

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

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Introduction

Substance use disorders remain a major behavioral-health concern in the United States, but drug use, substance misuse, and a diagnosable disorder should not be treated as interchangeable concepts. The National Survey on Drug Use and Health, conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA), measures substance use, mental health, and treatment among people aged 12 or older in the civilian, noninstitutionalized population. The 2025 NSDUH, released in 2026, estimated that about 69.8 million people aged 12 or older used an illicit drug during the previous year, including approximately 61.6 million who used marijuana, while 44.6 million people met criteria for a substance use disorder during the previous year (SAMHSA, 2026a; SAMHSA, 2026b). These categories describe different phenomena and should not be collapsed into one measure of “addiction.” Treatment planning must therefore begin with individual assessment, severity, medical risk, co-occurring conditions, motivation, and personal goals rather than assuming that every reported use requires the same clinical response.

Group Treatment and Its Therapeutic Purpose

Group treatment can expand access to care while providing benefits that individual counseling cannot reproduce in exactly the same way. Participants may discover that other people have experienced similar shame, isolation, craving, relationship damage, or difficulty sustaining change, which can reduce the belief that their problems are uniquely hopeless. Groups also create opportunities for interpersonal learning: members practice listening, asking for help, setting boundaries, giving and receiving feedback, managing disagreement, and recognizing behaviors that may also affect relationships outside treatment. Evidence supports several group-based approaches for substance use disorders, including cognitive behavioral therapy, motivational interventions, relapse-prevention methods, contingency-management elements, and structured social-support models in appropriate populations (López et al., 2021; Boness et al., 2023). Group treatment, however, should not be chosen merely because it is less expensive or serves more people. It is most effective when its format,

membership, leadership, and goals are matched to participant needs and coordinated with other required services.

Treatment area	Possible group goals
Engagement	Build trust and willingness to participate in treatment.
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 response plan.
Peer support	Reduce isolation and build recovery-supportive relationships.
Risk reduction	Reduce overdose, infection, impaired driving, and other harms.
Recovery planning	Connect treatment gains with medical, community, and peer resources.

Assessment and Pre-Group Planning

Effective group care begins before the first meeting. The leader should define the group's purpose and assess whether prospective participants can benefit safely from the planned format. Relevant information includes substances used, severity of the disorder, intoxication or withdrawal risk, medical conditions, psychiatric symptoms, suicide or violence risk, cognitive or communication needs, medications, trauma history, family support, cultural and language needs, and legal or employment requirements affecting attendance (SAMHSA, 2015a; SAMHSA, 2020). A brief pre-group interview can explain expectations and identify people who first require withdrawal management, urgent psychiatric intervention, a higher level of care, or more individualized treatment. Assessment should guide placement without becoming a rigid judgment about the person. Substance use disorders often occur with depression, anxiety, post-traumatic stress disorder, bipolar disorder, psychotic disorders, or other conditions, so integrated assessment is especially important. Group treatment should be one component of a broader plan rather than a substitute for medical, psychiatric, or social services that remain clinically necessary.

Beginning the Group, Confidentiality, and Safety

The opening sessions establish expectations that influence the group's later cohesion. Leaders should explain the purpose, session format, attendance expectations, respectful communication standards, and limits of confidentiality in direct language. Participants can be invited to introduce themselves without being forced into immediate disclosure of traumatic or highly personal experiences.

Confidentiality deserves special attention because members may discuss drug use, health conditions, family conflict, illegal conduct, or other sensitive information. Federally assisted substance use disorder programs may be subject to 42 C.F.R. Part 2 in addition to applicable HIPAA requirements. HHS's 2024 final rule aligned several Part 2 provisions more closely with HIPAA, and regulated entities were required to comply with the applicable updated requirements by February 16, 2026 (U.S. Department of Health and Human Services, 2026). The program can explain its legal duties and require members to protect one another's disclosures, but it cannot truthfully guarantee that every participant will maintain confidentiality outside the room.

Closed and Open Group Structures

Closed and open groups organize continuity differently. In a closed or fixed-membership group, the same participants usually begin together and remain until a planned ending date. This structure can support cohesion and sequential curricula because later sessions may build directly on earlier skills. An open or rolling-admission group allows new participants to enter while others complete treatment, making it useful in outpatient or residential settings where people need timely access rather than waiting for a new cycle (Wendt & Gone, 2017). Open groups can expose new members to people at later stages of recovery, but changing membership requires repeated orientation and deliberate rebuilding of trust. Their curricula often work best as self-contained modules rather than a single sequence. Neither format is inherently superior. Selection should depend on treatment goals, service setting, participant stability, access needs, staffing, and whether the intervention requires cumulative skill development. The structure should serve clinical purpose rather than organizational convenience.

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

Feature	Closed group	Open or rolling group
Access	Participants may wait for a new cycle	New participants can often enter sooner

Leadership, Medication, and Co-Occurring Needs

Group leaders need more than subject knowledge. Effective leadership requires empathy, active listening, emotional stability, clear boundaries, cultural humility, and skill in managing conflict, silence, domination, avoidance, and crisis. Leaders may provide more structure early in treatment and gradually encourage greater member responsibility, but they retain responsibility for safety and therapeutic direction. Care should also be integrated with medication and other evidence-based services when indicated (National Institute on Drug Abuse, 2018). For opioid use disorder, for example, medication can be a central treatment component rather than something that makes a person less committed to recovery. Participants may also need individual counseling, psychiatric care, withdrawal management, harm-reduction services, peer support, family involvement, housing assistance, or employment support. Treatment goals should be individualized because some people pursue abstinence while others initially focus on overdose prevention, reduced use, medication adherence, or sustained engagement. A group becomes clinically stronger when it supports these goals without assuming that all members share one diagnosis, culture, motivation, or definition of recovery.

Interpreting the Treatment Gap

The current NSDUH data show why treatment systems need multiple accessible pathways. In 2025, an estimated 44.6 million people aged 12 or older had a substance use disorder in the previous year. SAMHSA classified a larger group as needing substance use treatment because that category includes people with a disorder as well as some people who received treatment that may have prevented them from continuing to meet diagnostic criteria. Among those classified as needing treatment, approximately 7.6 million people, or 16.0 percent, received substance use treatment during the year (SAMHSA, 2026a). These statistics demonstrate a substantial treatment gap, but they should not be used to imply that group therapy alone can close it. Access depends on insurance, geography, stigma, workforce capacity, transportation, childcare, legal concerns, readiness, and availability of appropriate services. Group care can increase capacity and peer support, yet quality depends on assessment, trained leadership, privacy protection, and integration with the larger behavioral-health system.

Conclusion

Group treatment for substance use disorders is most effective when it is planned as a clinical intervention rather than simply a meeting of people with similar diagnoses. Current national data show substantial substance use and a continuing gap between treatment need and treatment receipt, making accessible care an important public-health priority (SAMHSA, 2026a; SAMHSA, 2026b). Well-designed groups can reduce isolation, strengthen motivation, build coping and interpersonal skills, and create sustained recovery support. Their success depends on appropriate assessment, purposeful membership, clear structure, informed consent, confidentiality practices, competent leadership, and coordination with medication, individual therapy, medical care, mental-health treatment, peer services, and social supports. Closed and open groups each have advantages when matched to the right setting and curriculum. The central principle is individualized care: people enter treatment with different substances, risks, histories, cultures, goals, and resources. A therapeutic group becomes valuable when those differences are respected and shared experience is transformed into practical learning, accountability, hope, and safer long-term recovery.

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