

Substance Abuse

Includes Alcoholism. Also called Chemical Dependency, Addiction

Description of the Disability

Substance Abuse / Addiction is a chronic, progressive, and potentially fatal condition based on a lifestyle focused on compulsive and overwhelming drug use (for this discussion, the term substance use / abuse includes alcoholism). A person with substance abuse will be preoccupied with drug use (either continuously or periodically), will not be able to control the drug use even when there are serious consequences, and will justify the drug use with convoluted, odd reasoning. Someone with substance abuse starts to believe that being partly drunk/high/intoxicated is their “normal” condition and will find functioning sober/clean increasingly uncomfortable and difficult. They will also consider taking the drug to be a normal way of dealing with life-events such as successes, failures, holidays, boredom, and relaxation. Recovery from this lifestyle has been described as a never-ending state of readjustment.

A person who is abusing a substance may or may not have a physical dependence on the drug involved, in addition to the psychosocial / lifestyle dependence. Many different biological, social, environmental, spiritual, and psychological factors affect the specific symptoms and stages a person experiences.

Researchers do not know what causes substance abuse but most think of it as a type of disease. This “Disease Model of Addiction” is the most popular of many ways of describing substance abuse. According to the disease model, difficulty with social functioning, low life satisfaction, and problems with employment (among other things) are symptoms of the substance abuse. Stopping or even decreasing the substance abuse should decrease or stop these and other symptoms. Critics argue that simply stopping the drug use may not improve these aspects of the person’s life. In fact, these difficulties with life may be contributing causes, not symptoms. Critics also object to calling substance abuse a disease when some people see it as a lifestyle choice, even though the person may not be able to give the lifestyle up once they have made the initial choice to use the drug. It may be most useful to say it is a chronic, progressive “disease-like” condition that interferes with major life activities.

Even though we do not know if they are truly diseases in the traditional sense, alcoholism and drug addiction qualify as a disabilities under the Americans with Disabilities Act as “an impairment that substantially limits one or more major life activities.” However, individuals who are actively using / abusing an illicit drug do not qualify for ADA protection. For someone with substance abuse to qualify as a person with a disability for substance abuse, the person must have stopped using the drug and be in drug treatment or have successfully completed treatment. However, this ignores the real-world issues of relapse. Researchers now consider relapses into substance abuse to be a common part of the long-term recovery process. Many individuals will experience at least one relapse and possibly a long string of relapses following treatment. It is important that rehabilitation counselors understand the likelihood of relapse and plan how they will respond to a client who is relapsing.

Medical and Biological Issues

All addictive drugs significantly affect the brain and the liver in addition to affecting other parts of the body in different ways. The effects on the brain (euphoria, disinhibition, excitement, distorted senses, or other effects) are the reason people take them as recreational drugs. They affect the liver because one of the liver's main jobs is filtering foreign substances such as drugs from the blood. Over time, both the brain and the liver will show significant physical damage from substance abuse. Even before that damage happens, both the brain and the liver will adjust to the continued presence of the drug in the body. The brain will try to reach a new chemical balance of whatever neurotransmitters the drug is affecting, which means altering the way the brain works so it can be relatively normal in the presence of the new drug. Meanwhile, the liver will increase its enzymes to try to remove the drug more quickly. Both of these effects contribute to **Tolerance** – the apparent decreased effectiveness of the drug and the need for the person to increase the amount he or she takes to get the same “high”. This tolerance can also apply to other drugs in the same class as the one the person is abusing, an effect called **Cross-Tolerance**.

Sometimes, the body's reaction goes the other way: if a person has taken the drug long enough to damage the body's ability to adjust to it or metabolize it, the person may need to take only small amounts to get large effects. This is called **Reverse Tolerance**. For example, if someone has damaged their liver so much that it cannot process alcohol effectively, it may only take a couple of drinks to make that person very drunk.

Dependence happens when taking the drug has become “normal” for the person. **Physical dependence** means that the body has adapted so thoroughly to the presence of the drug that it cannot function well without the drug. When the person stops taking the drug, the body goes into **Withdrawal** – abnormal function as the body tries to adjust to the absence. Different drugs have different withdrawal symptoms, but the most common withdrawal symptoms include sweating, chills, diarrhea, and general discomfort. For some drugs (including alcohol) rapid withdrawal can cause dangerous medical complications. Withdrawal from the combination of alcohol and sedatives can be especially dangerous. For other drugs (including heroin) it is just very uncomfortable. In some cases, long-term substance abuse may change the brain chemistry in permanent ways, making depression and other emotional disorders more likely.

Psychological Dependence means the person has become so used to the effects of the substance on their life that they have trouble facing life without it, separate from the biological issues of physical dependence. For example, they may miss the social interaction they associate with taking the drug, or they may not be able to feel calm and confident without the feeling of being “high”, or they may not know what to do with their spare time if they are not taking the drug. Psychologically, they consider the feeling of the drug's effect on their body to be the normal way to feel. Substance abuse is also often deeply connected to a person's family and social life. Many people with substance abuse have trouble staying sober after treatment because they are returning to the same family and social situation that supported the substance abuse. Often their friends and family are used to relating to them in the context of the substance abuse and have trouble learning a new way to interact. Some individuals are more successful in recovery if they move to an entirely different neighborhood or community and make new friendships.

When a person starts abusing a substance in childhood or adolescence, it can delay or stop normal cognitive and emotional development. This can decrease the person's ability to have relationships, their self-esteem and self-concept, and their ability to identify and solve personal problems. It can make it hard for the person to deal with feelings of frustration, isolation and loneliness. They may also depend too much on "immature" defense mechanisms to respond to problems, such as anger, denial, or withdrawal. Along with missed or delayed personality milestones, individuals may miss important "vocational milestones." The lack of vocational milestones can show up as a limited work history, a sporadic work history ("job hopping") or a history of only entry-level jobs with no promotions.

Individuals seeking VR services for a primary diagnosis of substance abuse often have some distinct characteristics. They tend to:

- **Bottoming Out:** "Bottoming out" is an unofficial term for the time when the symptoms of substance abuse most disrupt a person's life, either before treatment or during relapses. The details and severity of bottoming out vary from person to person, but people seeking VR support are usually the ones who have experienced the most severe disruptions and challenges.
- **Have Lost Options:** Individuals who can get treatment and step back into their previous lives afterwards usually do not look to VR for support. Individuals who come to VR usually are experiencing a deeply ingrained addiction with which they continually struggle.
- **Have Good Employment Potential:** Individuals with substance abuse problems can often have average or above average intelligence and a lot of transferable job skills. They may have either a lot of formal education or a lot of vocational training. With a set of supports to help them manage their substance abuse, they can be excellent VR clients.

Types of Addictive Substance

The six basic categories of drugs include:

- **Hallucinogens & Dissociatives:** LSD, PCP, Mescaline, Psilocybin (mushrooms), Cannabis (Marijuana), Ecstasy, others
 - Alter perceptions and mood. Some create hallucinations that blur the boundaries between the self and outer world
- **Opiates:** Morphine, Heroin, Codeine, others
 - Suppress physical sensation and response to stimulation
 - Produce a feeling of euphoria, but no major changes in cognitive abilities
 - Highly addictive
- **CNS Depressants, Sedatives, Hypnotics:** Alcohol, Barbiturates, Pain Killers, Benzodiazepines (anti-anxiety drugs), Tranquilizers, others
 - Reduce anxiety, cause euphoria

- Inhibit the nervous system, slowing down mental and physical activity
- Hypoglycemia is very common among active alcoholics. Alcohol has a high sugar content and when people quit drinking their body may actually crave the sugar. People in recovery need to understand that their body's cravings for sugar get mixed up with their cravings for alcohol
- **Stimulants:** Amphetamines, Cocaine, Nicotine, Crack, Methamphetamines (Meth), Ritalin, others
 - Increase central nervous system activity, increasing alertness, sexuality, and euphoria
 - Produces feelings of intense pleasure, euphoria, increased energy and alertness, and increased self-confidence
 - Rapid progression from first use to regular use and tolerance effects, compared to other drugs
- **Inhalants:** paints, organic solvents, cleaning agents, gasoline, glue
 - Substances that give off fumes that are intoxicating. Depending on the substance, breathing the fumes may cause euphoria, floating, hallucinations, disinhibition.
 - Toxic to liver, kidneys, and nerve cells. May cause permanent brain damage.
- **Polysubstance Abuse:** It is very common for someone to combine different drugs. This can enhance the effects of the drugs and help manage the side effects of coming down from one drug. The most common combinations include cocaine and alcohol, cocaine and heroin, and alcohol and marijuana. Many people with substance abuse are actually addicted to three or four different drugs.

Coexisting Disabilities

Substance abuse is more common among people with acquired disabilities than among the average population (on the other hand, it seems to be slightly less common among people born with disabilities). There are several factors that probably contribute to this increase:

- Many acquired disabilities are linked to accidents, such as spinal cord injuries or traumatic brain injuries. These accidents, in turn, are more common among people who are already using drugs/alcohol.
- Someone who acquires a disability already has a self-image from beforehand. Adjusting their lifestyle and self-image to include the disability can be very stressful and difficult, possibly pushing them towards self-medicating this way.
- Many of the medications for people with disabilities have psychoactive effects, either as their main purpose or as a side effect. This means they will strongly interact with recreational drugs/alcohol, usually enhancing the cumulative mood altering effects and increasing the likelihood of addiction. The individual may not seem to be taking a lot of recreational drugs, but effectively they are because of the interaction effects. One example is anti-spasticity drugs taken for spinal cord injury.

- Individuals with acquired mental illnesses are usually taking prescribed medication to alter their mood. This can make taking a substance to feel better emotionally seem like an acceptable response to stress, which is often the reason someone takes recreational drugs/alcohol.
- Many people with disabilities experience various types of discomfort (pain, spasms, aches, etc.) because of their disability. In some cases, this can increase the likelihood of self-medication with alcohol or other drugs, which may in turn lead to substance abuse.
- Some people with disabilities may feel marginalized – left out of the mainstream of society. They may end up joining local subcultures in which substance abuse is an important social activity.

Undiagnosed Substance Abuse

Many people with disabilities have problems with substance abuse but do not have any formal diagnosis or treatment. Some will openly admit that they abuse drugs or alcohol if you ask; others will deny they have a problem. Some experts suggest that VR counselors should routinely ask all their clients a few basic questions:

- Do they have a problem with drugs or alcohol?
- What are their drinking or drug habits?
- What drugs or alcohol have they had in the last few days?
- Has anyone ever told them that they have a problem with drugs or alcohol?

Other signs that a person with a disability is also abusing drugs/alcohol include:

- A work history of frequent job changes (if not related to the person's primary disability) or firings.
- A pattern of declining salary with each new job
- Unstable relationships or family disruptions
- A pattern of work absences on Mondays
- Defensive, glib, or evasive answers to questions about their drug or alcohol history and its impact on work
- The person probably will NOT look high or drunk. Most people will not show obvious signs, for several reasons: the effects of tolerance, a learned ability to pass as sober, and a fear of losing services if they show up intoxicated, among others. They will not usually show up reeking of alcohol or looking disheveled. Most VR clients will stay home and miss the appointment if they are in that condition.

When a Client is in Denial

Surprisingly, many times clients will give honest, upfront answers to the questions above and indicate a significant, undiagnosed substance abuse problem. However, it is also common for people with substance abuse to deny there is a problem, even when their comments point to one.

In that case, there are several steps a VR counselor can take to convince the person to seek treatment.

- With written permission from the person, talk to family members about the person, his or her employment situation, and any barriers to employment, including the impact of possible substance abuse. See if they feel the person has an addiction.
- Schedule a formal psychological evaluation, vocational evaluation, or similar evaluation that will require the person to show up on time for several days. Then see if they are able to meet that schedule. If they miss the appointments, talk to them about what happened, whether substance abuse is involved, and what implications this might have for continuing with VR services.
- With the person's permission, schedule a formal substance abuse screening.
- Get the person a transitional job to demonstrate that they can hold steady employment.

Tests for Addiction

There are several common tests that substance abuse treatment professionals use to diagnose addiction. They include:

- CAGE – a four-question test to screen for alcoholism. The acronym CAGE is based on the four questions.
- Michigan Alcoholism Screening Test (MAST) – a 25 question test to screen for alcoholism
- Substance Abuse Symptom Checklist (SARDI test) – a 13 question test to identify the role substance abuse plays in a person's life
- MacAndrew Alcoholism Scale (Mac) – part of the MMPI that tests for alcoholism based on personality questions. The questions are not obviously about alcoholism.
- Substance Abuse Subtle Screening Inventory (SASSI) – a proprietary one-page test to identify substance abuse and help plan treatment. It includes questions that are not obviously about substance abuse, for assessing people who may deny they have a problem. There is an adult version and an adolescent version.

Undiagnosed Coexisting Disabilities

It is also common for people with substance abuse to have undiagnosed secondary disabilities, such as mental illness or a learning disorder. This can seriously reduce the effectiveness of treatment, since the functional issues associated with the undiagnosed disability may be pushing the person back to the substance abuse. Most substance abuse treatment centers have many individuals with undiagnosed coexisting disabilities but do not have the facilities to detect and address the problem. If a counselor suspects a second disability, he or she should schedule a formal evaluation for the person and consult ahead of time with the evaluator.

The Recovery Process

An important aspect of the disease model of substance abuse is the idea that there is a progression to addiction and a similar process to recovery. One widely accepted model of

recovery, the Developmental Model, proposes six stages through which people pass to reach long-term recovery:

- Transition – the person adjusts to the idea that safe, controlled use of alcohol or drugs is not possible for them - they are an addict.
- Stabilization – detox, when the person goes through physical and psychological withdrawal and removes themselves from situations that reinforce their addiction.
- Early Recovery – the person adjusts to the need for a new chemical-free lifestyle
- Middle Recovery – the person begins developing the new lifestyle and repairing past damage to relationships and to him or her self.
- Late Recovery – the person begins to change the parts of their world view and self view that contributed to the addiction.
- Maintenance – the person stays with the new lifestyle on a long-term basis and continues developing ways to handle life stresses without drugs.

Relapse

It is important to understand that treatment for substance abuse is probably not a one-time proposition. A person with a substance abuse problem will be “recovering” for the rest of his or her life, and a significant number of people experience at least one relapse. Many experts now think of relapse as a common part of successful treatment rather than as a failure. Many things can help reduce the chances of relapse, including stable employment, new social relationships, and new leisure activities, but relapse is always still a possibility. The most important thing a counselor can do is make sure their client is comfortable enough to disclose a relapse or disclose feeling pressure to relapse. Then the counselor can get the person back into treatment as quickly as possible. For this reason, it is important to be clear that, even though VR services will have to stop when active substance abuse starts up again, those services can be easily reinstated after or during treatment. This can reduce the stigma the person feels about disclosing relapse.

Incidence Statistics

- Up to 10 million people may have both mental illness and addiction
- 52% of adults with a lifelong history of substance abuse also have a mental illness
- People with substance abuse problems are more likely to have a history of sexual or physical abuse
- 13.8% of unemployed adults are current substance users, compared to 6.5% of adults employed full-time
- Adults who are unemployed are twice as likely to be heavy drinkers
- An estimated 25% of people receiving welfare abuse alcohol or drugs
- People with incomes below \$5,000 a year report higher illegal drug use

- People with disabilities have a higher incidence of substance abuse than the general population
- An estimated 33% of people in treatment for substance abuse have coexisting disabilities
- 43% of VR clients reported that their vocational rehabilitation counselor did not know about their substance abuse problems
- 25-68% of people with TBI have a history of addiction
- Chemical dependency treatment incorporating vocational and employment services significantly decreases absenteeism and problems on the job, and increases number of days employed and retention. It also reduces the frequency and severity of relapse

Common Treatments, Medications, and Side Effects

There is no single recommended treatment for substance abuse. Most experts favor a holistic approach addressing a combination of medical, psychiatric, social, spiritual, legal, and other issues. Most treatment approaches use some variation on the Alcoholics Anonymous concepts, including: 1) confronting denial of abuse or dependence, 2) education about the disease concept, 3) counseling, and 4) referral to an AA-type support group for aftercare.

However, even following all that advice still includes a variety of possible approaches. There are 4 basic categories of treatments: detox, residential, outpatient, and peer self-help. They are frequently used in combination with each other.

Detoxification. “Detox” is the process of getting the drug out of the person’s body and life back to an equilibrium that does not depend on the drug. This means stopping the drug use and letting any withdrawal effects run their course. Detox is actually the first step in all recovery techniques, not a stand-alone treatment. Following detox, most people will need to follow through with one of the other treatments, but none of them can begin without detoxification first. Many people try **self-detoxification** first, going “cold turkey” in an unsupervised, informal way. This is occasionally successful, but often fails. The next version is **social detoxification** at a residential, non-medical treatment center, although it is sometimes done with an outpatient arrangement. Usually it involves rest, careful diet, vitamins, over the counter medications, and group counseling. This is frequently a good initial step for treatment. The most extreme level of detoxification is **medical detoxification**, done in a hospital setting with 24-hour care and medical monitoring.

Residential Treatment. There are several variations on residential treatment. **Inpatient Residential Programs** are usually 4-week-plus programs of intensive group therapy and patient education. Critics argue that these are not individualized enough, that people may be overloaded with information in such a short time while there can still be lingering after effects from their addictions, and that lessons from such an artificial setting may not transfer to real life. **Therapeutic Residential Communities** are longer-term programs that also use more structured, confrontational strategies for group counseling. Staff members are often recovering addicts and graduates of the program. The program emphasizes total behavioral change and there are strict consequences for breaking rules. Critics point to very high drop-out rates and to similar problems

with transfer to real life. **Residential Rehabilitation Programs** are a combination of these two. The program usually lasts 3-6 months, but residents/clients continue to work or go to school in the outside community during treatment. The therapy focuses on decision-making, judgment, and choice, but also uses confrontation and group sessions. Residential Rehab is often used as a transition from prison to society after drug offenders have completed their sentences. **Halfway Houses** are small residential facilities that use peer support and a small professional staff. Participants work in the community, pay rent, and participate in structured evening activities. There is more freedom than in other residential programs, but participants still have to stay drug-free.

Outpatient Treatment. In **Traditional Outpatient Treatment** participants still live at home and come in one to three times a week to meet with a professional counselor. The most common counseling format is group counseling. Outpatient treatment is widely used, less expensive, and less stigmatizing than other approaches, and can often include family participation. On the other hand, participants are still exposed to the same pressures that caused the initial addiction and the relapse rate is high. In addition, it is often difficult for counselors to effectively monitor a person's behaviors and progress in this setting. **Intensive Outpatient Treatment** increases the contact time to four hours a day, four times a week, for four weeks. The treatment uses group therapy and there may be daily drug tests. **Methadone Maintenance** is a variation of outpatient treatment for heroin addicts. Some experts originally thought methadone was a non-addictive, milder replacement for heroin and started offering it as a way to help heroin addicts recover. It turns out that methadone is also addictive, but many communities still offer the treatment. Participants get a daily dose of methadone to block the heroin cravings, and the dose lasts about one day. There is often no counseling or other support included in the treatment. Similarly, **Antabuse Therapy** for alcoholism involves giving participants the prescription drug Antabuse, which makes a person nauseous and uncomfortable if they drink. Antabuse therapy usually involves outpatient counseling.

Peer Self-Help Groups. In some ways, self-help groups are the end stage counterparts to detox – they are the most common approach to long-term maintenance following treatment. Usually only peers belong to the groups, no professional counselors, and the only requirement is willingness to change addictive behaviors. Most are specialized to one particular class of addiction, such as alcohol, narcotics, or cocaine. Most groups are modeled on Alcoholics Anonymous (AA) and its 12-step program. According to this model, addiction is a lifelong process without a cure - a person may be in remission but they are never “recovered”. Long-time members with significant recovery experience (but no formal training) usually serve as sponsors to newcomers. In addition, there are some peer self-help groups based on slightly different treatment models, especially in regards to underlying Judeo-Christian values of AA. These include Rational Recovery, Structural Model of Addiction- (Addictive Voice Recognition Technique), Secular Organizations for Sobriety (SOS), and Women for Sobriety. On the other end of the spectrum are some religious recovery groups, including Overcomers Outreach (evangelical Christian), and the CALIX Society (Catholic).

Possible Functional Issues

- Difficulty with problem solving
- Difficulty with anger management
- Difficulty dealing with authority figures
- Difficulty with time management
- Insecurity about abilities, identity
- Difficulty managing money
- Limited social skills because of missed developmental milestones or socialization into specialized sub-culture of substance abuse
- Over-reliance on defense mechanisms like anger, withdrawal, denial, and scorn
- Limited education
- Limited or unstable work history
- Limited job-seeking skills
- Need to avoid trigger situations
- Secondary mental health issues
- Secondary health problems (anemia, liver disease, etc.)
- Secondary learning disorder
- Physical strength not usually affected
- Coordination not usually affected
- Endurance not usually affected
- Reading and writing skills not usually affected

Initial Interview Considerations

Initial Questions

- How stable do they feel in their recovery?
- What are the use/relapse triggers for the person? What situations do they need to avoid?
- When was their last relapse, if ever?
- What secondary drugs have they taken, if any, in addition to their primary addiction?
- How long have they been abusing? How old were they when they began using the substance regularly? (gets at how deeply ingrained the lifestyle may be)
- What, if anything, has worked to help them stay clean and sober in the past?
- What legal problems, if any, has their substance abuse caused?
- What personal or family problems, if any, has their substance abuse caused?

- What community resources do they draw on to help with sobriety? (Such as AA, Narcotics Anonymous, local treatment centers, church, family, etc.) (NOTE – some people recover without community supports)
- How do they feel their substance abuse has affected their previous jobs?
- Why do they think the addiction started? (gets at issues of taking responsibility)
- What do they do on a typical weekend?
- What hobbies do they have?
- What is their living situation now? Are they living alone, with a roommate, with family?

Initial Observations

- None

Interview Accommodations (if any)

- None

Possible Accommodations and Assistive Technology

- Job coaching for job retention skills
- No late-night work shifts. After hours temptations to relax with drugs/alcohol are too great.
- Supports available by phone if the person feels tempted to relapse
- Jobs with regular work schedules, not changing shifts
- Jobs with adequate structure and supervision. Both too little supervision and too much supervision may promote relapse
- Jobs that do not involve a lot of travel or time in isolated settings
- Ways to pass the time or stay connected to family if the job does require travel or time in isolated settings
- Help with money management and credit issues. Some people are used to spending large amounts of money on their addiction or to having large amounts through drug dealing. Living moderately may be a challenge
- Flexible work schedule to allow time for attending treatment

Career Planning Issues

- Many Intermediate Goals and Responsibilities. Individuals with substance abuse, especially during relapse or recovery from relapse, can be secretive and manipulative about non-compliance. It is important for the VR counselor and client to set up a multi-step sequence of specific intermediate goals and clear responsibilities when planning VR services. More than

with most disabilities, there is a strong burden of proof on the part of the client to document compliance and sobriety. On the other hand, the VR counselor has an equal responsibility to obligate and release funds/resources in proportion to the client's progress. The sequence of goals and responsibilities should not be a significant burden or barrier for the client, but a detailed way to touch base and document that the employment plan is on track.

- Avoid careers that tend to have a lot of substance abuse in the work culture. These include construction, hospitality (hotels, resorts, restaurants), and entertainment.
- Have a Sobriety Plan. The client should have an understanding of his or her own weaknesses and temptations towards substance abuse and a plan for resisting them. The plan may draw on community resources such as Alcoholics Anonymous or Narcotics Anonymous, or on friends and family.
- Contingency Plans for Possible Relapse. Although VR services should be interrupted in the event of a relapse, the individual should also know that resumption will be easy once they demonstrate their sobriety. If the client thinks the door to services will slam shut and be difficult to reopen, they will try to hide the relapse and make the situation worse. The person needs to know that, although active substance abuse is not acceptable in the VR system, a return to treatment when needed is acceptable and will not be punished.
- Transitional Employment. If the individual is demonstrating sobriety after a relapse, it may be useful to provide structure to their life in the mean time with a temporary, low-demand job such as food service, cashier, or maintenance. The person should understand that this is not the final employment goal, just a temporary support to help them achieve stability.
- Lack of References. The person may have a history of poor job performance at their last few jobs. Supported or transitional employment may be one way to handle this situation.
- Pressure to Hurry. Many people with addiction also have strong personalities and exert pressure on the counselor to find a job quickly or to find a job beyond their current skill level. It is important to make sure the person chooses a career direction realistically and at an appropriate pace. Transitional, part-time employment may help if the person is eager to begin working quickly. Job shadowing may help if the person seems overly ambitious in their career choice.
- Signs of Relapse. It is important for the counselor to watch for signs of relapse during the vocational rehabilitation process. These signs include frequent illness/absence, declining performance (academic or work), poor excuse for inappropriate behavior/performance, increased stress, and changes in appearance. If the counselor suspects the person is abusing again, they should confront the person. The counselor should explain that a return to treatment has fewer consequences than hiding a spiral back into active addiction.
- Drug Testing. If the VR counselor knows the potential employers have drug screens as part of the interview process, the counselor might ask the person to go ahead and take a drug screen ahead of time to protect the counselor's reputation. This should only be done with the client's agreement.

Emerging Issues

- Acceptance of relapse as a possible part of long-term recovery
- Restrictive insurance coverage of treatment
- Rapid emergence of new “designer drugs” for which there is little reference information

Additional Information Resources

- Addiction Technology Transfer Center - easy to read summaries of clinical research - www.nattc.org
- Association for Medical Education and Research in Substance Abuse - www.amersa.org
- National Association of Alcohol Drugs and Disabilities - www.nadap.org
- National Center on Addiction and Substance Abuse (Columbia Univ.) - www.casacolumbia.org
- National Institute on Alcohol Abuse and Alcoholism - www.niaaa.nih.gov
- National Institute on Drug Abuse - www.nida.nih.gov
- Substance Abuse and Mental Health Services Administration - www.samhsa.gov (also includes the Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT))
- Alcoholics Anonymous - www.alcoholics-anonymous.org
- Narcotics Anonymous - www.na.org