Abstinence Policy for Recovering SUD Certified Professionals

MHACBO
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General Policy:
The MHACBO Board defines abstinence as continuous (uninterrupted) abstinence from: alcohol (non-sacramental), marijuana, illicit drugs, and non-directed use of prescription or over-the-counter drugs. MHACBO certified CADCs, CRM and PRCs in recovery from SUDs, must have a minimum of two years of continuous abstinence to maintain SUD certification with MHACBO. Failure to maintain abstinence as defined above shall result in suspension of certification until such time an individual obtains at least 2 years of continuous abstinence. (updated February 2019)

Policy:
The MHACBO Board of Directors use the following definition as it applies to MHACBO certification requirements, professional standards, eligibility and fitness approval decisions, and administrative sanction procedures when recovery mentors, alcohol and drug counselors, gambling addiction counselors, and mental health professionals have been found to have engaged in ethical misconduct including (but not limited to) the use of illegal drugs or use of illicit or illicit substances of abuse for those in recovery.¹

“Abstinence” means the continuous and total refraining from:

(1) Use of any legally or illegally sold products, foods, liquids, medications, chemicals, or substances which contain any quantity of alcohol², marijuana and cannabimimetic agents (synthetic cannabinoids), non-prescribed anabolic steroids, or illicit drugs;

(2) Unauthorized use of products, foods, liquids, medications, chemicals, or substances that are not prescribed to the individual;

(3) Excessive use of products, foods, liquids, medications, chemicals, or substances that are prescribed to the individual;

(4) Inappropriate or excessive use of over-the-counter or legally available products, foods, medications, chemicals, or substances that are taken for purposes other than what is listed on the manufacturer’s label and prescriber’s orders;

(5) Use of any legally or illegally sold products, foods, liquids, medications, chemicals, or substances³ for the purpose of inducing euphoria, dissociation, hallucination, unconsciousness, mood alteration, thought alteration, or changing of sense perceptions including vision, hearing, smell, and touch; and

(6) Use of legally or illegally sold non-prescribed products, foods, liquids, medications, chemicals, or substances that are scientifically associated with intoxication, mood alteration, withdrawal, physiological dependence, psychological dependence, potential for abuse, addictive qualities or behaviors, negative health consequences, or overdose.

¹ “Recovery [from mental health and substance use disorders] is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential” (SAMHSA, 2019).
² Over-the-counter products that contain alcohol (such as cold medicines or mouthwash) are excluded from the definition adopted by MHACBO, per; 309-019-0195[12]; ORS 813.200[5]; ORS 689.005.
³ The use of caffeine, nicotine, and any food, liquid, or substance used as part of a religious rite or service (including but not limited to sacramental wine) is excluded from the definition adopted by MHACBO, per 309-019-0195[12]; ORS 813.200[5]; ORS 689.005.
Oregon administrative rule requires those who are in recovery from a substance use disorder, to have a minimum of two years of continuous abstinence, to be employed, volunteer or intern in Oregon addiction services funded by public dollars.

Defining Abstinence

The term "abstinence" as it relates to administrative rule is referenced in OAR 309-019-0195(12): "...abstinence from use of intoxicants as evidenced by negative urinalysis reports, except as allowed in ORS 813.200." Exceptions are listed in ORS 813.200(5); these include: sacramental wine given or provided as part of a religious rite or service; a valid prescription for a substance and the person takes the substance as directed; or a nonprescription drug, as defined in ORS 689.0051. Moreover, the Health Systems Division, Oregon Health Authority has offered clarification (distributed to all programs through a memo) that marijuana falls under the category of illicit drugs as it pertains to federal funding for addiction treatment and recovery services.

The federal government (under the Controlled Substances Act, CSA), classifies marijuana and marijuana extracts as Schedule I drugs2. The CSA states: 'The term 'marihuana' [also marijuana] means all parts of the plant Cannabis sativa L., whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds or resin. Such term does not include the mature stalks of such plant, fiber produced from such stalks, oil or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture, or preparation of such mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of such plant which is incapable of germination.'3

1. ORS 689.005(25) "Nonprescription drugs" means drugs which may be sold without a prescription and which are prepackaged for use by the consumer and labeled in accordance with the requirements of the statutes and regulations of this state and the federal government.
2. 21 CFR Chapter II, Part 1308
3. 21 U.S.C. § 802(16)
Staff who are in recovery are expected to minimally meet the same identical standards of abstinence and recovery requirements that are imposed upon the clients. This is a “bona fide occupational qualification” (BFOQ).

Oregon Administrative Rule 309-019-0195(12) defines abstinence for clients of state approved residential and outpatient programs as the use of “…any alcohol or drugs except; sacramental wine given or provided as part of a religious rite or service; a valid prescription for a substance and the person takes the substance as directed; or a nonprescription drug, as defined in ORS 689.005 (Definitions), in accordance with the directions for use that are printed on the label for that nonprescription drug.”

Oregon statute, ORS 659A.315, currently permits employment discrimination against those who use tobacco products, if abstinence from those products is a “bona fide occupational requirement.” For example, if a person is a Smoking Cessation Specialist with a healthcare provider, the employer has a legal right to demand that the employee not consume tobacco products in their “on duty” and “off duty” time. It is a “bona fide occupational qualification” that Smoking Cessation Specialists abstain from tobacco consumption. ORS 659A.315 states, “It is an unlawful employment practice for any employer to require, as a condition of employment, that any employee or prospective employee refrain from using lawful tobacco products during nonworking hours, except when the restriction relates to a bona fide occupational requirement.”

In accordance with the policies set forth by MHACBO, ethical standards that guide the profession of addiction services, and Oregon regulations that govern the provision of safe and adequate services to individuals who are receiving treatment and support services for substance use disorders, management staff, clinical supervisors, program staff (including counselors and peers), contractors, volunteers, students, and interns who are in recovery are expected to minimally meet the same standards of abstinence that are expected from clients. Congruent conduct between professionals and clients at all times is a standard of competent practice and therefore is considered a “bona fide occupational qualification” (BFOQ).

Moreover, the expectation of abstinence among those staff who are in recovery from SUDs, as a bona fide occupational qualification, is an industry standard recognized by any reasonable person employed within Oregon addiction treatment programs. The 2018 Oregon Behavioral Health Workforce Survey (n=1,302), reported that 97.12% of Oregon addiction supervisors reported that their agency had a Drug Free Workplace Policy, and 95.19% reported that their policy explicitly included marijuana, despite its legal status.1

Oregon administrative rule requires certified SUD peers to meet the abstinence requirements of state certified alcohol or other drug treatment programs, irrespective of their place of employment, or employment status.

Oregon Health Authority maintains the expectation that Peer Support Specialists will comply with the abstinence rules for staff in addiction treatment programs, even if they are not currently employed in a state certified alcohol or other drug treatment program.

Oregon Administrative Rule 410-180-0305[b] states, ‘Peer Support Specialist’ means an individual providing services to another individual who shares a similar life experience with the peer support specialist (addiction to addiction, mental health condition to mental health condition, family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support specialist shall be:

(a) A self-identified individual currently or formerly receiving addictions or mental health services;

(b) A self-identified individual in recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;”
MHACBO defines abstinence in its’ registration process and requires ongoing abstinence of professionals in recovery from addiction.

The MHACBO Registration states, for those in recovery from a substance use disorder, “I hereby attest that I have not used alcohol, marijuana or illicit drugs, or have abused prescription or over the counter medication, for the ______ years immediately preceding this application.”

Professionals report their recovery status to MHACBO and are then expected to adhere to MHACBO’s abstinence policy. **The registration clearly states that an individual in recovery from and a substance use disorder must have a minimum of two years of abstinence in order to register with MHACBO.**

Moreover, MHACBO post its’ Abstinence Policy on its website in a prominent location next to its Code of Conduct, which applicants must review and sign in order to be certified. **MHACBO(ACCBO) is a private non-profit corporation in the State of Oregon and retains the right to establish its’ own rules for obtaining certification.**
5. If a CADC, CRM or PRC is recovering from just one substance, can they use other substances? No. Research clearly shows that most individuals with substance use disorders have a history of “multiple substance abuse” (multi-substance use) vs. “mono-substance use.”

Some individuals assert that they “only had an addiction to one single drug” and argue that they should be allowed to consume alcohol and take other drugs that fall outside of their drug of choice. An abundance of research, however, shows that this is rarely the case.

Substance abusing individuals who exclusively abuse a single substance have become progressively scarce and are unrepresentative of the general population of substance abusers in community, clinical, and self-help settings. Both population and clinical surveys have shown that the great majority of those with a current substance use disorders (1) use multiple psychoactive substances and (2) meet current or lifetime criteria for multiple substance use disorder diagnoses.1-6

For example, lifetime prevalence of alcohol dependence exceeds 65% in both treatment-seeking cocaine users as well as those not seeking treatment.7 The prevalence of marijuana abuse in cocaine-dependent patients ranges from 25% to 70%.8-10 Among heroin users; 50% of heroin patients are regular users of alcohol; 33% of heroin patients are regular users of benzodiazepines; 47% of heroin patients are regular cocaine users; and 69% of heroin patients are regular marijuana users.11 In a study that included methamphetamine users, researchers Darke and Hall found that “mono-drug abuse was rare” among 329 heroin abusers and 301 methamphetamine abusers during a 6-month study period.12 In another study that included methamphetamine users, Brecht, et al, found that on average, heroin users also used 5.2 other substances other than heroin, and that methamphetamine users used 6.3 other substances other than methamphetamine.13

Regardless of whether one is recovering from a single substance or many, it is the expectation that a professional who is certified, registered, or authorized through MHACBO will abstain from alcohol, marijuana and illicit drugs at all times.

Reference:
Individuals with a primary illicit drug of abuse (such as heroin, methamphetamine, or cocaine) who then abstain, often develop abuse of alcohol and marijuana with levels of consumption mirroring their original primary illicit drug of abuse.

A study of 1,197 post-treatment outcomes revealed, levels of alcohol and marijuana use were considerably higher among abstinent drug users, who formerly used methamphetamine, cocaine or heroin. This is consistent with prior studies. In fact, levels of marijuana and alcohol use were comparable to those of the primary drug for primary cocaine and methamphetamine user subsamples. Researchers have concluded "Users with longer use histories may profit from treatment which includes prevention/intervention for other drugs as well. Use of alcohol for cocaine users and use of alcohol and marijuana for meth users, on the other hand, were more consistently positively related to the use of the primary substance. This might suggest users' desire to counterbalance stimulant effects. Therefore, treatment for cocaine and meth users should also consider addressing alcohol and marijuana use, particularly among those with higher usage levels of the primary drug."1-4

One study asked cannabis users directly whether they would switch drugs if cannabis became harder to get, and about 1/3 said that they would switch to more alcohol use.5

In a 2013 systematic review of 567 post-treatment outcome studies, of which 13 research studies were assessed as fulfilling the rigorous inclusion criteria of a meta-analyses. The systematic review showed consistent support for the hypothesis that alcohol use increases relapse to drug use.6 Moreover, a 2015 study of methamphetamine users, showed that drinking alcohol increases the risk of methamphetamine relapse over 4 times. Compared with non-drinking days, drinking days and binge drinking days increased the odds of same day methamphetamine use by 4.22 and 4.50 times, respectively (p’s < 0.0001).7

6. Is it safe for individuals with a history of illicit drug dependence to start drinking alcohol and using marijuana? A substantial body of research suggests that it is not safe. Individuals with a primary illicit drug of abuse (heroin, methamphetamine, or cocaine) who then abstain, often develop abuse of alcohol and marijuana. Research is also stunningly clear that alcohol consumption increases the risk of relapse to other drug use.

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In a 2013 analysis, Rounsaville, et al, argue that research on mono-drug use is misleading regarding the efficacy of substance use disorder treatments. They state in studies, “samples of ‘pure’ abusers are likely to have a narrower range of drug-related consequences. They may be more amenable to treatment, thereby inflating estimates of the treatment’s efficacy. Thus, in the process of development and efficacy testing of treatments, focus on a single drug may be inefficient and lead to premature conclusions about a treatment’s promise, for both pharmacological and behavioral treatments.”

Increasingly, researchers declare, “We recommend that investigators consider moving away from a single drug.” “Substance abusing patients who exclusively abuse a single substance have become progressively scarce and unrepresentative of the general population of substance abusers in community and clinical settings.”

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1. Rounsaville, Petry, Bruce and Carrolla. Single versus multiple drug focus in substance abuse clinical trials research. Drug Alcohol Depend. Author manuscript; available in PMC 2013 May 23.
4. ibid (1)
8. Alcohol and drugs of abuse stimulate the same regions of the brain implicated in the etiology of addiction.

Research findings have revealed that alcohol and drugs of abuse affect the same brain structures. In addition, alcohol and drugs of abuse have a similar action on the brain that primes the brain for addiction. Outcomes from thousands of studies sponsored by the National Institute on Drug Abuse and National Institute of Health have provided evidence about how alcohol and drugs affect the brain’s "reward circuit" which includes the ventral tegmental area (VTA), the nucleus accumbens, and the prefrontal cortex. The studies have shown that when activated by a rewarding stimulus (alcohol, marijuana, cocaine, methamphetamine, heroin, prescription drugs of abuse, etc.), information travels from the VTA to the nucleus accumbens and then up to the prefrontal cortex. Most drugs affect the brain’s "reward circuit," causing euphoria as well as flooding it with dopamine (a neurotransmitter involved in “pleasure bursts”). Surges of dopamine in the reward circuit cause the reinforcement of pleasurable but unhealthy behaviors like taking drugs, leading people to repeat the behavior again and again.1 The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders Fifth Edition), states, "All drugs that are taken in excess have in common direct activation of the brain reward system, which is involved in the reinforcement of behaviors and the production of memories."

Research on medical treatments have also provided evidence that alcohol and drugs affect the same brain structures. As an example, the homogenous impacts of drugs and alcohol on the brain explains the fact that Disulfram (Antabuse) has been shown to reduce both craving in cocaine users as well as alcoholics.3-7 Additionally, research demonstrates that Naltrexone (an opioid antagonist) reduces craving for both alcohol and cocaine. These findings, along with those from brain studies, partially explain the replacement addiction phenomenon that is common among those in recovery.8-9

2. Diagnostic and Statistical Manual of Mental Disorders Fifth Edition. page 481.
MHACBO fully supports SAMHSA and FDA approved Harm Reduction evidence-based practices, including, but not limited to: Methadone, Suboxone, Sublocade, Probuphine, Subutex, Needle Exchange, Infectious Disease Risk Assessment and Risk Reduction Counseling, and SBIRT. These and other research-based practices can be located in the Substance Abuse and Mental Health Services Administration, Evidence-based Practices Resource Center.1,2

Giving alcohol and marijuana to abstinent (methamphetamine, cocaine, and heroin) illicit drug dependent persons, is not an evidence based practice reported by SAMHSA or the FDA. In fact, the National NOMs (National Outcome Measures) reported by SAMHSA are abstinence from alcohol and drugs.3 SAMHSA’s explicit desired treatment and recovery support outcomes for Americans participating in U.S. treatment and recovery support services includes abstinence.4

SAMHSA reports, “SAMHSA established recovery support systems to promote partnering with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience (including helping individuals with behavioral health needs be well, manage symptoms, and achieve and maintain abstinence)”4

### SAMHSA NOMs

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<td><strong>Outcome</strong></td>
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3. SAMHSA National NOMs (National Outcome Measures)
10. Summary

- Per this policy, abstinence means the total and continuous refraining from use of alcohol, marijuana and cannabimimetic agents, and illicit drugs among persons in recovery from substance use disorders.

- The use of caffeine, nicotine, and any food, liquid, or substance used as part of a religious rite or service (including but not limited to sacramental wine) is excluded from the definition of abstinence adopted by MHACBO.

- The use of medication assisted therapies (such as Methadone, Suboxone, Sublocade, Probuphine, and Subutex) are excluded from the definition of abstinence adopted by MHACBO.

- Over-the counter products that contain alcohol (such as cold medicines or mouthwash) if used properly are excluded from the definition adopted by MHACBO.

- Recovering management staff, clinical supervisors, program staff (including counselors and peers), contractors, volunteers, students, and interns who provide treatment, recovery, wellness, or support services are required to comply with continuous abstinence requirements set forth in Oregon Administrative Rules.

- Recovering professionals who are certified, registered, or authorized through MHACBO will continue to declare that they have not used illicit substances (including but not limited to marijuana and cannabimimetic agents [synthetic cannabinoids]) by signing the attestation of abstinence.

- Recovering professionals (including those with mono-drug and polydrug addictions) who are certified, registered, or authorized through MHACBO will exercise due diligence by taking proactive measures to reduce the risk of relapse by acknowledging the high prevalence of substitute addiction; the role of alcohol, marijuana, and cannabimimetic agents in relapse; and the brain mechanisms involved in addiction.
Appendix 1: Oregon Administrative Rules

Oregon Administrative Rules (OARs) are the regulations that govern the licensure by the Health Systems Division, Oregon Health Authority of residential behavioral health facilities and certification of outpatient behavioral health programs and providers. The following OARs contain references to abstinence requirements for management staff, clinical supervisors, program staff (including counselors and peers), contractors, volunteers, students, and interns who render treatment, recovery, wellness, or support services in these settings:

OAR 410-180-0300(13) "Peer Support Specialist" means an individual providing services to another individual who shares a similar life experience with the peer support specialist (addiction to addiction, mental health condition to mental health condition, family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support specialist shall be:
(b) A self-identified individual in recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;

OAR 309-018-0125(9) Program staff, contractors, volunteers, and interns recovering from a substance use disorder providing treatment services or peer support services in substance use disorders treatment programs, must be able to document continuous abstinence under independent living conditions or recovery housing for the immediate past two years.

OAR 309-019-0125(12) Program staff, contractors, volunteers, and interns recovering from a substance use disorder and providing treatment services or peer support services in substance use disorders treatment programs must be able to document continuous abstinence under independent living conditions or recovery housing for the immediate past two years.

OAR 415-020-0075(4) Management Staff — Recovering Individuals: For an individual recovering from a substance abuse related disorder, the performance of a program administrator's essential job functions in connection with staff and patients who themselves may be trying to recover from a substance abuse related disorder demands that an applicant or person hired as program administrator be able to demonstrate continuous sobriety under nonresidential, independent living conditions for the immediate past two years.

OAR 415-020-0075(10) Clinical Supervisors — Recovering Individuals: For an individual recovering from the disease of alcoholism /or from other drug dependence, the performance of a clinical supervisor's essential job functions in connection with staff and patients who themselves may be trying to recover from the disease of addiction demands that an applicant or person hired as clinical supervisor be able to demonstrate continuous sobriety under nonresidential, independent living conditions for the immediate past two years.

OAR 415-020-0075(17) Treatment Staff — Recovering Individuals: For an individual recovering from the disease of alcoholism or from other drug dependence, the performance of a counselor's essential job functions demands that an applicant or person hired as a counselor be able to demonstrate continuous sobriety under non-residential, independent living conditions for the immediate past two years.

OAR 415-050-0055: Management Staff Qualifications — Each Program must be directed by a person with the following qualifications at the time of hire:
(1) For an individual recovering from a substance-use disorder; continuous sobriety for the immediate past two years.

OAR 415-050-0060: Staff Qualifications — Each Program must have:
(1) An identified clinical supervisor who has the following qualifications at the time of hire:
(a) For an individual recovering a substance-use disorder; continuous sobriety for the immediate past two years;

OAR 415-050-0060: Staff Qualifications — Each Program must have:
(3) The Program's treatment staff must:
(a) For individuals recovering from a substance-use disorder, have maintained continuous sobriety for the immediate past two years at the time of hire;

OAR 415-050-0060: Staff Qualifications — Each Program must have:
(4) The Program's medical staff must:
(a) For an individual recovering a substance-use disorder; continuous sobriety for the immediate past two years;

OAR 415-050-0060: Staff Qualifications — Each Program must have:
(5) Detoxification Technicians, when employed by a program, must:
(a) For an individual recovering a substance-use disorder; continuous sobriety for the immediate past two years;

OAR 415-057-0110: Program Staff — (6) Recovering program staff: Any program staff, clinical supervisor, program manager, student, intern or volunteer applying or hired to provide services who are recovering from substance related disorders must be able to demonstrate continuous sobriety under nonresidential, independent living conditions for the immediate past two years.

410-180-0305(13)[b] states, “'Peer Support Specialist' means an individual providing services to another individual who shares a similar life experience with the peer support specialist (addiction to addiction, mental health condition to mental health condition, family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support specialist shall be:
(a) A self-identified individual currently or formerly receiving addictions or
(b) A self-identified individual in recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;"