent in the last survey (Grant et al., 2017).

As Grant and colleagues (2017) note, rising alcohol use comes with increases in alcohol-related health risks, injuries, and chronic conditions. Women face unique health risks tied to drinking. Sex differences in physiology affect how women absorb and metabolize alcohol, increasing their susceptibility to its harmful effects. Not only do alcohol-related problems such as brain atrophy and heart and liver disease progress more rapidly in women, but women also experience a "telescoping effect"—that is, they progress from alcohol use to dependence more quickly than do men. There are also specific risks to reproductive health, including alcohol-exposed pregnancy and Fetal Alcohol Spectrum Disorders (FASDs).

The good news is that evidence-based alcohol screening and intervention strategies are available for social workers to use in health centers, schools, counseling centers, and other clinical settings that serve women of reproductive age. A look at new data on patterns of alcohol risk behaviors among women highlights the critical need for prevention.

## ALCOHOL'S NARROWING "GENDER GAP"

Women born since the late 1980s are almost equally as likely as men to drink, engage in binge drinking, and experience problems related to alcohol dependence (White et al., 2015). Researchers suggest changing social norms, career pressures, and economic and life stressors as contributing factors. New alcoholic beverages and marketing strategies targeting women also play a role. Finally, experts note, it is easier to "binge" than a woman might think: Tracking consumption is tricky when many cocktails and craft beers have alcohol levels significantly higher than National Institute on Alcohol Abuse and Alcoholism, NIAAA's "standard drink" (U.S. Department of Health and Human Services, n.d.).

## BINGE DRINKING AMONG WOMEN

Overall, 18 percent of women ages 18 to 44 engaged in binge drinking in the past month. Among women ages 25 to 29, however, the prevalence

of reported binging rises to almost 24 percent, and peaks at 29 percent for women ages 21 to 24 (Tan, Denny, Cheal, Siezek, & Kanny, 2015). For adolescents, 43 percent of 12th-grade females (and roughly one in three females in grades 9 to 12, overall) report past month alcohol use, with nearly one in four reporting that she drank "five or more drinks in a row" (Kann et al., 2016).

## ALCOHOL-EXPOSED PREGNANCY

Women at risk of an alcohol-exposed pregnancy (AEP) are (a) consuming alcohol, (b) having vaginal sex with a male, and (c) not using contraception consistently and correctly. Alcohol use during pregnancy can have serious adverse effects on birth outcomes. The risk of having an AEP is not limited to women with substance use disorders: *AEPs occur in every demographic and socioeconomic group*—3.3 million U.S. women are at risk of an AEP, according to Center for Disease Control and Prevention, CDC estimates (Green, McKnight-Eily, Tan, Mejia, & Denny, 2016).

**Consider this fact:** Almost half of all U.S. pregnancies—and up to 75 percent of adolescent pregnancies—are unintended, and many women, unaware of their pregnancy, drink during early fetal development. Some pregnant women will continue to drink: more than 10 percent of pregnant women reported past month alcohol use; 3 percent reported binge drinking. Among binge drinkers, *pregnant women reported a higher frequency of binge drinking* than did nonpregnant women (Tan et al., 2015).

## FETAL ALCOHOL SPECTRUM DISORDERS

Along with the recent focus on the serious dangers of opioids and heroin to newborns, ongoing studies continue to document the lifelong, systemic damage caused by in-utero alcohol exposure. Alcohol is a potent teratogen—an agent that interferes with fetal development—and prenatal alcohol exposure is one of the leading causes of preventable birth defects and neurodevelopmental disabilities. FASDs—the umbrella term for the range of lifelong cognitive, behavioral, and physical consequences of prenatal alcohol exposure—affects up to one in 20 U.S. school children (May et al., 2018). Primary prevention that targets alcohol use by women who are preconceptional is key to reducing the prevalence of FASDs.

The combination of risky drinking, binge drinking, and the danger of an AEP reinforces the importance of prevention strategies targeting women. Routine alcohol screening, evidence-based interventions for risky drinkers, and clear, consistent messages about the dangers of alcohol use during pregnancy are critically important tools in reducing harmful drinking, AEPs, and the prevalence of FASDs.

## TOOLS FOR PREVENTION

Alcohol Screening and Brief Intervention (SBI) is a key clinical tool for identifying and helping individuals who may be drinking at harmful levels. Basically, SBI involves: (a) using a validated set of brief screening questions (e.g., AUDIT, CRAFFT) to identify clients' drinking patterns, (b) having a short conversation—a quick intervention to motivate change—with clients who are drinking at risky levels, and (c) making referrals to treatment for individuals with alcohol use disorders. Social workers in diverse practice settings are well positioned to employ SBI to help women. For practitioners looking to enhance their skills, numerous SBI resources are available online through the CDC, Substance Abuse and Mental Health Services Administration (SAMHSA), and NASW's Behavioral Health resource websites.

Social workers in primary care or integrated behavioral health settings may be positioned to offer the CHOICES intervention to women who screen positive for risk drinking. CHOICES* is an evidence-based extended intervention (adapted for two to four sessions) that uses motivational interviewing and personalized feedback to spur motivation and commitment to behavior change. The premise of CHOICES is that women can make the choice to change one

## DID YOU KNOW

**SAMHSA Locator is an on-line source of information about substance abuse and/or mental health treatment facilities in the United States. For more details visit: https://findtreatment.samhsa.gov/**

or both behaviors—risky alcohol use or ineffective contraception—to prevent an AEP. The book *Women and Drinking: Preventing Alcohol-Exposed Pregnancies* (Velasquez, Ingersoll, Sobell, & Sobell, 2016) outlines CHOICES and CHOICES-like interventions; free training guides are available on the CDC website.

## WHAT SOCIAL WORKERS CAN DO?

The field of social work is engaged in several national initiatives to promote and implement evidence-based practices to reduce risky drinking and AEPs. NASW is a member of CDC's cross-disciplinary national partnership to promote FASD awareness and the uptake of prevention strategies.

Social workers in the ATOD Specialty Practice Section are front-line members of teams aiming to improve the lives of individuals, families, and communities affected by substance use. Prevention and early intervention are essential elements in the continuum of care for clients. Across practice settings and in various roles, social workers are well prepared to:

- Advocate for and develop policies and procedures to implement and sustain evidence-based prevention services
- Screen for alcohol use, perform brief interventions, and treat or make referrals for treatment of problem drinking
- Screen sexually active teens for alcohol use and provide evidence-based interventions to reduce AEP risk
- Advise pregnant women to stop drinking, using nonjudgmental language and offering help if needed
- Clear up misconceptions about drinking while pregnant (that is, there is no known safe amount, no safe type, and no safe time)
- Communicate a consistent message: Women should not drink during pregnancy.

For more information and to access free online continuing education courses, please consult:

CDC Fetal Alcohol Spectrum Disorders Training and Resources
www.cdc.gov/FASDtraining

*NASW Practice Perspective: Fetal Alcohol Spectrum Disorders: A Guide to Resources* (Spring 2017) Retrieved from: www.socialworkers.org/LinkClick.aspx?fileticket=Xi0H5JNZ9Bg%3d&portalid=0

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## REFERENCES

Grant, B.F., Chou, S.P., Saha, T.D., Pickering, R.P., Kerridge, B.T., Ruan, W.J… & Hasin, D.S. (2017). Prevalence of 12-month alcohol use, high-risk drinking, and DSM-IV alcohol use disorder in the United States, 2001-2002 to 2012-2013. *JAMA Psychiatry, 74*(9), 911-923. doi:10.1001/jamapsychiatry.2017.2161

Green, P.P., McKnight-Eily L.R, Tan, C.H., Mejia, R., & Denny, C.H. (2016). Vital signs: Alcohol exposed pregnancies—United States, 2011-2013. *MMWR: Morbidity and Mortality Weekly Report, 65*(4), 91-97.

Kann, L., McManus, T., Harris, W.A., Shanklin, S.L., Flint, K.H., Hawkins, J., …Zaza, S. (2016). Youth risk behavior surveillance —United States, 2015. *MMWR: Surveillance Summaries, 65*(6), Table 51.

May, P.A., Chambers, C.D., Kalberg, W.O., Zellner, J., Feldman, H., Buckley, D., . . . Hoyme, H.E. (2018). Prevalence of fetal alcohol spectrum disorders in 4 US communities. *JAMA, 319*(5), 474-482. doi:10.1001/jama.2017.21896

Tan, C.H., Denny, C.H, Cheal, N.E., Sniezek, J.E., & Kanny, D. (2015). Alcohol use and binge drinking among women of childbearing age—United States, 2011–2013. *MMWR: Morbidity and Mortality Weekly Report, 64*(37), 1042-1046.

U.S. Department of Health and Human Services. (n.d.). *Rethinking drinking: Alcohol & your health.* [Online.] Retrieved from www.rethinkingdrinking.niaaa.nih.gov/

Velasquez, M.M., Ingersoll, K., Sobell, M., & Sobell, L.C. (2016). *Women and drinking: Preventing alcohol-exposed pregnancies.* Boston: Hogrefe Press.

White, A., Castle, I.-J.P., Chen, C.M., Shirley, M., Roach, D., & Hingson, R. (2015). Converging patterns of alcohol use and related outcomes among females and males in the United States, 2002 to 2012. *Alcoholism: Clinical and Experimental Research, 39*(9), 1712-1726. doi:10.1111/acer.12815

**The CHOICES name was originally an acronym that stood for Changing High-Risk Alcohol Use and Increasing Contraception Effectiveness Study. After the study was completed, the name remains but is no longer spelled out.*

# SPECIALTY PRACTICE SECTIONS UPCOMING LIVE WEBINARS

FRIDAY, NOVEMBER 9, 2018 - 1:00 - 2:00 PM (ET)

## Emotions and Politics: Responding to the Mental Health Needs of Immigrants

**Presenters: Cheryl Aguilar, LICSW, LCSW-C**
**CE Category: 1 Cross-Cultural Contact hour**

With immigration at the height of the political debate in the United States, a wide micro and macro response is needed to address the challenges migrant populations face. This workshop pays attention to immigrants with an undocumented status or temporary statuses.

WEDNESDAY, DECEMBER 12, 2018 - 1:00 - 2:00 PM (ET)

## Managing Ethical Dilemmas through Interest-Based Conflict Resolution

**Presenter: Allan Barsky, JD, MSW, PhD**
**CE Category: 1 Ethics Contact hour**

Ethics courses often provide social workers with strategic decision-making frameworks for analyzing ethical dilemmas. Although these frameworks help individuals make think critically, they do not provide guidance on how to manage conflicts when social workers, clients, and other stakeholders disagree about the most ethical course of action. This workshop demonstrates a conflict resolution approach to managing challenging ethical dilemmas, including situations where social workers have conflicting obligations under the NASW *Code of Ethics*.

**ON-DEMAND WEBINARS NOW AVAILABLE:**

- Treatment and Management of Opioid Addiction
- Integrating Smoking Cessation into Clinical Social Work
- Preventing Alcohol-Exposed Pregnancies: Tools and Strategies for the Social Work Practitioner

Register now for live or on demand webinars by visiting the SPS Webinar Catalog online.
**www.socialworkers.org/Careers/Specialty-Practice-Sections/SPS-Webinar-Catalog**

NASW 2018 VIRTUAL FORUM

# OPIOID CRISIS:

## NO COMMUNITY IS IMMUNE


NASW
VIRTUAL FORUM
2018

**Register now for the NASW 2018 Virtual Forum, Wednesday and Thursday, November 14 & 15.**

This two-day program will address the opioid crisis from a social work perspective, feature both plenary and breakout sessions, and offer CE credits. Live streamed from the NASW National Office, you will be able to view it from your home, your office, or even on a mobile device.

**TOPICS COVERING:**

- Implications for Ethics
- Self-care
- Local, State, and Federal Policy Initiatives
- Use in the LGBTQ community
- Addressing Opioid Addiction through Integrated Health
- Best Practices in Treatment
- Impact on Children and Families
- And more!

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# 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?*

Evidence shows that low-level drug arrests, especially for possession of marijuana, have a disproportionate impact on adolescents.

**For more information, visit SocialWorkers.org/Sections**

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