

SAMHSA Drug Use Survey and Group Treatment for Substance Use Disorders Analysis

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Introduction

Substance use remains a significant behavioral health concern in the United States. It affects not only people who use alcohol or drugs but also their families, workplaces, healthcare systems, and communities. However, drug use, substance misuse, and a substance use disorder are not interchangeable concepts. A person may report using an illicit drug without meeting the diagnostic criteria for a disorder, while another person may experience severe impairment requiring medical, psychological, and social support.

The Substance Abuse and Mental Health Services Administration conducts the National Survey on Drug Use and Health, commonly abbreviated as NSDUH. This annual survey provides national information about alcohol, tobacco, and other drug use, substance use disorders, treatment, mental health conditions, and recovery among people aged 12 or older in the civilian, noninstitutionalized population of the United States.

In 2013, approximately 24.6 million people aged 12 or older were classified as current illicit drug users, meaning that they had used an illicit drug during the month before the survey. That estimate represented 9.4 percent of the population in this age group (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

The most recent available annual NSDUH report presents data collected in 2024. It estimated that 73.6 million people aged 12 or older, or 25.5 percent of that population, had used an illicit drug during the previous year. The most commonly reported drug was marijuana, used by approximately 64.2 million people during that period. The increase in overall illicit drug use between 2021 and 2024 was largely associated with increased marijuana use (SAMHSA, 2025a).

The 2013 and 2024 figures should not be compared as though they measure exactly the same behavior. The 2013 estimate refers to use during the previous month, whereas the 2024 figure refers to use during the previous year. Survey questions and methods have also changed over time. More importantly, neither figure means that every person who reported drug use required treatment.

In 2024, SAMHSA estimated that 48.4 million people had a substance use disorder during the previous year. Approximately 52.6 million were classified as needing substance use treatment because they

either had a disorder or had received treatment that may have prevented them from continuing to meet diagnostic criteria. Only 10.2 million people received professional substance use treatment, representing approximately 19.3 percent of those classified as needing it (SAMHSA, 2025a).

These findings demonstrate a substantial treatment gap. Group therapy is one method of increasing treatment access while providing peer support, education, accountability, and opportunities to practice recovery skills. However, effective group treatment requires more than gathering several people in one room. It depends on careful planning, appropriate participant selection, skilled leadership, confidentiality, individualized goals, and coordination with medical and mental health services.

This essay uses information gathered from an interview with a substance use disorder professional and compares the practitioner's observations with formal clinical guidance and research. It examines pre-group planning, the beginning and development of treatment sessions, open and closed group structures, confidentiality, co-occurring disorders, medication, family participation, leadership qualities, and the goals of group treatment.

Understanding Substance Use Disorders

A substance use disorder is a health condition characterized by a problematic pattern of alcohol or drug use that causes clinically significant distress or impairment. The condition may affect health, relationships, employment, education, finances, judgment, and the ability to meet responsibilities.

Substance use disorders exist along a continuum from mild to severe. Their symptoms may include difficulty controlling consumption, unsuccessful efforts to reduce use, craving, tolerance, withdrawal, continuing use despite harm, neglecting important activities, and spending substantial time obtaining, using, or recovering from a substance.

Using respectful terminology is important. Expressions such as "substance abuser," "drug addict," or "user" can reduce a person to one behavior or diagnosis. Person-first terms such as "person with a substance use disorder" acknowledge the condition without treating it as the individual's entire identity.

Substance use disorders are treatable. Effective care may include behavioral therapy, individual or group counseling, medication, withdrawal management, peer recovery services, harm-reduction interventions, family support, recovery housing, and assistance with employment or other social needs. NIDA emphasizes that treatment should address the person's drug use together with associated medical, psychological, vocational, legal, and social concerns.

Group therapy can be an important part of this broader care system, but it should not automatically replace individual therapy, medical treatment, or other needed services.

The Role of Group Treatment

Group therapy brings together people who share certain treatment needs under the guidance of one or more trained professionals. Its value extends beyond the efficient delivery of information to several participants at once.

People entering substance use treatment may experience guilt, shame, loneliness, damaged relationships, or the belief that no one understands their situation. A well-functioning group challenges isolation by showing members that others have faced comparable problems. Participants may learn from one another's successes, mistakes, coping strategies, and perspectives.

Groups also provide opportunities for interpersonal learning. A member can practice asking for support, expressing disagreement respectfully, listening without interruption, setting boundaries, and receiving feedback. Patterns that affect the participant outside treatment may emerge within the group, allowing the leader and other members to respond to them constructively.

Research indicates that evidence-supported group interventions can help treat drug use disorders, although effectiveness varies according to the substance, intervention, participant population, and quality of delivery. A review of 50 studies found support for group-based cognitive behavioral therapy, contingency management, motivational interventions, relapse-prevention groups, social-support approaches, and specialized women's recovery groups in particular populations. The authors also warned that group treatments receive less research attention than individual interventions and should not be treated as universally interchangeable (López et al., 2021).

Group treatment should therefore be selected because it is clinically appropriate, not merely because it is less expensive or allows an organization to serve more people.

Principal Goals of Group Treatment

The central purpose of a substance use treatment group is to help participants make and sustain meaningful changes. The specific goal may differ across programs and individuals. Some participants pursue complete abstinence, whereas others initially focus on reduced use, overdose prevention, safer behavior, treatment engagement, or medication adherence.

Appropriate goals may include:

Treatment area	Possible group goals
Engagement	Increase willingness to participate in treatment and develop trust

Treatment area	Possible group goals
Education	Understand substance use disorders, craving, withdrawal, and recovery
Motivation	Explore ambivalence and identify personally meaningful reasons for change
Coping skills	Manage stress, anger, loneliness, boredom, and other triggers
Relapse prevention	Recognize warning signs and develop a written response plan
Peer support	Reduce isolation and establish recovery-supportive relationships
Cognitive change	Identify thoughts and beliefs that contribute to harmful behavior
Practical stability	Improve routines, sleep, employment, housing, and family functioning
Risk reduction	Prevent overdose, infections, impaired driving, and other harms
Emotional regulation	Express feelings without relying on alcohol or drugs
Recovery planning	Connect treatment gains to community, medical, and peer resources

Goals should be specific enough to guide treatment but flexible enough to reflect individual circumstances. A participant with opioid use disorder and a history of overdose may require medication, naloxone access, and overdose-prevention planning. Another participant may need help recognizing how alcohol use interacts with depression and family conflict.

The group leader should avoid assuming that every member has the same motivation, diagnosis, cultural background, legal situation, or definition of recovery.

Pre-Group Planning

The substance use disorder professional interviewed for this discussion identified pre-group planning as the most important preparation step. This observation is consistent with SAMHSA's guidance, which emphasizes participant assessment, appropriate placement, group composition, confidentiality, structure, and leadership preparation (SAMHSA, 2015a).

Before the first session, the leader should understand the purpose of the group. A psychoeducational group teaching the effects of substances requires a different structure from a relapse-prevention group or an interpersonal-process group.

The leader should review relevant assessment information about prospective members. This information may include:

- substances used and severity of the disorder;
- current intoxication or withdrawal risk;
- medical and psychiatric conditions;
- suicidal or violent thoughts;
- cognitive or communication limitations;
- motivation and readiness for treatment;
- previous treatment experiences;
- medications;
- family and social support;
- trauma history;
- cultural and language needs; and
- legal or employment requirements affecting attendance.

Reviewing information does not mean forming rigid judgments before meeting the participant. Records provide context, but the person should have an opportunity to describe current needs and goals directly.

A pre-group interview or orientation can help determine whether the participant understands the group's purpose and can function safely within it. It can also identify people who require stabilization or a different level of care before participating. Someone experiencing severe withdrawal, acute intoxication, uncontrolled psychosis, or immediate danger to self or others may require urgent medical or psychiatric intervention rather than routine group attendance.

SAMHSA also recommends screening and integrated assessment when substance use and mental disorders occur together. Depression, anxiety, post-traumatic stress disorder, bipolar disorder, attention-deficit/hyperactivity disorder, psychotic disorders, and personality disorders may influence attendance, communication, emotional regulation, and relapse risk (SAMHSA, 2020).

Preparing the Physical and Therapeutic Environment

The physical arrangement of the room communicates expectations before the leader begins speaking. Arranging chairs in a circle can encourage face-to-face communication and reduce the impression that participants are attending a lecture. However, the arrangement should also accommodate

mobility limitations, hearing or visual needs, personal space, and emergency access.

The environment should be private, quiet, and free from unnecessary interruption. Handouts, writing materials, educational resources, and crisis-contact information should be prepared in advance. If the session is conducted online, the leader should test the technology, establish privacy expectations, and consider whether each participant has a confidential location from which to join.

The leader should prepare an agenda while remaining flexible. A basic session may include a welcome, brief check-in, review of the previous topic, introduction of new material, structured discussion or practice, personal goal setting, and a closing summary.

Preparation also includes planning for difficult situations. The leader should know how to respond if a member arrives intoxicated, threatens another participant, discloses abuse, experiences a panic reaction, reveals suicidal intentions, or requires emergency assistance.

Beginning the Group

The first meeting establishes the emotional tone of the group. The leader should introduce themselves, explain their role, welcome participants, and describe the purpose and format of treatment in direct language.

Members may then be invited to introduce themselves in a way that does not force immediate disclosure of highly personal information. A participant might share a first name, a treatment goal, or one hope for the group. Requiring detailed personal histories during the first few minutes may increase anxiety and discourage future attendance.

The leader should explain the potential benefits and limits of group treatment. Members should understand that the group can provide education and support but is not guaranteed to solve every problem or replace all other forms of care.

Group rules should be developed or reviewed early. Common expectations include:

1. Arrive on time and attend consistently.
2. Allow one person to speak at a time.
3. Avoid threats, harassment, and degrading language.
4. Respect differences in background, belief, and recovery goals.
5. Do not attend in a condition that makes safe participation impossible.
6. Avoid romantic, financial, or exploitative relationships within the group.
7. Protect information disclosed by other members.
8. Participate without pressuring others to reveal more than they are ready to discuss.
9. Give feedback respectfully.
10. Follow established procedures when a safety concern arises.

Rules are most effective when their purpose is explained. Confidentiality protects trust, attendance supports continuity, and respectful communication allows disagreement without humiliation.

Confidentiality and Its Limits

Confidentiality is essential because participants may disclose drug use, trauma, illegal behavior, medical information, family conflict, or other sensitive experiences. Fear that such information will be repeated may prevent honest participation.

Treatment professionals and federally assisted substance use disorder programs may be governed by the Health Insurance Portability and Accountability Act and the additional protections contained in 42 C.F.R. Part 2. Federal Part 2 rules protect the confidentiality of certain substance use disorder treatment records and restrict their use in criminal investigations without patient consent or an appropriate court order. Updated compliance requirements took effect in February 2026.

Group members, however, may not be regulated in the same manner as treatment professionals. The leader can require every participant to agree not to repeat another person's disclosures, but cannot guarantee that every member will honor that agreement.

This limitation should be explained clearly during informed consent. Participants should also understand legal and ethical exceptions that may apply when there is an immediate risk of serious harm, suspected abuse of a child or vulnerable person, or another legally reportable situation. The precise requirements depend on jurisdiction and professional role.

The leader should avoid promising "absolute confidentiality." A more accurate statement is that the program will protect information according to applicable law and professional ethics, while every group member is expected to safeguard the privacy of others.

Closed and Open Groups

The original discussion refers to "fixed" and "revolving" groups. The more widely used terms are closed or fixed-membership groups and open or rolling-admission groups.

In a closed group, the same members begin together and normally remain together until a planned ending date. New participants are not added after the group has started. Closed groups are especially useful when the sessions follow a sequence in which each lesson builds on earlier material.

A 12-session cognitive behavioral skills group, for example, may begin with identifying triggers and proceed through coping practice, problem-solving, relapse planning, and termination. Missing early sessions can make later material difficult to understand.

Closed groups may also encourage cohesion because members become familiar with one another and

experience the group's development together. Their limitations include delayed admission, reduced access when someone needs immediate support, and disruption if several participants withdraw.

An open group admits new participants while other members complete treatment and leave. These groups are common in outpatient and residential substance use services. A survey of clinicians found that open groups were widely used in actual substance use treatment settings (Wendt & Gone, 2017).

Open groups can improve treatment access and allow participants to observe members at different stages of recovery. A newer member may gain hope from someone who has maintained progress for several months. An experienced member may reinforce personal learning by helping a newcomer.

However, repeated changes in membership can make trust and cohesion more difficult. New members also need orientation so that they understand established expectations. Topics may need to be organized into self-contained modules rather than a single sequence.

Neither format is inherently superior.

Feature	Closed group	Open or rolling group
Membership	Same participants throughout	Participants enter and leave over time
Duration	Usually fixed	Often ongoing
Curriculum	May build sequentially	Usually uses repeatable modules
Cohesion	Often easier to develop	Requires active rebuilding
Access	Participants may wait for a new cycle	More immediate admission
Best suited for	Structured skills or process work	Ongoing support, education, and continuing care
Main risk	Attrition may leave a small group	Changing membership may weaken trust

The format should be selected according to clinical purpose, available resources, attendance patterns, and participant needs. Revolving admission should not automatically be regarded as more effective simply because treatment may last longer.

Types of Treatment Groups

SAMHSA identifies several group models commonly used in substance use treatment.

Psychoeducational Groups

Psychoeducational groups teach participants about substance use disorders, health effects, treatment, recovery, medications, relapse, and community resources. They are generally structured and may use a manual, presentation, video, or worksheet.

Skills-Development Groups

These groups teach practical abilities such as refusing substances, managing cravings, communicating assertively, solving problems, regulating emotion, and planning high-risk situations.

Cognitive Behavioral Groups

Cognitive behavioral groups examine the relationships among thoughts, emotions, situations, and actions. Members learn to identify patterns that increase the likelihood of harmful use and practice alternative responses.

A 2023 systematic review gave cognitive behavioral therapy a strong recommendation as an empirically supported treatment for substance use disorders. It found small-to-moderate effects compared with inactive conditions, with stronger effects often appearing during earlier follow-up periods (Boness et al., 2023).

Support Groups

Clinician-led support groups allow members to discuss current difficulties, exchange feedback, strengthen confidence, and build supportive relationships. They should be distinguished from community mutual-help organizations, which are usually peer-led rather than clinical treatment.

The 2024 NSDUH explicitly classified professional counseling, medication, inpatient care, outpatient care, telehealth, and certain correctional treatment as substance use treatment. Support groups and peer recovery services were measured separately rather than automatically counted as professional treatment.

Interpersonal Process Groups

These groups use members' interactions to examine relationship patterns, emotional defenses, trust, shame, conflict, and attachment. They usually require advanced leader training and careful attention to safety.

SAMHSA's five-model framework also includes groups oriented toward cognitive behavioral treatment, support, interpersonal process, psychoeducation, and skills development.

Qualities and Responsibilities of the Group Leader

A competent leader needs more than knowledge about drugs. The leader must understand group dynamics, treatment ethics, crisis intervention, cultural differences, trauma, and the ways that substance use interacts with mental and physical health.

Important personal and professional qualities include:

- emotional stability;
- active listening;
- empathy;
- consistency;
- integrity;
- cultural humility;
- patience;
- appropriate confidence;
- clear boundaries;
- flexibility;
- accountability;
- the ability to manage conflict; and
- the ability to use humor without shaming participants.

Empathy does not mean agreeing with every statement or avoiding accountability. A skilled leader can communicate respect while challenging harmful behavior. For example, the leader may acknowledge that a participant feels ashamed while still asking the individual to take responsibility for deception or aggression.

Humor can reduce tension and create connection, but it should never target a participant, trivialize trauma, or make substance use appear glamorous. The leader also needs sufficient self-awareness to recognize personal biases and emotional reactions.

Clinical competence is essential. Research on real-world substance use groups has identified challenges involving large group sizes, limited facilitator training, rapidly changing membership, and

complex participant needs. These findings demonstrate that group treatment should not be assigned to an unprepared clinician simply because it appears straightforward.

Supervision and continuing education can help leaders examine difficult sessions, maintain ethical boundaries, and apply evidence-based interventions accurately.

Leadership Across the Stages of Group Development

The leader's style should change as the group develops, but support should not simply disappear during later treatment.

During the early stage, members are often anxious, uncertain, or guarded. The leader generally needs to be active and structured. Responsibilities include explaining rules, inviting participation, preventing domination, reducing hostility, and creating a predictable environment.

During the middle stage, members may become more willing to discuss difficult experiences and provide feedback. Conflict may arise as participants test boundaries or disagree. The leader should help members communicate directly rather than solving every problem for them.

As the group becomes more stable, the leader may become less directive and encourage greater member-to-member interaction. This change supports independence, but the clinician remains responsible for safety, purpose, and ethical conduct.

During the ending stage, members may experience pride, anxiety, grief, or fear of relapse. The leader should review progress, identify unfinished work, develop continuing-care plans, and help participants connect with medical care, individual counseling, peer support, family resources, or community programs.

The final phase should not be treated as an abrupt withdrawal of encouragement. It is a structured transition from reliance on the treatment group toward broader recovery support.

Medication and Group Treatment

Medication issues should be discussed accurately and without stigma. Evidence-based medications are available for opioid and alcohol use disorders, and medication can be combined with counseling and group treatment.

A participant taking methadone, buprenorphine, naltrexone, acamprosate, or another prescribed medication should not be described as failing to achieve recovery simply because medication remains part of treatment. Group members may bring misinformation about medications into the session,

making accurate education important.

The leader should remain within professional scope. A nonprescribing counselor should not advise a member to discontinue or alter medication. Concerns about side effects, dosing, interactions, or adherence should be coordinated with the prescribing professional.

Group treatment also cannot safely manage every withdrawal syndrome. Alcohol or sedative withdrawal can become medically dangerous, and opioid withdrawal may require clinical monitoring and medication. Participants should receive an appropriate medical assessment rather than being told to overcome withdrawal through group motivation alone.

Family Involvement

Substance use disorders frequently affect the entire family. Relatives may experience fear, financial stress, mistrust, disrupted routines, or uncertainty about how to help. Family participation can therefore strengthen treatment when it is clinically appropriate and authorized by the participant.

Family education may address communication, boundaries, overdose response, medication, relapse warning signs, and the distinction between support and enabling behavior. Family therapy may be appropriate when relationship patterns contribute to continued substance use or interfere with recovery.

However, family involvement must not violate the confidentiality of the treatment group. Information disclosed by other members should never be shared with a participant's relatives. The clinician should also assess whether family involvement could create danger, coercion, retaliation, or additional trauma.

SAMHSA recognizes family therapy and family support as potential components of comprehensive behavioral health care, but involvement should be individualized rather than automatically required.

Cultural Responsiveness and Individual Differences

People receiving substance use treatment represent every age, racial group, ethnicity, gender, social class, religion, and geographic community. They also differ in education, disability, sexual orientation, family structure, military experience, immigration history, and exposure to trauma.

A group leader should not assume that one model of recovery is appropriate for every participant. Spiritual language may be meaningful to one member and uncomfortable for another. Direct confrontation may be accepted in one setting but experienced as humiliating or unsafe in another.

Culturally responsive practice involves learning how participants understand substance use, treatment, family responsibility, privacy, and healing. It also requires examining whether group

materials assume one type of family, literacy level, economic position, or cultural experience.

Group composition may sometimes be intentionally specialized. Women's groups, adolescent groups, veteran groups, culturally specific groups, trauma-informed groups, and groups for people with co-occurring disorders may provide greater safety and relevance for particular populations.

Specialization should be based on clinical needs rather than stereotypes. Members within the same demographic group still possess different experiences and beliefs.

Measuring Group Progress

Attendance alone does not establish that treatment is effective. Programs should evaluate whether participants are achieving meaningful outcomes.

Measures may include:

- frequency and quantity of substance use;
- days of abstinence;
- overdose events;
- craving intensity;
- treatment retention;
- medication adherence;
- emergency department use;
- employment or educational participation;
- relationship functioning;
- mental health symptoms;
- coping-skill use;
- quality of life;
- recovery-support involvement; and
- progress toward individually selected goals.

Progress is rarely perfectly linear. A return to substance use should be addressed seriously but not automatically treated as proof that treatment has failed. The event can be analyzed to identify triggers, missing supports, medication needs, or weaknesses in the recovery plan.

At the same time, avoiding shame does not mean ignoring dangerous behavior. The leader must maintain boundaries and respond when a member brings substances into treatment, threatens others, attends while severely impaired, or repeatedly disrupts the group.

Conclusion

SAMHSA's National Survey on Drug Use and Health demonstrates the continuing scale of substance use and unmet treatment needs in the United States. In 2013, approximately 24.6 million people aged 12 or older reported past-month illicit drug use. In 2024, 73.6 million reported illicit drug use during the previous year. These figures measure different periods and should not be treated as directly equivalent.

The 2024 data also show why treatment access remains a serious concern. Approximately 52.6 million people were classified as needing substance use treatment, but only 10.2 million received professional treatment during the year. Group treatment can help address this gap, but increasing capacity should never come at the expense of clinical quality.

The professional interviewed for this discussion correctly emphasized the importance of pre-group planning. Leaders should review assessment information, determine whether participants are suitable for the group, prepare an accessible and private environment, establish a clear purpose, and anticipate safety concerns.

The first sessions should introduce the leader and members, explain treatment goals, establish rules, discuss confidentiality, and reduce anxiety without forcing premature disclosure. Closed groups and open or rolling-admission groups each offer benefits, and the appropriate format depends on the purpose of treatment.

Effective leadership requires empathy, active listening, emotional stability, integrity, boundaries, cultural humility, and a strong understanding of group processes. Leaders may be more structured during early sessions and gradually support greater member independence, but they retain responsibility for safety and therapeutic direction throughout treatment.

Group care should also be integrated with medication, medical services, individual counseling, family involvement, peer support, and treatment for co-occurring mental disorders when those services are needed. No single intervention can address every dimension of a substance use disorder.

Ultimately, group therapy is effective not because people with similar diagnoses are placed together, but because a carefully planned group can transform shared experience into education, accountability, hope, skill development, and sustained recovery support.

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