Breakout 12 — Managing Co-Occurring Mental Health Conditions — The Whole Person, Held Steady

One sentence for the board: Recovery and mental health walk together — this group teaches, in plain language, how to steady both, and how to get the right help, early, for each.

Purpose	Teach recovery education, in plain language, about living with both a substance use disorder and a mental health condition: how the two can travel together, what steadies daily life across anxiety, low mood, trauma responses, and anger, and how to stay connected to the counselor and to medical care — the group itself diagnoses no one, treats no one, and provides no clinical care.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant who lives with, or wonders whether they live with, both substance use and mental health struggles, and any participant supporting someone who does. No participant is asked to name a diagnosis, describe symptoms in detail, or share anything about their own care in group. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, the topic resources named in this outline, and the program's current crisis and

	referral information

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: this group is recovery education only — it does not diagnose or treat anyone, and help is available the same day for anyone who needs it.
5–30 min	Teaching	The teaching points below, in order, on the board: two struggles in one person, why they travel together, anxiety, low mood, trauma responses, and anger in plain language, what helps across all four, and staying with care.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one is asked to describe their own symptoms, diagnosis, or care.
45–55 min	Practice — my steady-days plan	Clients write a personal steady-days plan: early signs, one steadying skill for each area that applies, their care connections, and a same-day help plan. Writing stays with the client.
55–60 min	Close	Takeaways, the same-day help path restated, and one steadying step each client will actually do this week.

Teaching points

- **Two struggles, one person.** A co-occurring disorder means a substance use disorder and a mental health condition are present in the same person at the same time. That is common, not unusual, and it is not a character flaw or a sign of weak recovery. Each struggle can make the other harder: mental distress can drive a person toward use for relief, and use can deepen distress as it wears off or as consequences pile up. Neither struggle is treated as the only real one here. Both are taken seriously, and both are addressed — in care, together — because treating only one while the other goes unaddressed leaves the person carrying half the load alone.

- **Why the two travel together.** Researchers describe three broad pathways, and more than one can be true for the same person: shared risk factors can contribute to both; a mental health condition can contribute to substance use, as a person reaches for relief; and substance use can contribute to the development of a mental health condition. Symptoms also overlap — poor sleep, low mood, restlessness, and trouble concentrating can belong to either struggle, or to withdrawal, or to an ordinary hard week. Sorting that out takes a proper assessment by qualified clinicians over time, including time in abstinence. This group never sorts it in the room. What it teaches is steadiness and help-seeking while assessment and care do their work.
- **Anxiety, in plain language.** Anxiety is often described as worry that will not switch off, restlessness, a racing heart, tightness in the chest, dread before ordinary things, and avoidance of the places and people that stir it. It can drive use when a substance seems to quiet it for an hour. Steadying skills taught here are general and educational: name what is happening, slow the breathing, ground in the senses, keep a steady routine, and reach a support person early rather than waiting until the worry peaks. If worry is frequent, intense, or interfering with daily life, that is a same-day conversation with staff about a referral to the counselor — not a problem to white-knuckle through group skills alone.
- **Low mood, in plain language.** Low mood is often described as persistent sadness or emptiness, loss of interest or pleasure in things that used to matter, exhaustion, sleep and appetite changes, and hopeless thoughts. Substances can deepen low mood as their effects wear off, and low mood can make recovery feel pointless — which is why the group names it plainly instead of treating it as bad attitude. Steadying skills are small and concrete: a fixed wake time, one planned activity a day, movement, daylight, connection with one trusted person, and honest contact with the care team. A client who describes hopelessness, thoughts of harming themselves, or an inability to carry out daily life is connected to staff the same day, through program procedure, and the crisis path in this outline is followed without delay.
- **Trauma responses, in plain language.** After frightening or overwhelming events, people often describe intrusive memories or nightmares, feeling constantly on guard, being easily startled, avoiding reminders, and feeling numb or cut off. Those responses are the mind and body trying to protect themselves, and they can persist long after danger has passed. This group teaches trauma-informed steadiness only: safety, choice, and control stay with the client; no one is asked to retell what happened; grounding and routine are practiced; and triggers are handled with the client's own plan. Trauma is never processed in this group. A participant who wants trauma-focused care from the counselor is connected to staff the same day, and the facilitator follows program procedure for any disclosure of current danger.
- **Anger, in plain language.** Anger is a signal, not a verdict. It often arrives with body cues — heat, tightness, a clenched jaw, a raised voice — and with a story about unfairness or threat. The skill is to catch the signal early: pause, name the body cue, step back before speaking, and return when the surge has passed. Agreeing a time-out in advance — with family, housemates, and staff — makes the pause a plan instead of a walkout. Repair follows: own your part plainly, without excuses. Anger paired with substance use raises risk sharply, which is why anger skills belong in relapse prevention too. Anger that feels uncontrollable, or that has led to harm or threats, is a same-day staff conversation about care from the counselor.
- **What helps across all four.** The same foundations steady every area in this group: regular sleep, regular meals, daily movement, a steady routine, honest contact with support people, and staying engaged with treatment and peer support. Skills from Coping Skills — noticing,

breathing and grounding, reframing, riding out a surge, and reaching out — are the daily reps. A written plan helps most: the client's WRAP, their relapse-prevention plan, and the steady-days plan written in this session, kept where the client can find them on a hard day. No single skill is presented as a treatment, and no combination of skills is presented as a substitute for care.

- **Staying with care, for both.** Care for co-occurring disorders works best when it is integrated: mental health and substance use care considered together, in one coordinated plan, with screening for each whenever a person seeks help for the other. Skills in this group support care and connection to care; they are never a substitute for care. The facilitator's job is connection, not provision: help the participant name what they need, get to the right staff the same day, and keep appointments and medication decisions with their prescriber. Care from the counselor may include talking therapies and, where a prescriber decides it is appropriate, medication. Facilitators never name a therapy or a medication as right for a particular client, and never advise starting, stopping, or changing any medication.
- **The warrior's reading.** So the warrior's reading, said plainly: carrying two struggles does not make you two kinds of broken. It makes you a whole person whose care must be whole, too. Ask early, stay with your care team, use your skills daily, and tell someone the same day it gets hard. Warriors do not win by carrying everything alone. They win by holding the line together — with help, on purpose, one steady day at a time.

Cut points — teaching (25 minutes): teach the four conditions briefly and in order — anxiety, low mood, trauma responses, anger — then “What helps across all four” and “Staying with care.” If time runs short, compress the “why the two travel together” point to one sentence and shorten one condition's examples — never cut the same-day referral triggers, the crisis protocol, or the practice. Cut teaching, never skill practice.

Discussion prompts

- “What makes it hard to ask for help when two struggles are tangled together — and what would make asking easier?”
- “Which steadying foundation — sleep, routine, movement, or connection — slips first for most people, and what is the earliest sign it is slipping?”
- “What is the difference between a hard week that skills can steady and a situation that needs same-day help from staff?”
- “Who is one person you could reach the same day things get hard — and what words would you use to open that conversation?”

Practice — my steady-days plan (10 minutes, your plan stays with you)

1. In general terms, name the pattern you recognize: which areas in this group feel most present for you right now, and the earliest signs that tell you a hard stretch is starting. No detail is required, and nothing here is shared aloud.
2. Choose one steadying skill for each area that applies to you — from Coping Skills, from this session, or from your own experience — and write when this week you will use each one.

3. Name your care connections: the staff member, counselor, prescriber, or support person you will contact, and the question you want to ask them. If you do not yet have a connection for one struggle, write that you will ask staff for a referral the same day.
4. Write your same-day help plan: who you will tell, how you will reach them, and that you will call or text 988 in a crisis, or call 911 if anyone is in immediate danger. Keep the program's crisis and referral information with this plan.
5. Keep your page. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — Managing Co-Occurring Mental Health Conditions

- **Recovery education only — no diagnosis, no treatment.** This group teaches general information and steadiness skills. Facilitators do not assess, diagnose, label, or interpret any client's condition, symptoms, or history, and do not use clinical language about any individual. Do not ask clients to describe symptoms or name diagnoses. A client who asks what they have, or what treatment they need, is connected to clinical and medical staff the same day.
- **Same-day referral, every time.** Any disclosure of worsening mental distress, hopelessness, trauma material needing care from the counselor, uncontrollable anger, or a medication concern is routed to staff the same day through program procedure. The facilitator stays with the client, steadies the room, and makes the connection — the group does not become the treatment.
- **Crisis protocol, stated plainly.** If a client expresses thoughts of suicide or self-harm, or describes a plan or intent, follow the Facilitator Guide crisis protocol immediately: stay with the person, do not leave them alone, alert the Program Director or on-call supervisor at once, and use the crisis resources — call or text 988 for the Suicide and Crisis Lifeline, and call 911 if anyone is in immediate danger. Do not promise secrecy, do not minimize what was said, and do not attempt to assess risk yourself. See the escalation box at the front of this packet.
- **Medication affirmed; decisions referred.** Facilitators affirm clients who use medication exactly as prescribed, never advise a client to start, stop, or change any medication, and refer every medication question to medical staff the same day. Skills support care; they never replace it, and a client is never told that skills alone are enough when care from the counselor or medical providers is needed.
- **Warrior close:** Close with steadiness and the open door: “Two struggles, one whole person, one coordinated plan — and help the same day you ask for it. Use your skills, stay with your care, and reach out early. That is how warriors hold the line.”

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration. Substance Use Disorder Treatment for People With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42 — integrated treatment of co-occurring substance use and mental disorders, phased treatment, and the principle that both disorders are addressed together in a coordinated plan. National Institute on Drug Abuse. Common Comorbidities with Substance Use Disorders Research Report — the three pathways linking substance use disorders and mental illness: shared risk factors, mental illness contributing to substance use, and substance use contributing to mental illness; and the need for an integrated approach

that evaluates each disorder concurrently.

Recovery-support evidence: Substance Abuse and Mental Health Services Administration. Co-Occurring Disorders — integrated treatment and the “no wrong door” principle: a person seeking help for a mental disorder is routinely screened for substance use disorder, and a person seeking help for substance use disorder is screened for mental disorders, with treatment provided directly or through appropriate referral. Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57 (2014) — trauma-informed principles of safety, choice, and avoiding re-traumatization, as the background for how this group handles trauma responses. No outcome is promised for this group.

Note: No outcome is promised for any group in this packet.