



ANNUAL
AMERICAN
SUPPLEMENT

2026 EDITION

An addendum to
**Counseling Clients with Substance Use Disorders
and/or Problematic Behaviors**

SECOND EDITION

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About This Supplement

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For Professors and Instructors

The American Supplement is written for general circulation, and it also serves as an addendum to *Counseling Clients with Substance Use Disorders and/or Problematic Behaviors* (2nd ed.; Cognella). Its purpose is to gather in one place the United States data, policy changes, and research findings that have appeared since the second edition went to press. Nothing in this supplement repeats material already covered in the textbook. Instructors may request a review copy at the link below.

<https://titles.cognella.com/counseling-clients-with-substance-use-disorders-and-or-problematic-behaviors-9798823344197>

Textbook Highlights

- **CACREP (2024) criteria.** As in the first edition, the text addresses the CACREP (2024) entry-level specialized practice area criteria for addiction counseling.
- **NASAC (2022) criteria.** Unlike the first edition, the second edition covers nearly every NASAC standard for accrediting associate, bachelor's, master's, and doctoral-level programs.
- **Author-selected color photographs.** Color photographs appear throughout.
- **Improved layout and reduced cost.** Eight chapters (Part IV: Tobacco Use Disorder and Problematic Behaviors, more than 100,000 words) are available as a free download to adopters.

The text is thorough and is accompanied by an extensive set of instructor and student resources.

Instructor and Student Resources

Instructor Resources	Available to Everyone Using the Textbook
PowerPoint slides for all 22 chapters, including the eight free chapters	Eight free chapters to download
Extensive test bank	Case scenarios
Instructor guide	Quiz for each chapter
Student note supplement (optional handout)	Flashcards
Canadian Supplement and American Supplement	Six appendices

Your Suggestions Are Welcome

If you have suggestions for additions to this supplement, please write to me at alderson@ucalgary.ca. Suggestions will be incorporated into the next edition if the information is not already covered in the textbook.

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What Is New in the 2026 Edition

This is the first edition of the American Supplement. It gathers United States material that has appeared since the second edition of the textbook was completed and will be revised annually alongside the Canadian Supplement. The following material is new:

- National overdose mortality data for the full 2025 calendar year and provisional data through March 2026, covering the third consecutive annual decline.
- Findings from the 2025 National Survey on Drug Use and Health, released July 27, 2026, which for the first time since 2020 permits five years of comparable trend data.
- Findings from the 2025 Monitoring the Future survey of eighth, tenth, and twelfth graders.
- Findings from the Monitoring the Future Longitudinal Panel Study, which reports on adults aged 19 to 65 and is the single best source on how substance use is changing across the adult lifespan.
- New evidence on adulteration of the unregulated opioid supply, including medetomidine, which is largely replacing xylazine in several major cities and produces a withdrawal syndrome the textbook does not describe.
- A new section on tobacco and nicotine covering the 2025 National Youth Tobacco Survey, the arrival of nicotine pouches as an authorized and now reduced-risk-labeled product category, the rise of concept flavors and poly product use among adolescents, and the dismantling of the federal cessation infrastructure.
- Federal cannabis scheduling actions taken in April 2026 and the closing of the hemp-derived THC loophole.
- The Surgeon General's Advisory on Alcohol and Cancer Risk and the 2025 to 2030 Dietary Guidelines for Americans, which move in opposite directions.
- Randomized trial evidence on GLP-1 receptor agonists for alcohol use disorder, a treatment class that did not exist in the addiction literature when the second edition was written.
- Executive Order 14401 of April 2026 on psychedelic drugs and the FDA actions that followed it.
- The expansion of legal sports betting and the arrival of prediction markets, together with a new national problem gambling helpline number.
- A new section on problematic internet-based behaviors covering evidence that addictive use patterns, rather than total screen time, carry the mental health risk, and the arrival of AI companion chatbots as a clinical and regulatory concern.
- A new section on problematic food consumption behaviors covering the consolidation of ultra-processed food addiction as a research construct.
- The reorganization of the Substance Abuse and Mental Health Services Administration into the Administration for a Healthy America.
- Current wage and labor market information drawn from the Bureau of Labor Statistics rather than commercial salary aggregators.

A Note on Interpreting the Numbers

Counts of drug overdose deaths are provisional when first released, and they are revised as coroner and medical examiner investigations conclude, sometimes for two or three years after the reporting period. The 2024 national total illustrates the point twice over: it was first reported provisionally as 80,391, revised provisionally to 81,313, and finalized at 79,384. Figures published in earlier editions of this supplement may therefore differ from those printed here, and a provisional count should only ever be compared with another provisional count. Comparisons across states should also be made cautiously, because jurisdictions differ in how they identify, investigate, and report cases, and because small states produce unstable percentage changes.

The Overdose Crisis in the United States

The second edition described an overdose emergency that had been worsening for two decades. That is no longer the whole story. The United States is now in the third consecutive year of falling overdose mortality, and the decline is the steepest and most sustained since national tracking began. This is genuinely good news, and it should be taught as such. It is also fragile, unevenly distributed, and not entirely attributable to anything the treatment system did.

Where Things Stood at the End of 2025

Provisional data from the National Center for Health Statistics indicate that an estimated 69,973 people in the United States died from a drug overdose during the 2025 calendar year, a decrease of almost 14% from the 81,313 deaths provisionally estimated for 2024 (National Center for Health Statistics, 2026a). Overdose deaths involving opioids fell from an estimated 55,296 in 2024 to 44,564 in 2025. Deaths involving cocaine and psychostimulants such as methamphetamine also declined.

Final mortality data for 2024 became available in January 2026, placing that year's total at 79,384 deaths, with an age-adjusted rate of 23.1 per 100,000. The decline from 2023 to 2024 was 26.2% in rate terms, the largest single-year decrease on record. Rates fell for every age group, with the largest decreases among younger people, and for every race and Hispanic-origin group, with the largest decrease among Black non-Hispanic people. The rate for synthetic opioids other than methadone fell 35.6%, from 22.2 to 14.3 per 100,000 (Garnett & Miniño, 2026).

The decline has continued into 2026, although it is slowing. The most recent provisional estimate available when this supplement went to press predicted 67,798 overdose deaths for the 12 months ending in March 2026, a 12.3% decrease from the same period a year earlier (Centers for Disease Control and Prevention, 2026a; National Center for Health Statistics, 2026b). Nonfatal overdose is easing more slowly. Suspected overdoses accounted for 54.7 per 10,000 emergency department visits between April 2025 and March 2026, a decline of 2.6% from the previous year.

Table 1. Drug Overdose Deaths in the United States, 2022 to 2026

Period	Deaths	Status of count	Age-adjusted rate
2022 (peak)	107,941	Final	32.6 per 100,000
2023	105,007	Final	31.3 per 100,000
2024	79,384	Final	23.1 per 100,000
2024	81,313	Provisional	Not applicable
2025	69,973	Provisional	Not applicable

Period	Deaths	Status of count	Age-adjusted rate
12 months ending March 2026	67,798	Provisional	Not applicable

Note. Final counts for 2022 are from Spencer et al. (2024), for 2023 from Garnett and Miniño (2024), and for 2024 from Garnett and Miniño (2026). Provisional counts for 2024 and 2025 are from the National Center for Health Statistics (2026a), and the count for the 12 months ending March 2026 is from the Centers for Disease Control and Prevention (2026a). The columns should not be summed.

A Teaching Opportunity in Table 1

The 2024 row appears twice on purpose. The provisional count for 2024 was 81,313, and the final count, published in January 2026 after all investigations closed, was 79,384, a difference of 1,929 deaths. The provisional figure is nonetheless the correct basis for comparison for the 2025 provisional estimate, because provisional counts must be compared with provisional counts. This is the clearest available illustration of why students should never treat a widely reported overdose number as fixed, and why two credible sources can print different totals for the same year without either being wrong.

Why Deaths Are Falling

Students will ask what caused the decline, and the honest answer is that no single factor explains it. Researchers and federal agencies have pointed to four contributors, and the relative weight of each is contested.

- **A change in the illegal supply.** The most-discussed explanation is a reduction in the potency and consistency of illicitly manufactured fentanyl, linked in part to Chinese controls on precursor chemical exports to manufacturers in Mexico. A less potent supply produces fewer fatal doses even when the number of people using does not change.
- **Wider naloxone distribution.** Over-the-counter naloxone became available in 2023, and saturation distribution through state and community programs expanded substantially thereafter.
- **Better access to treatment,** including telehealth initiation of buprenorphine and the loosening of methadone take-home restrictions.
- **A smaller population at risk.** This is the explanation instructors most often omit, and it deserves emphasis. Part of the reason fewer people are dying is that so many have already died. More than a million Americans died of drug overdose over the past two decades, and the cohort at highest risk has been depleted.

Two cautions belong alongside the good news. First, at roughly 70,000 deaths a year, the toll still exceeds the number of Americans killed in the entire Vietnam War. Second, the conditions that produced the decline are not guaranteed to persist. Analysts have flagged narrowing Medicaid coverage, reductions in federal overdose prevention budgets, and new restrictions on drug checking supplies as risks to the trend (Centers for Disease Control and Prevention, 2026a).

Improvement Has Not Been Uniform

National averages conceal enormous state-level variation, and this is a point worth making in every class. In the 2025 data, Rhode Island, New York, North Carolina, Alabama, and Vermont recorded declines of 25% or more, while New Mexico, Arizona, and Colorado recorded increases of 10% or more (National Center for Health Statistics, 2026a). Counselors practicing in the Mountain West and Southwest should not assume that the encouraging national picture describes their own community.

The reverse is also true: a clinician in a state with a 30% decline should not assume the crisis is over, because the deaths that remain are concentrated among the most marginalized people who use drugs.

The Changing Unregulated Supply

The textbook describes fentanyl and its analogs. It does not describe the sedative adulterants that now dominate the supply in many cities, and this is the single most clinically important gap for anyone working with people who use unregulated opioids. A client who uses street opioids today is almost certainly being exposed to sedatives they did not choose and cannot dose.

Xylazine

Xylazine is a veterinary alpha-2 adrenergic agonist that has been added to opioids since roughly 2001 and spread rapidly through the Northeast after 2018. By 2021, more than 90% of opioid samples tested in Philadelphia contained it (Hamza et al., 2026). Xylazine produces sedation, bradycardia, hypotension, and respiratory depression, and it is associated with deep necrotic skin ulcers that can appear at sites distant from any injection. It does not respond to naloxone, because naloxone has no effect at alpha-2 receptors, which means that a person can be revived from the opioid component of an overdose and remain profoundly sedated.

Wound care has become a routine part of outreach and treatment work in affected cities.

Multidisciplinary guidance for xylazine-associated wounds is now available and is worth adding to any reading list for students headed into harm reduction settings (Yang et al., 2025). New ICD codes for xylazine-associated wounds have also been introduced, although uptake has been uneven (Teixeira da Silva et al., 2026).

Medetomidine

Medetomidine is a veterinary alpha-2 adrenergic agonist, related to the intensive care sedative dexmedetomidine, and it is estimated to be up to 300 times more potent than xylazine (Chertok & Roder, 2026). Medetomidine is both more potent and longer acting than either xylazine or clonidine, which is what makes its sedation so prolonged (Centers for Disease Control and Prevention, 2026b). Medetomidine is displacing xylazine, and quickly. It is a second veterinary alpha-2 agonist, related to the intensive care sedative dexmedetomidine, and it is up to 300 times more potent than xylazine (Chertok & Roder, 2026). It first appeared in Philadelphia's drug supply in May 2024. Between May 2024 and March 2026, the proportion of Philadelphia samples containing medetomidine rose from 29% to 90%, while the proportion containing xylazine fell from 97% to 28% (Substance Use Philadelphia, 2026). It has also been documented in Chicago and Pittsburgh and is presumed to be spreading to other regions (Chertok & Roder, 2026).

Three features matter clinically. Medetomidine intoxication resembles that of other alpha-2 agonists such as clonidine but is more potent, producing hypotension, bradycardia, and prolonged sedation; plasma levels peak within 10 to 30 minutes of ingestion, and effects that would otherwise last several hours can be prolonged by concurrent opioid exposure. Medetomidine does not appear to cause the wounds associated with xylazine, so the decline in xylazine wound presentations in Philadelphia should not be read as an improvement in the supply. And neither xylazine nor medetomidine is included in standard urine drug testing, so a negative panel tells the clinician nothing about exposure.

Naloxone remains the foundation of the acute overdose response even when medetomidine involvement is suspected, because the opioid component is what stops respiration. Airway protection and other supportive care may still be required after the opioid effect has been reversed (Chertok & Roder, 2026).

Recognizing and Managing Medetomidine Withdrawal

The most consequential development for counselors is a withdrawal syndrome that did not previously exist. Medetomidine withdrawal can begin abruptly within hours of last use and peaks within 18 to 36 hours. It produces profound tachycardia, hypertension, vomiting, and altered mental status. Vital signs can swing rapidly, moving from the hypotension and bradycardia of direct alpha-2 effects to hypertension and tachycardia a few hours later as withdrawal sets in. Hospitalization is frequently required, and intensive care may become necessary because of neurologic changes needing close monitoring, inability to tolerate oral medication, or hypertensive emergency with end-organ damage such as posterior reversible encephalopathy syndrome or non-ST elevation myocardial infarction (Chertok & Roder, 2026).

Treatment involves alpha-2 agonist replacement: oral or transdermal clonidine, oral tizanidine, oral guanfacine, and escalation to intravenous dexmedetomidine, which usually requires intensive care monitoring. Doses may exceed the usual upper limits of prescribing. Optimal tapering strategies are not yet established and may take days to weeks. Severe nausea and vomiting are common and are treated with antiemetics or with an antipsychotic such as olanzapine. None of this replaces medication for opioid use disorder, which remains the central intervention (Chertok & Roder, 2026).

There are no prediction rules identifying who is at higher risk of severe withdrawal. In settings where medetomidine contamination is ubiquitous, clinicians have begun prescribing oral alpha-2 agonists routinely at outpatient initiation of medication for opioid use disorder, treating alpha-2 withdrawal preemptively rather than waiting for it, and counseling patients on the signs that should prompt escalation of care (Chertok & Roder, 2026).

A Clinical Implication Worth Teaching

Chertok and Roder (2026) put the teaching point plainly: the long-standing adage that opioid withdrawal is uncomfortable but not dangerous is no longer reliable in a contaminated supply, because people who primarily use opioids can now have dangerous withdrawal from nonopioid contaminants. A client who has been stable in outpatient withdrawal management for years may present with a course that outpatient services cannot safely manage. When a client reports that withdrawal has become unrecognizably worse, the counselor should believe them and consult with medicine rather than reframing the report as drug-seeking or as poor motivation.

Nitazenes

Nitazenes are a family of synthetic opioids, some of them substantially more potent than fentanyl, that were originally synthesized in the 1950s and never marketed. They have appeared in the unregulated supply in several regions. Overdoses involving nitazenes may resist standard reversal and require repeated doses of naloxone (Hamza et al., 2026).

What This Means in the Counseling Room

- **Assume polysubstance exposure.** The client is not using one drug and probably does not know what they are using.
- **Do not rely on urine drug screens** to characterize exposure to adulterants.
- **Ask about sedation and withdrawal quality**, not just about substance and amount. Asking whether coming off has felt different lately is a more useful question than it was three years ago.
- **Prepare clients and families for the limits of naloxone.** Naloxone remains essential and reverses the opioid component. It will not fully wake a person sedated by an alpha-2 agonist, and families who expect it to may conclude, wrongly, that it failed.

- **Encourage drug checking where it exists.** Test strips detect a single contaminant, while laboratory drug checking can identify several at once and provides early warning of new ones (Chertok & Roder, 2026).
- **Know the local supply.** Regional drug checking programs and public health surveillance reports are now a legitimate part of clinical preparation, and reaching out to the local health department is a reasonable professional step.

Patterns of Substance Use Among Americans

The National Survey on Drug Use and Health (NSDUH) is conducted annually by the Substance Abuse and Mental Health Services Administration and collects data from people aged 12 and older. Results from the 2025 cycle were released on July 27, 2026, and are based on responses from more than 60,000 people. The 2025 cycle is the first since 2020 in which five consecutive years of comparable data are available, allowing trends from 2021 through 2025 to be reported for most indicators (Substance Abuse and Mental Health Services Administration, 2026a, 2026b).

Among people aged 12 or older in 2025, 56.0%, or 162.8 million people, used tobacco, vaped nicotine, drank alcohol, or used an illicit drug in the past month.

Table 2. Past-Month and Past-Year Substance Use in the United States, 2025

Indicator (aged 12 or older)	Percentage	Number of people
Any tobacco, nicotine vaping, alcohol, or illicit drug, past month	56.0%	162.8 million
Alcohol, past month	44.4%	129.1 million
Binge drinking, past month	19.5%	56.8 million
Nicotine products of any kind, past month	22.1%	64.2 million
Tobacco product, past month	16.2%	46.9 million
Cigarettes, past month	12.4%	36.1 million
Vaped nicotine, past month	10.1%	29.3 million
Any illicit drug, past month	16.4%	47.5 million
Marijuana, past year	21.2%	61.6 million
Hallucinogens, past year	3.1%	9.1 million
Prescription opioid misuse, past year	2.4%	6.9 million
Illegally made fentanyl, past year	0.3%	768,000

Note. Data from the Substance Abuse and Mental Health Services Administration (2026b). Illegally made fentanyl estimates should be interpreted with caution, because fentanyl is frequently present without the user's knowledge in products sold as heroin or as counterfeit prescription pills.

Of the 129.1 million people who drank alcohol in the past month, 56.8 million, or 44.0%, engaged in binge drinking during that period. Marijuana remained the most widely used federally controlled substance. Its legal status is uneven, however: it is still a Schedule I drug under federal law, while most states permit medical use and about half also permit nonmedical adult use. The National Survey on Drug Use and Health (NSDUH) counts all self-reported marijuana use regardless of whether it was legal in the respondent's state, so the national estimates below combine legal and illegal use. Marijuana is also the only major substance whose use rose across the five-year window: past-year use increased from 19.0%

(53.2 million people) in 2021 to 21.2% (61.6 million people) in 2025. That increase occurred among adults aged 26 or older. Among adolescents and among young adults aged 18 to 25, past-year marijuana use decreased.

Table 3. Selected Trends Among People Aged 12 or Older, 2021 to 2025

Indicator	2021	2025	Direction
Cigarette smoking, past month	16.0%	12.4%	Decreased
Binge drinking, past month	21.7%	19.5%	Decreased
Alcohol use, ages 12 to 20, past month	15.6%	13.7%	Decreased
Marijuana use, past year	19.0%	21.2%	Increased
Hallucinogen use, past year	2.7%	3.1%	Increased
Prescription opioid misuse, past year	3.0%	2.4%	Decreased
Nicotine vaping, past month (from 2022)	8.3%	10.1%	Increased
Any substance use disorder, past year	16.7%	15.3%	Decreased
Alcohol use disorder, past year	10.6%	8.9%	Decreased
Drug use disorder, past year	Not reported	Not reported	No change

Note. Data from the Substance Abuse and Mental Health Services Administration (2026b). The baseline year is 2022 rather than 2021 for nicotine vaping and for illegally made fentanyl. Estimates based on the multimode data collection used since 2021 are not comparable with those from 2020 or earlier.

Substance Use Disorders

In 2025, 44.6 million people aged 12 or older, or 15.3%, had a substance use disorder in the past year. This included 25.7 million people with an alcohol use disorder, 26.0 million with a drug use disorder, and 7.1 million with both. The overall prevalence declined from 16.7% (46.8 million people) in 2021, driven almost entirely by the fall in alcohol use disorder from 10.6% to 8.9%. Drug use disorder showed no change over the same period (Substance Abuse and Mental Health Services Administration, 2026b).

Prevalence was highest among young adults aged 18 to 25 (23.8%, or 8.6 million people), followed by adults aged 26 or older (14.9%, or 34.1 million), then adolescents aged 12 to 17 (7.4%, or 1.9 million).

Two severity findings deserve attention in the classroom. Most people with a substance use disorder had a mild disorder, and about one in five had a severe disorder. However, among adolescents aged 12 to 17 with a marijuana use disorder, 33.4% had a severe disorder, as did 25.3% of young adults aged 18 to 25 with a marijuana use disorder. Severity was also concentrated in stimulant use: among people with a central nervous system stimulant use disorder, about half (47.9%) had a severe disorder, compared with 38.4% of those with an opioid use disorder arising from heroin use or prescription opioid misuse.

The Treatment Gap

The 2025 cycle revised how treatment receipt is measured, so these estimates are presented for 2025 only and should not be compared with earlier years. The findings are sobering.

Table 4. Substance Use Disorder and Treatment Receipt in the United States, 2025

Indicator	Finding
People aged 12 or older with a past-year substance use disorder	44.6 million (15.3%)
Of those needing treatment, percentage who received it	16.0% (7.6 million)
Adolescents aged 12 to 17 needing treatment who received it	22.8%
Young adults aged 18 to 25 needing treatment who received it	9.6%
Adults aged 26 or older needing treatment who received it	17.1%
People with a substance use disorder who received neither treatment nor other services	86.4% (38.5 million)
Adults with a substance use disorder who did not receive treatment and did not seek it or think they needed it	94.5% (34.9 million)

Note. Data from the Substance Abuse and Mental Health Services Administration (2026b). Other services includes support groups, peer support or recovery coaching, emergency department services, withdrawal management, and receipt of overdose reversal medication; these were counted separately from treatment.

The most instructive number here is not the size of the gap but its composition. Among adults with a substance use disorder who did not receive treatment, only 0.5% sought treatment and could not get it, and a further 5.0% did not seek treatment but believed they should. The remaining 94.5% neither sought treatment nor thought they needed it. Whatever else this says, it says that the primary barrier in the aggregate is not waiting lists. It is that the great majority of people who meet criteria do not identify themselves as needing help.

This finding should shape how the textbook's material on the stages of change and motivational interviewing is taught. If roughly nine in ten people with a diagnosable disorder are in precontemplation, then the skills that matter most in general practice are the ones that work before someone identifies a problem: screening, brief intervention, and referral to treatment in primary care, emergency departments, schools, and workplaces. Waiting for clients to arrive at a treatment center means waiting for a small minority.

Young adults aged 18 to 25 stand out as the group with both the highest prevalence of substance use disorder (23.8%) and the lowest rate of treatment receipt (9.6%). That combination should inform where programs place their outreach effort.

Recovery

The survey also asks about recovery, and the findings are consistently more hopeful than the treatment figures suggest. In 2025, 30.6 million adults (11.6%) perceived that they ever had a problem with their use of drugs or alcohol. Among those adults, 73.0%, or 22.3 million people, considered themselves to be in recovery or to have recovered (Substance Abuse and Mental Health Services Administration, 2026b). For comparison, 63.8 million adults (24.3%) perceived that they ever had a mental health problem, and 69.4% of them considered themselves in recovery or recovered.

These are self-report data about self-defined problems, not diagnostic estimates, and they should be presented as such. Within those limits, they support a message the textbook makes repeatedly: most people who develop a problem with substances eventually resolve it, and a great many do so without formal treatment.

Adolescent Substance Use

The Monitoring the Future study, conducted by the University of Michigan with funding from the National Institute on Drug Abuse, has surveyed adolescents for more than 50 years. The 2025 survey collected 23,726 questionnaires from students in the eighth, tenth, and twelfth grades across 270 public and private schools, with completed questionnaires obtained from 86% of all sampled students (Miech et al., 2026).

The headline finding is stability at a historic low. Abstention, defined as no use of alcohol, cannabis, or nicotine by vaping or by cigarettes in the past 30 days, reached record highs of 91% in eighth grade and 82% in tenth grade. In twelfth grade, the 2025 level of 66% was one percentage point below the record high of 67% set the previous year, a difference that was not statistically significant. For perspective, past-30-day abstention was 69% in eighth grade and 51% in tenth grade when first tracked in 1991, and 24% in twelfth grade when first tracked in 1976. Lifetime abstention followed the same pattern at lower levels: 73%, 61%, and 41% in the eighth, tenth, and twelfth grades, respectively.

That result answers a question with real policy weight. Two explanations competed for the pandemic-era drop in adolescent use. Either the disruption of school and community peer networks produced a durable change, or use would rebound once students returned to buildings. Five years on, the lowered levels have held and have continued to drift downward. Miech et al. (2026) read this as evidence that the change is lasting.

Several patterns within that stability are worth noting for practice:

- **Alcohol continues a decline that began in the late 1990s.** Past-12-month use in 2025 was 41% in twelfth grade, 24% in tenth, and 11% in eighth grade, compared with 75%, 65%, and 46%, respectively, in 1997.
- **Cannabis is at or near a three-decade low** in the upper grades, with past-12-month use of 26% in twelfth grade and 16% in tenth grade. Eighth grade has held at 8% for four years after dropping from a pre-pandemic 11% in 2020.
- **Nicotine vaping has completed a reversal.** Past-12-month use in 2025 was 20% in twelfth grade, 14% in tenth grade, and 9% in eighth grade, close to the levels first recorded in 2017 and well below the 2020 peaks of 35%, 31%, and 17%.
- **Nicotine pouches are the one product moving upward.** Lifetime use rose from 7% to 10% in twelfth grade, 4% to 5% in tenth, and 0.8% to 1.4% in eighth between 2024 and 2025, although none of these increases reached statistical significance. Past-12-month use in twelfth grade stands at 7%, against 20% for nicotine vaping. Miech et al. (2026) note that smokeless tobacco reached a lifetime prevalence of 32% in the early 1990s, which suggests the ceiling for oral nicotine products is a good deal higher than current levels.
- **Method of cannabis use continues to shift.** Vaping cannabis and edibles have become common routes among older adolescents. Both are perceived as lower risk and easier to conceal from adults.
- **Heroin and cocaine use increased.** Past-12-month heroin use rose significantly in all three grades, from 0.2% to 0.5% in eighth, 0.1% to 0.5% in tenth, and 0.2% to 0.9% in twelfth. Past-12-month cocaine use rose to 0.6%, 0.7%, and 1.4% in the eighth, tenth, and twelfth grades, with the increases statistically significant in the eighth and twelfth grades.

The heroin and cocaine increases are small in absolute terms, and prevalence remains below 2% in all three grades, so they should not be overstated. They are nonetheless the first upward movement in several years in two highly addictive drugs, and Miech et al. (2026) flagged them as warranting close monitoring. Given how frequently fentanyl now appears in counterfeit pills and in powder sold as

something else, even low-prevalence experimentation carries a mortality risk that did not attach to it a decade ago. That point connects directly to the prevention material in Chapter 8.

Substance Use Across Adulthood

The Monitoring the Future Longitudinal Panel Study follows the same individuals from a modal age of 18 across the lifespan and now reports on adults aged 19 to 65 (Patrick et al., 2026). It is the best available window on how substance use changes with age in the United States, and it is a useful corrective to a common classroom assumption that substance use is primarily a young person's problem. The 2025 report shows the opposite pattern for cannabis.

Table 5. Substance Use Across the Adult Lifespan, 2025

Indicator (past 12 months unless noted)	Ages 19 to 30	Ages 35 to 50	Ages 55 to 65
Alcohol	80.0%	82.2%	80.3%
Alcohol, past 30 days	61.6%	64.1%	63.9%
Binge drinking, past 2 weeks	23.6%	23.2%	18.7%
Cannabis, any mode	41.9%	29.9%	21.3%
Cannabis, past 30 days	28.8%	20.2%	15.0%
Daily cannabis, past 30 days	11.8%	8.5%	6.2%
Cannabis edibles	19.2%	15.6%	7.4%
Nicotine, any mode	38.6%	29.2%	29.5%
Cigarettes	18.6%	13.2%	14.0%
Cigarettes, past 30 days	8.3%	8.6%	10.6%
Other drugs	17.8%	15.0%	11.4%

Note. Data from Patrick et al. (2026). Other drugs is an index of nonmedical use of any drug other than cannabis, including hallucinogens, cocaine, stimulant medications, sleeping medications, anti-anxiety medications, and opioids. Daily cannabis use is defined as use on 20 or more occasions in the past 30 days. Data for ages 55 to 65 have been available for the full age band only since 2023, so long-term trends for that group cannot yet be calculated.

Young Adults Aged 19 to 30

Alcohol remains the most used substance in this group, but nearly every measure of drinking reached a historic low again in 2025, including past-12-month use, past-30-day use, daily drinking, and binge drinking. Cigarette smoking in the past 30 days has fallen by almost three-quarters since 2005, from 27.6% to 8.3%, although the rate of decline may be slowing (Patrick et al., 2026).

Cannabis moved in the opposite direction. Daily cannabis use reached a new all-time study high of 11.8%. Past-12-month and past-30-day use remained at or near record levels, with significant increases over the past decade. Nicotine vaping in the past 30 days also reached the highest level ever recorded, having more than tripled since it was first measured in 2017. Nicotine pouch use, first measured in 2023, has more than doubled, reaching 12.7% past-12-month use in 2025.

Four one-year changes were statistically significant. Heroin use rose from 0.2% to 0.6%, nonmedical use of prescription drugs from 8.3% to 10.5%, and nonmedical use of sleeping medications from 2.0% to 3.0%. Hallucinogen and psychedelic use fell from 8.9% to 7.2%, although this followed the highest level

ever recorded in 2024 and the ten-year trend remains upward. Driving after using cannabis in the past two weeks fell from 13.5% to 8.2%, which is a genuinely encouraging prevention result.

Midlife Adults Aged 35 to 65

The midlife findings are the ones most likely to surprise students. Among adults aged 35 to 50, past-12-month and past-30-day cannabis use have doubled or nearly doubled over the past decade. Daily cannabis use reached a new all-time high of 8.5%, vaping cannabis reached a new high of 9.8%, and edible use rose from 12.0% in 2020 to 15.6% in 2025. Symptoms of cannabis use disorder among those aged 40 to 50 rose from 4.8% in 2024 to 6.5% in 2025, with a significant five-year increase. Hallucinogen and psychedelic use held at its all-time high of 5.3%, and stimulant medication use rose from 1.9% in 2015 to 3.0% in 2025 (Patrick et al., 2026).

Among adults aged 55 to 65, past-12-month cannabis use rose to a new high of 21.3%, and daily cannabis use reached an all-time high of 6.2%. Past-12-month use of any nicotine, large cigars, hookah, smokeless tobacco, and nicotine pouches all increased, which Patrick et al. (2026) described as consistent and large increases across forms of tobacco use. Alcohol use in the past 12 months increased to 80.3%, abstention from alcohol decreased, and overall abstention from all substances combined fell to 12.6%.

Alcohol among adults aged 35 to 50 moved the other way, reaching or continuing near historic lows. Past-30-day use hit a new low of 64.1%, daily drinking fell to 7.3%, and binge drinking reached a new low of 23.2%. Cigarette smoking on every measure continued to decline significantly over five and ten years.

College and Noncollege Young Adults

Among adults aged 19 to 22, past-30-day alcohol use reached a new historic low of 52.0% among college students. Binge drinking reached historic lows in both groups, at 20.3% for college students and 16.6% for those not in college, and college men recorded an all-time low of 23.0%. Noncollege young adults had a higher prevalence of daily cannabis use, cigarette smoking, and nicotine vaping. Past-30-day cannabis vaping reached historic highs in both groups (Patrick et al., 2026).

What the Panel Data Add

Three teaching points follow.

- **The alcohol story and the cannabis story are moving in opposite directions at every age.** Drinking is falling among adolescents, young adults, and adults in early midlife, while cannabis use is rising and is rising fastest in the age groups the field has historically ignored.
- **Cannabis is aging upward, and so is cannabis use disorder.** A 47-year-old client using cannabis daily is now a more typical presentation than a 19-year-old doing so. Programs and screening protocols built around adolescent cannabis use will miss this.
- **Nicotine is diversifying rather than disappearing.** Cigarette smoking is in long-term decline in every adult age band, but pouches, vaping, cigars, and hookah are increasing, including among adults aged 55 to 65. Asking a client whether they smoke is no longer an adequate nicotine screen.

Tobacco and Nicotine in the United States

Chapter 15 covers tobacco use disorder in depth. What has changed since the second edition is the product mix, the regulatory posture, and the federal cessation infrastructure. All three have moved substantially, and in different directions.

Where Use Stands

Among people aged 12 or older in 2025, 22.1% (64.2 million) used a nicotine product of any kind in the past month, 16.2% (46.9 million) used a tobacco product, 12.4% (36.1 million) smoked cigarettes, and 10.1% (29.3 million) vaped nicotine. Cigarette smoking fell from 16.0% in 2021, while nicotine vaping rose from 8.3% in 2022 (Substance Abuse and Mental Health Services Administration, 2026b).

Among adolescents, the 2025 National Youth Tobacco Survey found that 7.2% of middle and high school students, about 2.02 million young people, currently used any tobacco product. E-cigarettes remained the most used product at 5.2%, and nicotine pouches were second at 1.7%, about 460,000 students. Current use declined between 2022 and 2025 for tobacco products overall, for combusted products, and for e-cigarettes (U.S. Food and Drug Administration, 2026b). An independent analysis of the same public use dataset found that nicotine pouches were the only product to increase over the five-year window, doubling from 0.8% in 2021, when the survey began tracking them, to 1.7% in 2025, and that in 2024 they overtook cigarettes to become the second most widely used tobacco product among youth (Glantz, 2026).

Use is far from evenly distributed. Current use of any tobacco product was reported by 14.3% of Native Hawaiian or Pacific Islander students, 11.5% of American Indian or Alaska Native students, 10.0% of multiracial students, 7.9% of Middle Eastern or North African students, 7.8% of White students, 7.7% of Black students, 6.5% of Hispanic students, and 3.0% of Asian students. Male and female use was similar overall, at 7.4% and 7.0%, with two exceptions: pouches (2.4% among males versus 1.0% among females) and smokeless tobacco (1.5% among males versus 0.4% among females) (Glantz, 2026).

Table 6. Nicotine and Tobacco Indicators in the United States, 2025

Indicator	Estimate	Source
Any nicotine product, past month, aged 12 or older	22.1%	NSDUH
Cigarettes, past month, aged 12 or older	12.4%	NSDUH
Vaped nicotine, past month, aged 12 or older	10.1%	NSDUH
Any tobacco product, middle and high school students	7.2%	NYTS
E-cigarettes, middle and high school students	5.2%	NYTS
Nicotine pouches, middle and high school students	1.7%	NYTS
Multiple tobacco products, middle and high school students	2.8%	NYTS
Nicotine pouches, lifetime, twelfth graders	10%	MTF
Nicotine vaping, past 12 months, twelfth graders	20%	MTF
Nicotine pouches, past 12 months, ages 19 to 30	12.7%	MTF Panel
Any nicotine, past 12 months, ages 55 to 65	29.5%	MTF Panel

Note. NSDUH figures are from the Substance Abuse and Mental Health Services Administration (2026b), NYTS figures from the U.S. Food and Drug Administration (2026b) and Glantz (2026), Monitoring the Future school figures from Miech et al. (2026), and Monitoring the Future Longitudinal Panel figures from Patrick et al. (2026). The surveys use different populations, age ranges, and recall periods, so the rows are not directly comparable.

A Survey That Almost Did Not Happen

The provenance of the 2025 adolescent data is itself worth teaching, because it illustrates how quickly a data series can become fragile. Data collection for the 2025 National Youth Tobacco Survey was stopped

in April 2025, and the CDC announced it would no longer publish tobacco reports with external partners in the Morbidity and Mortality Weekly Report, which had long been the standard vehicle for these findings. The FDA released a 2025 public-use dataset in March 2026, and the analysis described here was produced independently of that dataset, using a total sample of 23,630 students (Glantz, 2026). The FDA published its own summary and a peer-reviewed article in June 2026 (U.S. Food and Drug Administration, 2026b).

Two practical consequences follow. Estimates from the FDA analysis and the independent analysis differ slightly due to different statistical software and variable construction, so students citing either should state which one they used. And formal statistical testing of trends was not possible in the independent analysis because 5 years is too short a window to support a reliable meta-regression over time (Glantz, 2026). Where this supplement reports that something doubled or declined, it is describing a change in point estimates, not a tested trend.

Nicotine Pouches and the Regulatory Turn

Nicotine pouches are small fiber pouches containing nicotine powder and flavoring, placed between the lip and gum. They contain no tobacco leaf and require no spitting, which makes them almost undetectable in a classroom, an office, or a session. Chapter 15 notes that they deliver lower toxicant exposure than combustible products. What is new is their regulatory status.

In January 2025, the FDA authorized the marketing of 20 ZYN products through the premarket tobacco product application pathway, the first time any nicotine pouch had been authorized (U.S. Food and Drug Administration, 2025a). By December 2025, 26 pouch products had been authorized: the 20 ZYN products plus six on! PLUS products. Then, on June 30, 2026, the FDA issued modified risk granted orders for the same 20 ZYN products, permitting them to be marketed with a claim that switching from cigarettes to ZYN places the user at lower risk of mouth cancer, heart disease, lung cancer, stroke, emphysema, and chronic bronchitis (U.S. Food and Drug Administration, 2026a). This was the first modified risk authorization ever granted to a nicotine pouch. The orders expire in five years, require postmarket surveillance and behavior studies, and may be withdrawn if youth uptake rises significantly.

Two further actions in 2026 widened the market. On May 5, 2026, the FDA authorized Glas e-cigarettes in two menthol varieties and in two concept flavors, gold (mango) and sapphire (blueberry), the first authorization of fruit-flavored e-cigarettes for adults. Three days later, on May 8, 2026, the agency announced that it would exercise enforcement discretion and permit e-cigarettes, other electronic nicotine delivery systems, and nicotine pouches to be sold, so long as the manufacturer had submitted a premarket application, which, in practice, allows the marketing of products the agency has not evaluated. The May 5 authorization was issued while the public comment period on the agency's own draft guidance about flavored products was still open (Glantz, 2026).

The decisions drew immediate objection from the American Lung Association, the American Cancer Society, and other health organizations, whose central concern is that pouches are already the second most used tobacco product among young people and that ten of the authorized ZYN products are flavored, with mint the most popular flavor among youth users.

Flavors, Intensity, and Poly Use

Three findings from the 2025 survey change what a thorough nicotine assessment should ask about.

Flavors dominate, and the flavor names have changed. Among youth who use e-cigarettes, 63.2% used an ice flavor, which delivers a cooling sensation through a synthetic cooling agent rather than menthol, 59.3% used fruit, 36.5% used menthol or mint, and 31.7% used candy. Among youth who use pouches the ranking is different: 65.5% used menthol or mint, 24.3% fruit, and 22.8% ice. Most important for anyone talking with a young person, 27.2% of youth e-cigarette users and 14.3% of pouch

users reported using a concept flavor, meaning a product named with a word that describes no flavor at all, such as solar, purple, jazz, island bash, or fusion. These names exist to evade flavor restrictions. A counselor who asks what flavor a client uses may be told a word that sounds like nothing, and should treat that answer as informative rather than evasive (Glantz, 2026).

Use is intensifying even as prevalence falls. Among youth who currently use e-cigarettes, daily use rose from 9.4% in 2014 to 35.4% in 2025 and use on 20 or more days a month rose from 14.8% to 52.9% of current users. Very occasional use, on one or two days a month, fell from 47.1% to 34.3%. Among pouch users the most common pattern remains one or two days a month, but daily use rose from 6.9% in 2021 to 23.6% in 2025. In other words, fewer adolescents are using these products, and those who do are using them harder. Ten percent of youth tobacco users reported using tobacco within five minutes of waking, a classic marker of dependence (Glantz, 2026).

Pouch use is rarely pouch use alone. About 80% of youth pouch users also use at least one other tobacco product, with 49.7% using three or more and only 23.0% using pouches by themselves. Among e-cigarette users, sole use remains the most common pattern at 59.8%, but it is declining while poly use rises. Glantz (2026) raises a specific concern worth putting to students: pouches may be functioning as a bridge product, sustaining nicotine use in settings where smoking or vaping is not possible, such as classrooms and workplaces covered by smoke-free policies, rather than replacing other products.

Table 7. Flavor and Use-Pattern Indicators Among Youth Who Currently Use E-Cigarettes or Nicotine Pouches, 2025

Indicator (percentage of current users of that product)	E-cigarettes	Nicotine pouches
Ice flavor	63.2%	22.8%
Fruit flavor	59.3%	24.3%
Menthol or mint	36.5%	65.5%
Candy flavor	31.7%	8.0%
Concept flavor	27.2%	14.3%
Unflavored	8.8%	5.9%
Daily use (30 days per month)	35.4%	23.6%
Sole use of that product only	59.8%	23.0%
Use of three or more products	21.3%	49.7%

Note. Data from Glantz (2026) and the 2025 National Youth Tobacco Survey public-use dataset. Percentages within the flavor block sum to more than 100 because respondents could report more than one flavor. Concept flavors are products named with a word that does not describe a flavor, such as solar, purple, jazz, island bash, or fusion.

What This Means for Assessment

Four practical consequences follow for counselors. First, a client may now encounter federally sanctioned language describing a nicotine product as lower risk, and may reasonably read that as low risk. The claim is comparative, and it is comparative against cigarettes, which is the most harmful available benchmark. Second, pouches are the most concealable nicotine product yet marketed. A parent, teacher, or partner will see no smoke, no vapor, no odor, and no spitting. Nicotine screening questions written around smoking and vaping will return false negatives. Third, ask about pouches by name and about every other product alongside them, because four out of five young pouch users use something else as well. Fourth, ask how often rather than only whether, since the population trend is toward heavier use among a smaller number of users, and a client who vapes daily is a different clinical proposition from one who vapes twice a month.

Two Rules That Did Not Happen

Instructors who taught the first edition may have told students that a federal menthol ban was imminent. It is not. The proposed product standards prohibiting menthol as a characterizing flavor in cigarettes and prohibiting characterizing flavors in cigars were formally withdrawn on January 21, 2025, ending both rulemakings, although litigation over the FDA's inaction continues and a future administration could revive either proposal (Anderson, 2025). Chapter 15 reviews the evidence on menthol, including its disproportionate role among Black smokers; that evidence has not changed, but the policy response to it has stalled.

A second proposal remains alive but unfinished. On January 16, 2025, the FDA proposed a product standard that would cap nicotine in cigarettes and certain other combusted tobacco products at a minimally or nonaddictive level. The comment period closed on September 15, 2025. The rule has not been finalized or withdrawn (U.S. Food and Drug Administration, 2025b). If finalized, it would be the most consequential tobacco control action in decades, because it would change the addictiveness of the product itself rather than trying to change the behavior of the person using it. Students should be able to explain why a nicotine cap is a different kind of intervention from a flavor ban.

The Cessation Infrastructure

On April 1, 2025, the CDC's Office on Smoking and Health was eliminated as part of the broader Department of Health and Human Services restructuring described later in this supplement. That office was the primary federal mechanism for tobacco prevention and cessation. It funded state quitlines, ran the Tips From Former Smokers campaign, and administered youth tobacco surveillance.

The practical effects reached clients quickly. Distribution of grants to state tobacco control programs was delayed from April 2025 to the end of the federal fiscal year in September, and some states reduced or suspended quitline services in the interim, in several cases scaling back to a single counseling call or discontinuing free cessation medication (American Lung Association, 2026). Congress subsequently approved level funding for the CDC tobacco control program for fiscal year 2026 (Campaign for Tobacco-Free Kids, 2026), but service levels vary considerably by state.

The clinical implication is simple and immediate. 1-800-QUIT-NOW routes callers to a state quitline, and what that quitline offers now varies widely depending on the state. Before handing a client the number, a counselor should check what their own state's quitline currently provides, particularly whether free nicotine replacement therapy is still included. Referring a client to a service that has been quietly cut is worse than not referring at all, because it costs the client the chance to try.

Cannabis in the United States

Two federal developments have changed the legal landscape since the second edition went to press, and both will affect what students find when they research this topic.

Federal Scheduling Actions in 2026

The proposal to move marijuana from Schedule I to Schedule III of the Controlled Substances Act, first published in May 2024, remained unresolved for two years. In December 2025, an executive order directed the Attorney General to expedite the process. On April 23, 2026, the Acting Attorney General issued an order that did two things (U.S. Department of Justice, 2026).

- **It immediately placed two categories in Schedule III:** marijuana contained in an FDA-approved drug product, and marijuana subject to a qualifying state medical marijuana license. The final order was published in the Federal Register and took effect on April 28, 2026, without notice-and-comment rulemaking, pursuant to the authority of the United States' obligations under the 1961 Single Convention on Narcotic Drugs.
- **It initiated an expedited administrative hearing** to consider whether marijuana more broadly, including recreational marijuana, should be moved to Schedule III. The Drug Enforcement Administration held that hearing from June 29 to July 15, 2026 (Drug Enforcement Administration, 2026).

As of the date this supplement went to press, no final rule on broader rescheduling had been issued. The proceeding had reached closing arguments, with the DEA itself filing a post-hearing brief arguing that marijuana no longer satisfies the criteria for Schedule I, and the matter awaiting a recommendation from the administrative law judge. Students and clinicians should be precise about what is and is not true: some medical marijuana is now in Schedule III; recreational marijuana, bulk marijuana, and extracts not incorporated into an FDA-approved product remain in Schedule I; synthetically derived THC is unaffected and remains in Schedule I; the status of hemp is unaffected; and nothing in these actions legalized recreational marijuana nationally. Because a decision may issue at any time, readers should check the DEA marijuana rescheduling page rather than relying on this paragraph.

The practical effects of Schedule III status for covered products are chiefly research- and tax-related. Schedule III eases some restrictions on research registration and removes the punitive effect of Internal Revenue Code Section 280E for activity actually within Schedule III. It does not create a federal medical marijuana program, and it does not change state law.

The Hemp Loophole and Its Closing

The 2018 Farm Bill defined hemp as cannabis containing no more than 0.3% delta-9 THC by dry weight. Because the statute named only the delta-9 isomer, an entire intoxicating product market grew up around compounds that stayed under that line: delta-8 THC, delta-10 THC, HHC, THCP, and raw THCA flower, which is not delta-9 until it is heated. These products were sold in gas stations, smoke shops, and convenience stores in most states, frequently without age verification.

Section 781 of Public Law 119-37, signed November 12, 2025, closed that gap. It rewrites the statutory definition of hemp in three ways. It measures total tetrahydrocannabinols, expressly including tetrahydrocannabinolic acid, against the 0.3% dry weight threshold rather than counting delta-9 alone, which is what removes THCA flower from the definition. It excludes any cannabinoid that the plant cannot naturally produce, and any cannabinoid that the plant can produce but that was synthesized or manufactured outside the plant, which is what removes converted delta-8, delta-10, and HHC. And it caps finished hemp-derived cannabinoid products at 0.4 milligrams per container, measured as the combined total of tetrahydrocannabinols and any other cannabinoid with similar effects (Continuing

Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, 2025).

Three details of the drafting matter. The cap is per container, not per serving, and the Act defines container as the innermost packaging in direct contact with the product, such as a jar, bottle, packet, or cartridge; a typical hemp gummy contains 2.5 to 10 milligrams, so the cap alone removes the large majority of currently available products, including many full-spectrum CBD preparations. Industrial hemp grown for fiber, grain, seed, and other non-cannabinoid uses is separately defined and preserved. And FDA-approved drug products are excluded from the restriction, so Epidiolex is unaffected.

The law provided a one-year runway to November 12, 2026, and that date has already moved once. Section 2019 of the Continuing Appropriations and Extensions Act, 2027, signed September 2, 2026, delayed most of the Section 781 restrictions to December 11, 2026. The delay reaches only cannabinoids capable of being naturally produced by the plant, which means THCA flower and hemp delta-9 products, so converted cannabinoids such as delta-8 lose federal hemp status on November 12, 2026, as originally scheduled (Continuing Appropriations and Extensions Act, 2027, 2026). Bills are pending to delay the change until 2028, to repeal it, and to regulate hemp beverages separately, and litigation is underway. This is an unstable area, and any date printed here may be superseded; the effective date should be verified before it is taught.

The Importance of This Clinically

A large, legal, unregulated, essentially age-unrestricted market in intoxicating cannabinoids is being withdrawn over the course of a few months. Counselors should expect three things: clients who have been using high-dose hemp products without regarding themselves as cannabis users; a migration of demand toward state-licensed dispensaries in the states with medical programs and toward the illicit market elsewhere; and product substitution toward whatever cannabinoid is not yet named in the statute. Ask clients specifically about delta-8, THCA flower, and hemp-derived edibles rather than asking whether they use marijuana.

Alcohol in the United States

Alcohol has moved in two opposite directions in United States federal policy over the past 18 months, and the contradiction is itself worth teaching.

The Surgeon General's Advisory on Alcohol and Cancer

On January 3, 2025, the Surgeon General issued an advisory on alcohol and cancer risk (Office of the Surgeon General, 2025). It concluded that alcohol is the third leading preventable cause of cancer in the United States, after tobacco and obesity, and that alcohol use causally increases the risk of at least seven cancers: breast (in women), colorectal, esophageal, liver, mouth, pharynx, and larynx. The advisory estimated roughly 100,000 alcohol-attributable cancer cases and about 20,000 alcohol-attributable cancer deaths in the United States each year, a figure that exceeds annual alcohol-related traffic deaths.

The advisory noted that breast cancer risk begins to rise at levels as low as one drink per day, and that most Americans are unaware of the link. It recommended four actions: updating the health warning label on alcoholic beverages to include cancer risk; strengthening public education; informing patients in clinical settings and promoting screening, brief intervention, and referral to treatment; and reassessing the recommended drinking limits in light of current evidence.

The warning label has not changed. Awareness, however, appears to have moved: tracking surveys found that the proportion of adults who said alcohol increases cancer risk rose from about 40% in

September 2024 to about 56% shortly after the advisory (Drug Addiction Now, 2026). Instructors should treat awareness figures cautiously, because estimates vary considerably by survey method and by beverage type.

The 2025 to 2030 Dietary Guidelines

On January 7, 2026, the Department of Health and Human Services and the Department of Agriculture released the Dietary Guidelines for Americans, 2025 to 2030 (U.S. Department of Health and Human Services & U.S. Department of Agriculture, 2026). The guidance on alcohol was substantially rewritten. The numeric limits that had stood essentially unchanged since 1980: no more than two drinks per day for men and one for women on days when alcohol is consumed, were removed. In their place is the statement that people should consume less alcohol for better overall health. The guidelines retain the recommendation that pregnant women avoid alcohol entirely.

The change drew immediate criticism from liver, cancer, and cardiovascular organizations, which argued that removing a number does not convey lower risk but rather conveys nothing measurable (American Association for the Study of Liver Diseases, 2026). Beverage industry associations supported the simplification. This is a live policy dispute rather than a settled scientific question, and it is a good candidate for a classroom debate exercise.

A Practical Note for Counselors

Clients now encounter federal guidance that gives them no threshold at all. Some will read the removal of the limits as permission. It is not, since "less" has no upper bound built into it, and the guidance points in the same direction as the Surgeon General's advisory, even though it declines to quantify. For clinical work, the National Institute on Alcohol Abuse and Alcoholism definitions of moderate, heavy, and binge drinking remain in force and remain the appropriate reference for screening and goal setting.

GLP-1 Receptor Agonists as a Possible Addiction Pharmacotherapy

This class of medications does not appear in the second edition as an addiction treatment, and it is now the most actively investigated new pharmacotherapy in the field. Glucagon-like peptide-1 receptor agonists were developed for the treatment of type 2 diabetes and obesity. Semaglutide received FDA approval for diabetes in 2017 and for obesity in 2021. Reports of reduced drinking among people taking these medications followed quickly, and they were preceded by a substantial preclinical literature showing that GLP-1 receptor agonists reduce voluntary alcohol consumption in animals. The endogenous peptide is secreted from L-cells in the small intestine and is also synthesized in brain regions implicated in reward and addiction, which is the mechanistic basis for the hypothesis (Klausen et al., 2026).

The context matters. Alcohol use disorder carries one of the largest treatment gaps of any health condition, and the FDA has approved only three medications for it, disulfiram, acamprosate, and naltrexone, in the past 75 years. Fewer than 2% of Americans with alcohol use disorder receive any of them (Hendershot & Klein, 2026).

The Two Anchoring Trials

Hendershot et al. (2025) conducted a phase 2, double-blind trial in which 48 non-treatment-seeking adults with alcohol use disorder received low-dose semaglutide or placebo over nine weeks. Relative to placebo, semaglutide reduced the amount of alcohol consumed in a laboratory self-administration procedure, significantly reduced weekly craving, and reduced some but not all measures of weekly consumption. In a subgroup who smoked, it also reduced cigarettes per day.

Klausen et al. (2026) reported a larger and more clinically relevant trial in *The Lancet*. In this 26-week, single-center, double-blind, placebo-controlled trial conducted at the Mental Health Centre Copenhagen, 108 treatment-seeking adults with moderate to severe alcohol use disorder and comorbid obesity were randomly assigned to once-weekly subcutaneous semaglutide (up to 2.4 mg) or saline placebo. Every participant in both arms also received standard cognitive behavioral therapy, up to ten sessions. The sample was 49% female with a mean age of 52 years, and 88 participants (81%) completed the full intervention.

Heavy drinking days, the primary endpoint, fell by 41.1 percentage points from baseline in the semaglutide group compared with 26.4 percentage points in the placebo group, an estimated treatment difference of 13.7 percentage points (95% CI [-22.0, -5.4], $p = .0015$). Secondary outcomes moved in the same direction. Drinks per drinking day fell by 3.5 in the semaglutide group against 2.1 in the placebo group, and craving on the Penn Alcohol Craving Scale fell by 9.2 points against 6.1. Participants receiving semaglutide were significantly more likely to achieve a two-level reduction in WHO risk drinking level, an endpoint recently qualified by the FDA, with a number needed to treat of 4.3. For comparison, the number needed to treat for existing alcohol use disorder medications on that endpoint is generally 7 or higher (Hendershot & Klein, 2026; Klausen et al., 2026).

Adverse events were mostly transient, mild-to-moderate gastrointestinal effects and were more frequent in the semaglutide group. Mean weight loss in the semaglutide arm was 11.4% and change in heavy drinking days correlated with weight loss, which raises a question the trial could not fully resolve about how much of the alcohol effect is independent of weight change.

The author list is itself informative. It includes George Koob, director of the National Institute on Alcohol Abuse and Alcoholism, and Nora Volkow, director of the National Institute on Drug Abuse, which indicates how seriously this line of work is being taken at the federal level.

What the Wider Evidence Base Shows

Four qualifications belong with these findings, and students should be able to state them.

- **The randomized evidence base is small and not uniformly positive.** A systematic review and meta-analysis identified three randomized trials with 430 participants in total, along with six observational studies involving more than 2.7 million people. Pooled across the randomized trials, reductions were non-significant for alcohol consumption (SMD = -0.24, 95% CI [-0.70, 0.23]), drinks per drinking day (SMD = -0.23, 95% CI [-0.64, 0.19]), and craving (SMD = -0.14, 95% CI [-2.84, 2.55]), although semaglutide specifically showed greater craving reduction ($p = .024$). The observational studies found substantially reduced alcohol-related events (HR = 0.64, 95% CI [0.59, 0.69]) and reduced intoxication (HR = 0.50), but observational designs cannot rule out confounding by indication. The authors concluded that larger randomized trials are needed (Sinha & Ghosal, 2026).
- **Findings are not uniform across agents.** Semaglutide has shown the largest effects. A trial of exenatide was not significant, though both arms in that study also received cognitive behavioral therapy, which may have attenuated the drug effect.
- **The Klausen et al. sample had comorbid obesity** and was recruited at a single center in Denmark, with a sample that was 94% White. Generalizability to people with alcohol use disorder and normal weight is unknown, and weight loss itself will constrain the population that can be treated safely.
- **No GLP-1 receptor agonist is FDA-approved for any substance use disorder.** Prescribing for this purpose is off-label, and off-label prescribing has already run ahead of the evidence. The textbook's framework for discussing off-label medication with clients applies directly.

Where the Field Is Heading

Eight drugs in the incretin class or related metabolic classes are now under investigation for alcohol use disorder or alcohol-related liver disease: exenatide, semaglutide, mazdutide, tirzepatide, pemvidutide, brenipatide, cagrilintide, and NNC0194-0499. Industry-sponsored programs dedicated to alcohol use disorder have begun, which is a genuine change; the first five registered semaglutide trials in this area relied on an improvised mix of small grants and philanthropic and institutional funds (Hendershot & Klein, 2026).

Several questions remain open and are worth assigning to students as a critical appraisal exercise. What is the minimum effective dose, and does the alcohol effect require the metabolic effect? Do gains persist after treatment ends, or is sustained treatment required, as in metabolic disease? Why did some participants show little or no reduction, and can responders be identified in advance? Will the effect replicate in real-world settings where weekly visits and cognitive behavioral therapy are not available? And can people afford it, given the cost and adherence problems already evident in metabolic care (Hendershot & Klein, 2026)?

Clients will ask about this, and many are already reading about it. The accurate answer as of late 2026 is that the signal is real and promising, that the largest trial to date found a clinically meaningful benefit when the medication was added to cognitive behavioral therapy rather than used instead of it, that an efficacy signal is not the same as clinical effectiveness, and that definitive answers are still a few years away.

Psychedelic-Assisted Therapy: The 2026 Federal Shift

The textbook discusses psychedelic-assisted therapy, its optimism, and its limitations. The regulatory environment has changed dramatically since then, and the change reflects a shift in policy direction rather than new evidence of efficacy. That distinction is the point instructors should press hardest.

On April 18, 2026, Executive Order 14401, Accelerating Medical Treatments for Serious Mental Illness, directed the FDA to issue Commissioner's National Priority Vouchers to psychedelic drugs holding Breakthrough Therapy designation, directed the FDA and the Drug Enforcement Administration to establish a pathway for eligible patients to access investigational psychedelic drugs, including ibogaine compounds, under the Right to Try Act, and required the Department of Health and Human Services to allocate \$50 million through the Advanced Research Projects for Health program to match state investments in psychedelic research for people with serious mental illness. It also directed the Attorney General to begin rescheduling reviews upon successful completion of phase 3 trials (The White House, 2026). Despite its title, the order does not direct the FDA to prioritize a disease area; it directs the agency to prioritize a specific class of products, which is unusual and has drawn regulatory commentary.

The FDA acted quickly. On April 24, 2026, six days after the order, it issued Commissioner's National Priority Vouchers to three programs: Compass Pathways for psilocybin (COMP360) in treatment-resistant depression, the Usona Institute for psilocybin in major depressive disorder, and Transcend Therapeutics for methylone in post-traumatic stress disorder (U.S. Food and Drug Administration, 2026c). These vouchers are designed to substantially compress review timelines. The FDA also cleared an investigational new drug application for noribogaine hydrochloride, an ibogaine derivative, marking the first United States clinical study of an ibogaine derivative. In July 2026, the agency finalized its guidance for industry on clinical investigations of psychedelic drugs and announced a public hearing on their potential therapeutic use.

What has not changed is equally important:

- **No classic psychedelic is FDA-approved for any indication.** Psilocybin, MDMA, LSD, DMT, and ibogaine remain unapproved, and the executive order neither approved any drug nor changed any scheduling status. Esketamine, a ketamine derivative, is the only related approved product, and it is administered only in certified settings under a risk evaluation and mitigation strategy.
- **MDMA-assisted therapy for PTSD was not approved.** The FDA issued a complete response letter on August 9, 2024, after an advisory committee voted against both effectiveness and the benefit-risk balance. An application was resubmitted in August 2026 relying on a third-party audit, a phase 1 cardiac safety study, and follow-up data rather than a new phase 3 trial.
- **Breakthrough Therapy designation is routinely misread as near-approval.** It is not. It speeds up meetings and review logistics for drugs showing preliminary promise on serious conditions and says nothing final about whether a drug works.
- **Ibogaine has no FDA efficacy trials at all.** The existing evidence is observational, self-selected, and mostly gathered abroad, and ibogaine carries documented cardiac risk, including QT prolongation and fatal arrhythmias in unscreened settings. Texas Senate Bill 2308, signed June 11, 2025, created a \$50 million matched fund to take ibogaine through FDA trials for opioid use disorder, PTSD, and traumatic brain injury. Harvard researchers received an \$11 million NIDA grant in July 2026 to study ibogaine for opioid use disorder.

For counselors, the practical implication is an increase in clients who have used, or are planning to use, psychedelics outside a clinical trial, sometimes at underground or overseas providers, often for a substance use disorder, and sometimes on the strength of headlines about federal support. The clinical task is to hold two things at once: not to dismiss what may prove to be an important treatment, and not to let regulatory momentum be mistaken for evidence of efficacy or safety. Ibogaine in particular is not a drug to be taken without cardiac screening and monitoring.

Gambling and Problematic Betting Behaviors

The gambling landscape described in Chapter 13 has been transformed by the expansion of legal online sports betting since the 2018 Supreme Court decision, and by a second wave of products that did not exist in a meaningful way when the second edition was written.

A 2026 national survey found that 27% of Americans, and 52% of men aged 18 to 49, had an active account with an online sportsbook (Siena Research Institute, 2026). Indicators of harm rose alongside participation. Among bettors, 42% said they had bet more than they should, up from 37% the previous year; 43% said they had felt bad or ashamed after losing a bet, up from 37%; and 15% said they had called a problem gambling helpline or otherwise sought help, up from 9% in each of the two preceding years. Overall, 22% of respondents said they knew someone who had a problem with online sports betting, up from 16% a year earlier.

An analysis of electronic health records covering more than 197 million adults with at least one qualifying health care encounter between January 2018 and March 2026 found a clear divergence between states (Bartelt et al., 2026). In the 39 states and the District of Columbia that had legalized sports betting, the quarterly rate of diagnosed gambling disorder rose from 3.0 per 100,000 patients in the first quarter of 2018 to 4.8 per 100,000 in the first quarter of 2026, an increase of about 61%. In the 11 states that had not legalized it, the rate fell from 3.1 to 2.2 per 100,000, a decrease of about 29%.

Adults aged 30 to 49 had the highest overall rate throughout, reaching 5.8 per 100,000 by early 2026, but the largest proportional increase occurred among adults aged 18 to 29, whose rate more than doubled. Rates rose in both sexes and across all age groups, with the male-to-female gap widest among adults under 50.

Three cautions accompany these findings, and the researchers themselves raised all of them. This is a rate of diagnoses recorded during health care encounters, not a population prevalence estimate, and gambling disorder is substantially under-recognized in clinical settings. Changes in coding practices, clinician awareness, and health care utilization during and after the pandemic may account for part of the movement in either direction. And the increases rose broadly in parallel across legalizing states rather than following each state's individual year of legalization, which is not the pattern one would expect if state legalization were the sole driver. Bartelt et al. (2026) offered one explanation for the parallel rise that is worth taking seriously: the simultaneous nationwide growth of online prediction markets, which are not regulated as gambling at the state level and are accessible regardless of where a user lives.

Prediction Markets

Prediction markets are platforms on which users trade contracts on the outcome of real-world events. Contracts cost between one cent and 99 cents, correct contracts pay one dollar, and losing contracts pay nothing. Because the operators classify themselves as Designated Contract Markets under federal commodities regulation, they are not subject to state laws prohibiting betting, and they operate in all 50 states.

The growth has been extraordinary. Combined trading volume on the two largest platforms rose from about \$5 billion in September 2025 to about \$24 billion in April 2026, and totaled \$61 billion between January and April 2026, exceeding the \$51 billion recorded for all of 2025 (Gerlacher & Cohen, 2026). Sports contracts account for most of that volume. A 2026 survey found that 15% of Americans had placed a sports bet through a prediction market, including 33% of men aged 18 to 49 (Siena Research Institute, 2026).

The National Council on Problem Gambling adopted a formal resolution in February 2026 stating that trading event contracts on prediction markets carries substantially similar consumer risk to traditional sports betting, including chasing losses, impulsivity, financial harm, and the development or escalation of gambling-related harm. The Council's central concern is that users do not perceive what they are doing as gambling and are therefore less likely to use responsible gambling tools or to seek help (National Council on Problem Gambling, 2026b).

A Screening Implication

A client who trades event contracts may answer no truthfully when asked whether they gamble. The language of these platforms is the language of trading and investment, not of betting. When screening for gambling disorder, ask specifically about sportsbook apps, daily fantasy, event contracts and prediction markets, cryptocurrency trading, and options trading. The DSM-5-TR criteria in Chapter 13 apply regardless of what the platform calls itself.

State-level responses began in 2026. Colorado passed the first law restricting daily deposits on sports betting apps and banning solicitation push notifications, Pennsylvania approved the first legislatively funded digital gambling support platform, and Minnesota passed the first explicit prediction market ban framed as youth harm reduction.

A New National Helpline Number

Instructors and clinicians must update their referral materials. On January 29, 2026, the National Council on Problem Gambling adopted 1-800-MY-RESET as the National Problem Gambling Helpline number (National Council on Problem Gambling, 2026a). The change followed the expiration of the Council's agreement to use 1-800-GAMBLER, which is owned by the Council on Compulsive Gambling of

New Jersey. Callers to the new number reach the same National Problem Gambling Helpline Network of 24 contact centers. The prior access point, 1-800-522-4700, remains active. Adoption varies by state due to differing regulatory requirements, so both numbers should be provided to clients.

Problematic Internet-Based Behaviors

Chapter 16 covers general problematic internet behaviors, internet gaming disorder, and problematic social media behaviors. Two developments since the second edition deserve a place in teaching, and one of them concerns a technology that did not exist in consumer form when the chapter was written.

Addictive Use Matters More Than Screen Time

Much of the public argument about young people and screens has been conducted in units of time. A large longitudinal study has now shifted the terms of that argument in a way that maps directly onto how Chapter 16 already teaches assessment.

Xiao et al. (2025) followed 4,285 children in the Adolescent Brain Cognitive Development cohort across 21 United States sites, from a mean age of 10 years through four years of follow-up, modeling trajectories of addictive use of social media, mobile phones, and video games. Addictive use was defined by the features clinicians already look for: inability to stop, distress when not using, and using the device to escape from problems. Three trajectories emerged for social media and for mobile phones and two for video games, and nearly one third of participants were on an increasing addictive-use trajectory for social media or mobile phones beginning around age 11. Compared with the low trajectory, an increasing addictive-use trajectory for social media carried a risk ratio of 2.14 (95% CI [1.61, 2.85]) for suicidal behaviors, and a high-peaking trajectory carried a risk ratio of 2.39 (95% CI [1.66, 3.43]). High addictive-use trajectories for every screen type were associated with suicide-related outcomes and with worse internalizing and externalizing symptoms. At the four-year follow-up, 218 participants (5.1%) reported suicidal behaviors and 760 (17.9%) reported suicidal ideation. Total baseline screen time, by itself, was not associated with these outcomes.

There were consistent demographic differences. Girls were more likely to fall into high or increasing addictive-use trajectories for social media and mobile phones, and boys were more likely to fall into the high trajectory for video games. Youth who were Black or Hispanic, from lower-income or less-educated households, or whose parents were unmarried were also more likely to be in high addictive-use trajectories.

The study is observational and relies on self-report, and the follow-up period overlapped with the pandemic, so causal claims should be made cautiously. Its practical value is nonetheless considerable. It supports what the measures in Chapter 16 already assess, and it gives counselors a defensible answer to the question parents ask most often. The useful question is not how many hours, but whether the pattern shows loss of control, distress on interruption, and use as escape. A parent worried about a two-hour daily total may be worrying about the wrong thing, while a parent reassured by a one-hour total may be missing a compulsive pattern.

AI Companion Chatbots

AI companion applications simulate an ongoing personal relationship with the user. They are distinct from general-purpose assistants in that the relationship itself is the product, and their design commonly includes features intended to maintain engagement over long periods. Chapter 16 does not cover them, because they were not a consumer category when it was written.

The clinical concerns raised so far cluster into four areas: emotional dependency on a system engineered to sustain attachment; exposure of minors to sexual or otherwise inappropriate content through role-

play; failure to respond appropriately when a user discloses suicidal ideation; and displacement of human relationships in young people who are already socially isolated. Litigation has followed, including wrongful death claims brought by families of adolescents; several such claims were settled in early 2026.

The regulatory response has been unusually fast, and it is happening at the state level rather than federally. By mid-2026, more than a dozen states had enacted statutes governing companion chatbots (Hennessey & Burke, 2026; Rieper, 2026). The common elements are worth knowing, because they describe what a reasonably safe product is now expected to do:

- **Disclosure.** Operators must make clear that the user is interacting with a machine, with recurring reminders, commonly every three hours for all users and more frequently for minors.
- **Crisis protocols.** Operators must implement procedures to detect expressions of suicidal ideation or self-harm and route users to crisis resources such as the 988 Suicide and Crisis Lifeline.
- **Protections for minors.** Most states require operators to prevent sexually explicit content, romantic interaction, emotional manipulation, and engagement techniques designed to foster dependency in interactions with minors.
- **Limits on clinical impersonation.** Tennessee's Senate Bill 1580, effective July 1, 2026, prohibits AI systems from presenting themselves as licensed mental health professionals and creates a private right of action. Several other states include similar prohibitions.

California's Senate Bill 243 took effect January 1, 2026, New York's AI companion provisions took effect in November 2025, and Nebraska's Conversational AI Safety Act was signed in April 2026, with compliance required by July 2027. Effective dates, definitions, and enforcement mechanisms differ considerably from state to state, so any counselor advising a family should check their own state's law rather than generalizing.

Two points matter for practice. First, most of these statutes are built around minors, which leaves adult use largely unregulated even though adults are using these systems for emotional support in very large numbers. Second, companion use belongs in the internet-behavior assessment alongside gaming and social media. Clients are unlikely to volunteer it, partly because of embarrassment and partly because they may not think of it as a technology-use question at all. Asking directly, in the same neutral register used for gaming and social media, is the way to find out.

Where Gambling and Internet Behavior Now Overlap

The boundary between Chapter 13 and Chapter 16 has become porous. Sportsbook apps, prediction markets, cryptocurrency exchanges, and zero-commission options trading platforms are all internet-delivered, continuously available, notification-driven, and designed around variable reward. A client whose difficulty presents as excessive phone use may be describing a gambling problem, and a client who describes trading may be describing a behavior that meets the DSM-5-TR criteria for gambling disorder. Assessment should cross the two chapters rather than treating them as separate territories.

Problematic Food Consumption Behaviors

Chapter 19 presents problematic food consumption behaviors as a contested construct, and that remains an accurate description. Three developments since the second edition are worth adding.

A Narrowing of the Construct

The research literature has been consolidating around the term ultra-processed food addiction rather than food addiction. The shift is more than cosmetic. The weakest part of the addiction analogy was

always that food in general is necessary for survival and cannot be abstained from, which made the substance-use comparison awkward. Narrowing the target to industrially formulated combinations of refined carbohydrate and added fat gives the construct a more defensible object, one that did not exist in the human diet until recently and that can, in principle, be abstained from.

An international group of clinicians and researchers completed a Delphi process aimed at consensus on naming, definition, assessment, and intervention, and a coordinated body of work is now organized under that heading (Unwin et al., 2025). The debates the process was designed to settle are the ones Chapter 19 already identifies: whether the condition is best understood as substance-related or as a behavioral addiction, how it should be distinguished from binge eating disorder, and whether abstinence or harm reduction is the appropriate treatment frame. None of this has produced a diagnosis. Neither DSM-5-TR nor ICD-11 recognizes a food-related addictive disorder, and instructors should be clear with students that a research construct with a consensus definition is still not a diagnostic category.

A Measurement Problem Worth Teaching

Worth et al. (2026) made an argument that is unusually useful for a research methods discussion. Over the past 60 years, the proportion of highly processed foods rich in refined carbohydrate and added fat in the food environment has risen, and binge eating has risen alongside it. To test whether the two are connected, the authors synthesized the foods reported in binge-eating episodes across 41 studies. Every one of the 41 studies reported at least one highly processed food, and of the 404 food types named across all studies, 70.3% were highly processed while only 14.9% were minimally processed. Only 13 studies (31.7%) reported any minimally processed food at all. The foods named most often were cake, ice cream, cookies, and chocolate.

The finding the authors emphasize, however, is a limitation rather than a result. Food descriptions in this literature are frequently too vague to classify, which means the central hypothesis in this area, that the food environment is driving the behavior, cannot be properly tested with the data the field has been collecting. They set out recommendations for standardized food reporting.

The clinical translation is straightforward. When taking a history of binge episodes, record what was eaten, not just how much. The specific foods a client loses control around carry information about triggers and about the plausibility of the addiction framing in that individual case, and that information is lost when the history captures quantity alone.

GLP-1 Medications and the Shared-Reward Argument

Chapter 19 lists semaglutide and tirzepatide among the approved pharmacotherapies for obesity. The development since then is that the same medications are now being tested, with some success, for alcohol use disorder, as described earlier in this supplement. This gives the shared-reward-pathway argument, which underpins the food addiction construct, more empirical traction than it previously had. If a medication developed to reduce food intake also reduces alcohol craving and consumption in randomized trials, the claim that eating and drinking engage overlapping reward circuitry is doing real predictive work rather than serving as an analogy.

Three cautions belong with that observation. The direction of evidence does not settle the diagnostic question. The randomized evidence in alcohol use disorder is still thin, as set out above. And no GLP-1 receptor agonist is approved for any addictive disorder, food-related or otherwise.

A Practical Note on Assessment

GLP-1 prescriptions are now common in the general population, and clients frequently do not mention them, either because they do not consider a metabolic medication relevant to addiction treatment or because of stigma attached to weight-loss drugs. Asking about them belongs in the routine medication review, and the answer is relevant in two directions: it may bear on changes in the client's eating and drinking that they have not connected to the medication, and it opens a conversation that clients are often relieved to have.

One resource correction belongs here as well. The National Eating Disorders Association helpline has been permanently discontinued. Any handout, syllabus, or referral list that still lists it should be updated to the National Alliance for Eating Disorders helpline at 1-866-662-1235, which is staffed by licensed clinicians.

Treatment Access and Federal Policy

Telehealth Prescribing of Controlled Medications

The pandemic-era flexibilities that allowed practitioners to prescribe controlled medications without a prior in-person evaluation have been extended repeatedly rather than replaced. On December 31, 2025, the Drug Enforcement Administration and the Department of Health and Human Services issued a fourth temporary extension, effective January 1 through December 31, 2026 (Drug Enforcement Administration & Department of Health and Human Services, 2025). Under this extension, DEA-registered practitioners may prescribe Schedule II through V controlled medications through audio-video telemedicine without a prior in-person evaluation and may use audio-only telemedicine for FDA-approved Schedule III through V medications used in maintenance and withdrawal management for opioid use disorder.

Separately, a final rule titled Expansion of Buprenorphine Treatment via Telemedicine Encounter took effect December 31, 2025, making the buprenorphine-specific telemedicine flexibilities permanent and allowing a patient to receive up to a six-month supply of buprenorphine following a telephone consultation, subject to the rule's own requirements. A companion rule addresses continuity of care for Veterans Affairs patients.

The proposed Special Registrations for Telemedicine rule, which would create a permanent registration framework and a national prescription drug monitoring program, has not been finalized. The agency has indicated an intention to consider a final rule in November 2026. If no final rule or further extension issues before December 31, 2026, patients will lose telemedicine access to these medications. Counselors working with clients on telehealth-initiated buprenorphine should be aware of this cliff and should not assume continuity.

Opioid Settlement Funds

More than \$50 billion is being paid to states, counties, cities, and tribal governments over roughly two decades under settlements with opioid manufacturers, distributors, and pharmacies. Nearly all jurisdictions have now established governance structures to guide allocation, and attention has shifted from allocation to stewardship (Deehr & Severin, 2026).

Two problems recur and are worth assigning to students as a policy exercise. The first is transparency. Most settlement agreements require that funds go to opioid remediation, usually defined through a list of approved uses, but few require a uniform, public, itemized accounting of what was purchased. The

most complete public picture of early spending was assembled not by government but by journalists: KFF Health News, working with researchers at Johns Hopkins and Shatterproof, built a database cataloging more than 10,500 examples of how settlement money was used (KFF Health News, 2026). The second problem is substitution, in which settlement dollars pay for services a state was already funding, freeing existing money for other purposes.

For students entering the field, this is where a great deal of new program funding is coming from and understanding how their state allocates it is practical career knowledge.

A Change in the Federal Machinery of Government

Readers of earlier editions should note an important structural change. On March 27, 2025, the Department of Health and Human Services announced a restructuring that consolidates the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, the Office of the Assistant Secretary for Health, the Agency for Toxic Substances and Disease Registry, and the National Institute for Occupational Safety and Health into a new entity, the Administration for a Healthy America (Congressional Research Service, 2025). The announcement accompanied a reduction of approximately 20,000 HHS staff positions.

SAMHSA, which had roughly 900 staff and an \$8 billion budget at the start of 2025, was among the first agencies to be folded into the new structure. Provider organizations have reported processing delays and program consolidation. HHS has stated that critical SAMHSA programs will continue under the Administration for a Healthy America. Professional associations including Mental Health America and the American Psychiatric Association raised concerns that behavioral health expertise would be diluted at a time of overlapping overdose, suicide, and youth mental health crises.

Practically, this affects three things students should know. SAMHSA-branded resources and URLs may be moved or renamed. Federal grant timelines have been less predictable. And the agency that produces NSDUH, the Treatment Episode Data Set, the Drug Abuse Warning Network, and the National Substance Use and Mental Health Services Survey is undergoing structural change, which may affect the continuity of the data series this field relies on. Students researching federal addiction policy should search both SAMHSA and the Administration for a Healthy America.

The same restructuring eliminated the CDC's Office on Smoking and Health, with the consequences for state quitlines described in the tobacco section above.

One consumer-facing change has already occurred. On July 17, 2025, the 988 Suicide and Crisis Lifeline discontinued its specialized services for LGBTQ+ youth, known as the Press 3 option and the text PRIDE option (Howard, 2025). SAMHSA stated that the Lifeline would no longer silo these services and would focus on serving all help seekers; the Department of Health and Human Services stated that the subnetwork, which had been operated by a third party under congressionally directed funding, had fully expended more than \$33 million allocated to it, and that continuing it would have required reallocating money away from the main Lifeline. The subnetwork had served nearly 1.3 million contacts since September 2022. The Press 1 option for veterans and the Press 2 option for Spanish-language services remain in operation, and the Lifeline continues to serve all callers.

Counselors who previously referred LGBTQ+ young people to that specific pathway should update their referral lists. The Trevor Project continues to operate its own crisis services independently of the 988 networks, at 1-866-488-7386 or by texting START to 678-678.

Job Classification, Education, and Wages

In the United States, addiction counseling is captured within Standard Occupational Classification 21-1018, substance abuse, behavioral disorder, and mental health counselors, which combines the former codes 21-1011 (substance abuse and behavioral disorder counselors) and 21-1014 (mental health counselors). Related classifications include 21-1021 (child, family, and school social workers) and 21-1093 (social and human service assistants).

Education and licensure requirements vary by state more than in almost any other helping profession. Some states credential addiction counselors at the certificate or associate level; others require a bachelor's or master's degree for independent practice. Because requirements differ by state and change frequently, readers should consult the state licensing board and the certifying bodies listed in the next section rather than relying on any general statement, including this one.

Wages and Labor Market Outlook

Table 8. Wages for Substance Abuse, Behavioral Disorder, and Mental Health Counselors, May 2025

Indicator	Figure
Median annual wage	\$59,350
Lowest 10 percent earned less than	\$38,940
Highest 10 percent earned more than	\$97,590
Projected employment growth, 2025 to 2035	18% (much faster than average)
Projected annual openings, average over the decade	About 50,500

Note. Data from the Bureau of Labor Statistics (2026). Wages vary substantially by state, metropolitan area, setting, and credential. Hospital-based counselors earn more than counselors in residential facilities. Consult the BLS state and area data for local figures and record the date they were retrieved.

The Bureau of Labor Statistics notes that many of the projected openings will arise from the need to replace workers who transfer to other occupations or leave the labor force. That framing understates something students deserve to hear plainly: a substantial share of turnover in this field is burnout. Work in addiction treatment is emotionally demanding, frequently underpaid relative to the credential required, and often performed in under-resourced settings. The self-care material in Chapter 2 is not a soft addendum to this curriculum. It is a retention strategy.

A Note for Students on Salary Data

Commercial salary aggregators and the AI-generated summaries that now sit atop many search results, frequently disagree with one another and with official sources. When citing compensation figures in coursework or in career planning, use the Bureau of Labor Statistics Occupational Employment and Wage Statistics, state agency data, union contracts, or actual employer postings, and record the date they were retrieved.

Accreditation and Certification

The bodies below accredit programs or certify individuals in the United States. Requirements change; verify current criteria directly with each organization.

Program Accreditation

- **Council for Accreditation of Counseling and Related Educational Programs (CACREP).** <https://www.cacrep.org/>
Accredits master's and doctoral counseling programs, including the addiction counseling specialized practice area. The second edition of the textbook addresses the 2024 CACREP standards, which are reproduced in Appendix A.
- **National Addiction Studies Accreditation Commission (NASAC).** <https://nasacaccreditation.org/>
Accredits addiction studies programs at the associate, bachelor's, master's, and doctoral levels. The second edition covers nearly every NASAC standard; the curriculum standards are reproduced in Appendix B.
- **Commission on Accreditation of Rehabilitation Facilities (CARF).** <https://www.carf.org/>
Accredits treatment programs and services, not academic programs.
- **The Joint Commission.** <https://www.jointcommission.org/>
Accredits behavioral health care organizations, including opioid treatment programs.

Individual Certification and Credentialing

- **NAADAC, the Association for Addiction Professionals, and the National Certification Commission for Addiction Professionals (NCC AP).** <https://www.naadac.org/>
Offers the National Certified Addiction Counselor credentials at Levels I and II, the Master Addiction Counselor credential, and specialty endorsements. The NAADAC and NCC AP Code of Ethics is discussed in Chapter 2.
- **International Certification & Reciprocity Consortium (IC&RC).** <https://internationalcredentialing.org/>
A consortium of member boards whose credentials are reciprocal across most states, which matters to any counselor who may relocate.
- **National Board for Certified Counselors (NBCC).** <https://www.nbcc.org/>
Administers the National Counselor Examination and the Master Addictions Counselor credential.
- **American Society of Addiction Medicine (ASAM).** <https://www.asam.org/>
Publishes the ASAM Criteria used for level-of-care determination, discussed in Chapter 8.
- **American Board of Preventive Medicine, Addiction Medicine subspecialty.** <https://www.theabpm.org/>
The physician credential pathway, recognized as a subspecialty since 2016.
- **American Board of Psychiatry and Neurology, Addiction Psychiatry subspecialty.** <https://www.abpn.org/>
The psychiatric subspecialty credential.

Resources for Americans

The list below is not exhaustive, and services change. Verify current listings before referring a client.

National Helplines and Crisis Services

- **SAMHSA National Helpline.** 1-800-662-HELP (4357); TTY 1-800-487-4889;
<https://www.samhsa.gov/find-help/helplines/national-helpline>

Free, confidential, 24 hours a day, 365 days a year, in English and Spanish. Provides treatment referral and information, not crisis intervention. Text a five-digit ZIP code to 435748 (HELP4U) for local referrals in English.

- **988 Suicide and Crisis Lifeline.** Call or text 988; <https://988lifeline.org/>
For suicidal, substance misuse, or mental health crises and any other emotional distress. Press 1 for the Veterans Crisis Line; press 2 for Spanish. The LGBTQ+ youth Press 3 subnetwork ended July 17, 2025.
- **Veterans Crisis Line.** 988 then Press 1, or text 838255; <https://www.veteranscrisisline.net/>
- **National Problem Gambling Helpline.** 1-800-MY-RESET (adopted January 2026) or 1-800-522-4700; <https://www.ncpgambling.org/>
Both numbers reach the same 24-hour network of 24 contact centers. State adoption of the new number varies, so give clients both.
- **National Alliance for Eating Disorders Helpline.** 1-866-662-1235; <https://www.allianceforeatingdisorders.com/>
Free, clinician-staffed helpline. The former NEDA helpline has been permanently discontinued.
- **1-800-QUIT-NOW.** <https://smokefree.gov/>
Routes to the caller's state quitline. Services and free nicotine replacement availability now vary by state following the 2025 federal funding disruption; verify locally before referring.
- **Disaster Distress Helpline.** 1-800-985-5990; <https://www.samhsa.gov/find-help/helplines/disaster-distress-helpline>
- **National Alliance on Mental Illness (NAMI) HelpLine.** 1-800-950-NAMI (6264); <https://www.nami.org/help>
- **The Trevor Project (LGBTQ+ young people).** 1-866-488-7386, or text START to 678-678; <https://www.thetrevorproject.org/>
Operates independently of the 988 network.
- **211.** Dial 211; <https://www.211.org/>
Connects callers to local food, housing, and essential services, which are frequently the practical barrier to engaging in treatment.

Treatment Locators and Federal Information Services

- **FindTreatment.gov.** <https://findtreatment.gov/>
SAMHSA's confidential and anonymous locator for substance use and mental health treatment in the United States and its territories.
- **Opioid Treatment Program Directory.** <https://www.samhsa.gov/find-help/locators/opioid-treatment-program-directory>
Locates programs authorized to dispense methadone.
- **NIAAA Alcohol Treatment Navigator.** <https://alcoholtreatment.niaaa.nih.gov/>
Walks a client or family member through choosing among alcohol treatment options. An excellent handout.
- **NIAAA Rethinking Drinking.** <https://www.rethinkingdrinking.niaaa.nih.gov/>
Free self-assessment and change tools.
- **CDC Overdose Prevention Data Channel.** <https://www.cdc.gov/overdose-prevention/>
Launched August 31, 2026. Centralized fatal and nonfatal overdose data by state and time period, drawing on three CDC surveillance systems.

- **National Institute on Drug Abuse.** <https://nida.nih.gov/>
- **National Institute on Alcohol Abuse and Alcoholism.** <https://www.niaaa.nih.gov/>

Mobile Applications

New applications appear continually, and readers should search current app stores. Most target a specific disorder; the ones listed here are generic. Evidence of effectiveness varies widely and is generally weak; recommend them as adjuncts, not as treatment.

- **I Am Sober.** <https://apps.apple.com/us/app/i-am-sober/id672904239>
- **Sober Time.** <https://apps.apple.com/us/app/sober-time-sobriety-counter/id1158895079>
- **Loop Habit Tracker.** <https://play.google.com/store/apps/details?id=org.isoron.uhabits>
- **WEconnect Health.** <https://apps.apple.com/us/app/weconnect-health/id1441566550>
- **Sober Grid.** <https://www.sobergrid.com/>
- **SoberTool.** <http://www.sobertool.com/>
- **NA Meeting Search.** <https://apps.apple.com/us/app/na-meeting-search/id627643748>
- **Everything AA.** <https://apps.apple.com/us/app/everything-aa/id1565768051>
- **Al-Anon Family Groups.** <https://apps.apple.com/us/app/al-anon-family-groups/id1493951058>
- **Talk. They Hear You. (SAMHSA, for parents and caregivers).**
<https://www.samhsa.gov/substance-use/prevention/talk-they-hear-you/mobile-application>

Resources for Partners and Families

- **SMART Recovery Family & Friends.** <https://www.smartrecovery.org/family/>
A secular, CRAFT-informed alternative to Al-Anon.
- **Co-Dependents Anonymous.** <https://coda.org/>
- **Partnership to End Addiction Helpline.** <https://drugfree.org/helpline/>
Free, confidential support from specialists for parents and caregivers, by phone, text, email, or chat.
- **Allies in Recovery.** <https://alliesinrecovery.net/>
CRAFT-based online training for family members.
- **National Family Support Technical Assistance Center.** <https://www.nfstac.org/>

Mutual Support Groups by Textbook Chapter

How to Use This List

The chapter numbers below correspond to the textbook *Counseling Clients with Substance Use Disorders and/or Problematic Behaviors* (2nd ed.). Chapters 15 through 22 are in the free downloadable Part IV. Meeting availability changes frequently, and most of these organizations now offer online and telephone meetings in addition to in-person groups. Verify current listings on each organization's website before referring a client.

Chapter 9. Alcohol Use Disorder

For the Individual

- **Alcoholics Anonymous.** <https://www.aa.org/>
Meetings in every state. The online meeting finder covers most regions.
- **SMART Recovery.** <https://www.smartrecovery.org/>
Secular and CBT-based; extensive United States coverage and daily online meetings.
- **LifeRing Secular Recovery.** <https://lifering.org/>
- **Secular Organizations for Sobriety.** <http://www.sossobriety.org/>
- **Women for Sobriety.** <https://womenforsobriety.org/>
- **Recovery Dharma.** <https://recoverydharma.org/>
Buddhist-informed; discussed in Chapter 7.
- **Moderation Management.** <https://moderation.org/>
For non-dependent problem drinkers pursuing reduction rather than abstinence.
- **Dual Recovery Anonymous.** <http://www.draonline.org/>
For co-occurring disorders.

For the Partner or Family Member

- **Al-Anon.** <https://al-anon.org/al-anon-meetings/>
- **Alateen.** <https://al-anon.org/newcomers/teen-corner-alateen/>
Part of Al-Anon, for young people.
- **Adult Children of Alcoholics and Dysfunctional Families.** <https://adultchildren.org/>
- **Co-Dependents Anonymous.** <https://coda.org/>
- **Recovering Couples Anonymous.** <https://recovering-couples.org/>

Chapter 10. Cannabis Use Disorder

For the Individual

- **Marijuana Anonymous.** <https://marijuana-anonymous.org/find-a-meeting/>
In-person meetings concentrated in California and the Northeast, plus phone and online meetings nationally.
- **SMART Recovery.** <https://www.smartrecovery.org/>

For the Partner or Family Member

- **Marijuana Anonymous (for families).** <https://marijuana-anonymous.org/>

Chapter 11. Opioid Use Disorder

For the Individual

- **Narcotics Anonymous.** <https://na.org/>
- **Opiates Anonymous.** <https://opiatesanonymous.org/>
- **Medication-Assisted Recovery Anonymous (MARA).** <https://www.mara-international.org/>
Explicitly supportive of members on methadone or buprenorphine, which addresses a longstanding barrier for clients on medication who have encountered stigma in other 12-step rooms.

- **SMART Recovery.** <https://www.smartrecovery.org/>
- **LifeRing Secular Recovery.** <https://lifering.org/>

For the Partner or Family Member

- **Nar-Anon.** <https://www.nar-anon.org/>
- **SMART Recovery Family & Friends.** <https://www.smartrecovery.org/family/>
- **Partnership to End Addiction Helpline.** <https://drugfree.org/helpline/>

Chapter 12. Other Substance Use Disorders

For the Individual

- **Cocaine Anonymous.** <https://ca.org/>
- **Crystal Meth Anonymous.** <https://www.crystalmeth.org/>
- **Narcotics Anonymous.** <https://na.org/>
- **Pills Anonymous.** <https://pillsanonymous.org/>
- **SMART Recovery.** <https://www.smartrecovery.org/>
- **Women for Sobriety.** <https://womenforsobriety.org/>

For the Partner or Family Member

- **Nar-Anon.** <https://www.nar-anon.org/>
- **Co-Dependents Anonymous.** <https://coda.org/>

Chapter 13. Gambling Disorder

For the Individual

- **Gamblers Anonymous.** <https://gamblersanonymous.org/>
- **National Problem Gambling Helpline.** 1-800-MY-RESET or 1-800-522-4700
Connects to the caller's state affiliate.
- **Freedom From Problem Gambling (free self-help workbook).**
<https://uclagamblingprogram.org/freedom-from-problem-gambling/>
An excellent free resource for clients and clinicians alike.
- **SMART Recovery.** <https://www.smartrecovery.org/>
Runs gambling-specific online meetings.

For the Partner or Family Member

- **Gam-Anon.** <https://www.gam-anon.org/>
- **National Council on Problem Gambling.** <https://www.ncpgambling.org/help-treatment/>
Directory of state affiliates and treatment providers.

Chapter 15. Tobacco Use Disorder

For the Individual

- **Nicotine Anonymous.** <https://nicotine-anonymous.org/>
- **1-800-QUIT-NOW.** https://www.cdc.gov/tobacco/quit_smoking/
Routes to the caller's state quitline. Coaching and free nicotine replacement availability now vary by state; verify locally.

- **Smokefree.gov.** <https://smokefree.gov/>

Includes SmokefreeTXT and quit apps.

- **This is Quitting (Truth Initiative), for vaping.** <https://truthinitiative.org/thisisquitting>

Text-based program aimed at young people quitting e-cigarettes. No comparable national program yet exists for nicotine pouches.

For the Partner or Family Member

- **How to Support Your Quitter.** <https://smokefree.gov/help-others-quit/how-to-support-someone-quitting>
- **American Cancer Society.** <https://www.cancer.org/>

Chapter 16. Problematic Internet-Based Behaviors

For the Individual

- **Online Gamers Anonymous.** <https://www.olganon.org/>
- **Internet & Technology Addicts Anonymous.** <https://internetaddictsanonymous.org/>
- **Media Addicts Anonymous.** <https://www.mediaaddictsanonymous.org/>
- **Emotions Anonymous.** <https://emotionsanonymous.org/>

For the Partner or Family Member

- **OLG-Anon.** <https://www.olganon.org/>
Companion program for family and loved ones.

Chapter 17. Problematic Sexual Behaviors

For the Individual

- **Sex Addicts Anonymous.** <https://saa-recovery.org/>
- **Sexaholics Anonymous.** <https://www.sa.org/>
- **Sex and Love Addicts Anonymous.** <https://slaafws.org/>
- **Sexual Compulsives Anonymous.** <https://sca-recovery.org/>
- **Sexual Recovery Anonymous.** <https://www.sexualrecovery.org/>
- **SMART Recovery.** <https://www.smartrecovery.org/>

A secular alternative for clients who object to the 12-step framework or to the disease model as applied to sexual behavior.

For the Partner or Family Member

- **COSA (Codependents of Sex Addicts).** <https://cosa-recovery.org/>
- **S-Anon International Family Groups.** <https://sanon.org/>
- **Recovering Couples Anonymous.** <https://recovering-couples.org/>
- **CoSex and Love Addicts Anonymous.** <http://coslaa.org/>

Chapter 18. Problematic Romantic Relationship Behaviors

For the Individual

- **Sex and Love Addicts Anonymous.** <https://slaafws.org/>
- **Love Addicts Anonymous.** <https://loveaddictsanonymous.org/>

For the Partner or Family Member

- **CoSex and Love Addicts Anonymous.** <http://coslaa.org/>
- **Co-Dependents Anonymous.** <https://coda.org/>

Chapter 19. Problematic Food Consumption Behaviors

For the Individual

- **Overeaters Anonymous.** <https://oa.org/>
- **Food Addicts in Recovery Anonymous.** <https://www.foodaddicts.org/>
- **Food Addicts Anonymous.** <https://www.foodaddictsanonymous.org/>
- **National Alliance for Eating Disorders Helpline.** 1-866-662-1235;
<https://www.allianceforeatingdisorders.com/>

Free clinician-staffed helpline. Note that the former NEDA helpline has been permanently discontinued; update any handout that still lists it.

For the Partner or Family Member

- **Overeaters Anonymous.** <https://oa.org/>
- **F.E.A.S.T. (Families Empowered and Supporting Treatment of Eating Disorders).**
<https://www.feast-ed.org/>

Chapter 20. Problematic Exercise Behaviors

For the Individual

- **Recoveries Anonymous.** <http://www.r-a.org/i-exercise-addicts.htm>
- **SMART Recovery.** <https://www.smartrecovery.org/>

Its tools transfer well to behavioral targets for which no dedicated fellowship exists.

For the Partner or Family Member

- **Co-Dependents Anonymous.** <https://coda.org/>

Chapter 21. Problematic Shopping Behaviors

For the Individual

- **Debtors Anonymous.** <https://debtorsanonymous.org/>
- **Spenders Anonymous.** <http://www.spenders.org/>
- **Recoveries Anonymous.** <http://www.r-a.org/i-compulsiveshopping.htm>
- **National Foundation for Credit Counseling.** <https://www.nfcc.org/>

Not a mutual support group, but the practical financial consequences frequently need addressing alongside the behavior.

For the Partner or Family Member

- **Co-Dependents Anonymous.** <https://coda.org/>
- **Debtors Anonymous.** <https://debtorsanonymous.org/>

Chapter 22. Problematic Work Behaviors

For the Individual

- **Workaholics Anonymous.** <https://workaholics-anonymous.org/>

- **Recoveries Anonymous.** <http://www.r-a.org/i-work-addiction.htm>
- **SMART Recovery.** <https://www.smartrecovery.org/>

For the Partner or Family Member

- **Work-Anon.** <https://workanonzoom.org/>

For friends and family of a person with problematic work behaviors.

Summary

The United States is in the third consecutive year of declining overdose mortality. An estimated 69,973 people died of a drug overdose in 2025, almost 14% fewer than in 2024, and provisional data predicted 67,798 deaths for the 12 months ending March 2026. Opioid-involved deaths fell from about 55,296 to 44,564 between 2024 and 2025. The decline is attributed to a combination of changes in the illegal supply, wider naloxone distribution, improved treatment access, and a smaller population at risk because so many people have already died. Improvement is not uniform: several states recorded declines of more than 25%, while New Mexico, Arizona, and Colorado recorded increases of more than 10%.

The unregulated opioid supply has changed in ways the textbook does not describe. Xylazine, a veterinary alpha-2 agonist that produces necrotic wounds, is being displaced by medetomidine, which is up to 300 times more potent, does not produce those wounds, and causes a severe withdrawal syndrome that begins within hours, peaks at 18 to 36 hours, and frequently requires hospitalization or intensive care. Neither drug responds to naloxone, and neither appears on standard urine drug screens. Naloxone should still be administered because both are found almost exclusively in combination with fentanyl, and the opioid component is reversible even when the sedation is not. In Philadelphia, medetomidine rose from 29% to 90% of samples between May 2024 and March 2026 while xylazine fell from 97% to 28%. The old teaching that opioid withdrawal is uncomfortable but not dangerous is no longer reliable.

The 2025 National Survey on Drug Use and Health found that 56.0% of people aged 12 or older, or 162.8 million, used tobacco, vaped nicotine, drank alcohol, or used an illicit drug in the past month. Cigarette smoking, binge drinking, underage drinking, prescription opioid misuse, alcohol use disorder, and overall substance use disorder all declined between 2021 and 2025. Marijuana use, hallucinogen use, and nicotine vaping increased, driven by adults aged 26 or older. In 2025, 44.6 million people (15.3%) had a substance use disorder, and only 16.0% of those needing treatment received it. Among adults with a substance use disorder who did not receive treatment, 94.5% neither sought treatment nor believed they needed it, which locates the primary barrier in problem recognition rather than in service capacity. Among the 30.6 million adults who perceived they ever had a substance problem, 73.0% considered themselves in recovery or recovered.

Adolescent substance use remained near historic lows for the fifth consecutive year, with past-30-day abstinence at record highs of 91% in eighth grade and 82% in tenth grade, and 66% in twelfth grade. Alcohol, cannabis, and nicotine vaping all trended downward. Nicotine pouches were the exception, rising in all three grades. Heroin use increased significantly in all three grades and cocaine use in two, from very low baselines.

The Monitoring the Future Longitudinal Panel Study showed a striking divergence across adulthood. Alcohol reached historic lows among young adults and adults aged 35 to 50, while cannabis rose to all-time highs at every adult age, including daily use by 11.8% of adults aged 19 to 30, 8.5% of those aged 35 to 50, and 6.2% of those aged 55 to 65. Cannabis use disorder symptoms among adults aged 40 to 50

rose from 4.8% to 6.5% in a single year. Nicotine is diversifying rather than disappearing, with pouches, cigars, hookah, and smokeless tobacco all rising among adults aged 55 to 65.

Tobacco and nicotine policy moved sharply. The 2025 National Youth Tobacco Survey found 7.2% of middle and high school students currently using any tobacco product, with e-cigarettes at 5.2% and nicotine pouches at 1.7%, now the second most used product. The FDA authorized 20 ZYN pouch products in January 2025 and, in June 2026, permitted them to carry a modified risk claim, the first such authorization for any nicotine pouch. The proposed menthol cigarette and flavored cigar standards were withdrawn in January 2025; the proposed cap on nicotine in combusted products remains unfinalized. The CDC's Office on Smoking and Health was eliminated in April 2025, disrupting state quitline services, and data collection for the 2025 youth survey was halted in the same month. Two patterns within the adolescent decline matter clinically: use is intensifying among those who continue, with daily e-cigarette use rising from 9.4% of current users in 2014 to 35.4% in 2025, and roughly four in five youth pouch users also use another tobacco product.

Two federal cannabis actions changed the legal landscape. In April 2026, FDA-approved marijuana drug products and marijuana subject to a qualifying state medical license were placed in Schedule III, and an expedited hearing on broader rescheduling was held in June and July 2026 without a final rule at press time. Separately, Section 781 of Public Law 119-37 redefined hemp on a total THC basis that counts THCA, excluded cannabinoids synthesized outside the plant, and capped finished products at 0.4 milligrams per container, effectively ending the intoxicating hemp market. Most of those restrictions were delayed until December 11, 2026, but converted cannabinoids, such as delta-8, lose hemp status on November 12, 2026, as originally scheduled.

Federal alcohol policy moved in two directions. The January 2025 Surgeon General's Advisory identified alcohol as the third leading preventable cause of cancer, causally linked to at least seven cancers and responsible for roughly 100,000 cases and 20,000 deaths annually, and called for updated warning labels. The January 2026 Dietary Guidelines removed the numeric daily limits that had stood since 1980, replacing them with the advice to consume less alcohol for better overall health.

Two treatment developments deserve attention. Randomized trials of semaglutide have shown reductions in craving and heavy drinking, most convincingly in a 26-week Lancet trial in which semaglutide added to cognitive behavioral therapy produced a 13.7 percentage point greater reduction in heavy drinking days than placebo, with a number needed to treat of 4.3 on the WHO risk drinking level endpoint. Eight incretin-class or related drugs are now under investigation for alcohol use disorder, compared with three FDA-approved medications in the past 75 years. No GLP-1 receptor agonist is approved for any substance use disorder. Separately, Executive Order 14401 of April 2026, followed by FDA priority vouchers and final guidance, has accelerated psychedelic drug development, although no classic psychedelic is FDA-approved for any indication and ibogaine has no efficacy trials at all.

Legal sports betting and prediction markets have expanded rapidly. 27% of Americans and 52% of men aged 18 to 49 hold an active sportsbook account, and 15% have bet through a prediction market. Gambling disorder diagnoses rose in states that legalized sports betting and fell in those that did not. The National Problem Gambling Helpline number changed to 1-800-MY-RESET in January 2026, with 1-800-522-4700 remaining active.

In problematic internet-based behaviors, a large longitudinal study established that addictive use patterns, rather than total screen time, predict suicidal behavior and worse mental health in early adolescents, which validates the assessment emphasis already taken in Chapter 16. AI companion chatbots emerged as a new category of concern, and more than a dozen states enacted statutes in 2026 requiring disclosure, crisis protocols, and protections for minors. In problematic food consumption behaviors, the field has been consolidating around ultra-processed food addiction as a narrower and

more defensible construct, although no such diagnosis exists in DSM-5-TR or ICD-11, and the same GLP-1 medications now under study for alcohol use disorder have strengthened the shared-reward-pathway argument.

This supplement also reviewed telehealth prescribing flexibilities, which expire December 31, 2026 absent further action; the stewardship of more than \$50 billion in opioid settlement funds; the consolidation of SAMHSA into the Administration for a Healthy America and the July 2025 discontinuation of the 988 LGBTQ+ youth subnetwork; current Bureau of Labor Statistics wage and outlook data showing a median annual wage of \$59,350 and projected growth of 18% through 2035; accreditation and certification pathways; and resources and mutual support groups for Americans experiencing substance use disorders and problematic behaviors, and for their partners and families.

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A Note on Preparation

I used Claude, an artificial intelligence assistant developed by Anthropic, to help prepare this supplement: to locate and summarize recent sources, to assemble data reported in tables, and to draft and edit portions of the text. I reviewed the material, but AI systems can make mistakes, including confident ones. Where absolute accuracy matters to you, please consult the original sources listed in the references above rather than relying on this document. If you find an error, I would be grateful to hear about it at alderson@ucalgary.ca.