CareCertify LLC

Co-Occurring Disorders 12-Hour Series

COD-01

Foundations of Co-Occurring Care

Participant Guide

Co-Occurring Disorders 12-Hour Series · Audience: Treatment Directors · Supervisors · Nurses · Counselors

Updated July 2026 — aligned to Minn. Stat. 245G.13, subd. 2(f) competencies

One person, one team, one plan

Foundations of Co-Occurring Care opens CareCertify's Co-Occurring Disorders 12-Hour Series — Minnesota 245G co-occurring disorders training built for licensed substance use disorder treatment programs. Co-occurring mental health and substance use disorders are the rule in SUD treatment, not the exception: roughly half of people with a substance use disorder will also experience a mental health disorder. This lesson establishes the philosophy that the rest of the series builds on — both disorders are primary, and they are treated together by one team in one plan.

Learning Objectives — by the end of this module you will be able to:

- Define co-occurring disorders and explain why both conditions are treated as primary
- Describe Minnesota's 12-hour co-occurring training rule and who it applies to
- Contrast integrated care with parallel and sequential approaches
- Explain 'no wrong door' and what it means for your program
- Recognize how untreated mental health symptoms undermine SUD recovery
- Identify your role on the integrated team — and its limits

Section 1: Why co-occurring care matters

In SUD treatment, co-occurring is the rule — not the exception.

- **Half your caseload.** Roughly half of people with a substance use disorder will also experience a mental health disorder — and vice versa.
- **Symptoms wear disguises.** Depression looks like low motivation. Anxiety looks like resistance. Untreated symptoms get misread as noncompliance.
- **Treating half fails.** Address the substance use alone, and untreated mental illness keeps pulling the client back toward relapse.
- **The rules require it.** Minnesota's 245G standards build co-occurring competencies into screening, assessment, planning, and staff training.

Section 2: What 'co-occurring' means

At least one mental health disorder and one substance use disorder — together.

- **One person, two disorders.** A mental health disorder and a substance use disorder, active in the same person during the same period of time.
- **They interact.** Each worsens the other: symptoms drive use, use intensifies symptoms, and withdrawal can mimic mental illness.
- **Any combination counts.** Depression and alcohol, PTSD and opioids, bipolar disorder and stimulants — there is no single pattern to watch for.

Section 3: The 12-hour training rule

Minn. Stat. 245G.13, subd. 2(f) — the requirement this series meets.

- **Hours of training.** Treatment directors, supervisors, nurses, and counselors must have at least 12 hours of co-occurring disorders training.
- **Months for new staff.** A new staff member who hasn't had the training must complete it within six months of employment.
- **Prior credit counts.** Relevant training obtained before employment may be credited — documented in the personnel file.

This series delivers all eleven required competencies across twelve one-hour lessons.

Section 4: Sequential treatment

Treat one disorder first, then the other — and lose people in between.

- **How it works.** The client must 'finish' one treatment before the other begins — sobriety first, therapy later.
- **The wait.** Mental health symptoms don't pause while a client works on sobriety — they sabotage it.
- **Who gets lost.** Clients bounced between systems tend to drop out in the gap between programs.
- **When it fits.** Rarely the plan of choice — only when acute stabilization truly must come first.

Section 5: Parallel treatment

Two providers, two plans — and the client carries the coordination.

- **How it works.** The client sees a SUD program and a separate mental health provider at the same time.
- **Split messages.** Two teams that don't talk can give conflicting advice on medications, priorities, and goals.
- **The burden.** The clients least able to coordinate care are asked to be their own case managers.
- **Make it work.** If care must be parallel, signed releases and active coordination pull it closer to integrated.

Section 6: Integrated treatment

One team, one plan, both disorders — the standard your program aims for.

- **How it works.** The same team addresses mental health and substance use together, in one treatment plan.

- **Why it wins.** Better engagement, fewer crises, and stronger recovery than split approaches deliver.
- **What it takes.** Cross-trained staff, screening at the door, consultation pathways, and shared documentation.
- **Your part.** Every staff member who can spot both disorders moves the program toward integration.

Section 7: How the disorders feed each other

Six patterns you will see again and again in co-occurring work.

- **Self-medication.** Drinking or using to quiet symptoms — until relief becomes its own disorder.
- **Masked symptoms.** Intoxication and withdrawal mimic depression, anxiety, even psychosis.
- **Costs pile up.** Jobs, money, and relationships strain under the weight of both disorders.
- **Unstable housing.** Losing safe housing worsens symptoms and puts recovery further away.
- **Relapse loop.** Untreated symptoms trigger use; use deepens symptoms; repeat.
- **Missed care.** Each system treats its half and misses the whole person.

Section 8: No wrong door

Wherever a client enters, they've come to the right place.

- Every entry point — SUD, mental health, or primary care — is the right one
- Screen for both disorders at the door, no matter which door it is
- Never turn someone away for having 'the wrong diagnosis' — connect them
- Welcome clients back after relapse or dropout, without shame
- Your job is to open doors, not to guard them

Section 9: Both disorders are primary

No chicken-or-egg debates — treat what's in front of you.

- **Primary, together.** Neither disorder is 'just a symptom' of the other. Each needs its own attention, in one plan.
- **Don't wait.** Treatment for each begins as soon as it's identified — not after the other is 'fixed.'
- **One person.** Clients don't experience two separate illnesses — they experience one hard life. Care should feel whole too.

Which came first matters less than what keeps both going — treat the person, not the order.

Section 10: The integrated client journey

This series follows the client's path through your program.

1. Welcome and screen (COD-04)
2. Assess all six dimensions (COD-05)
3. Diagnose and recommend care (COD-06)
4. Plan with the person (COD-07)
5. Treat, document, adjust (COD-08–10)
6. Coordinate and discharge (COD-11–12)

Recognition skills (COD-02) and trauma-informed care (COD-03) run underneath every step of this path.

Section 11: What integrated care delivers

Decades of practice point in the same direction.

- **People stay.** Clients stick with treatment longer when their mental health is taken seriously from day one.
- **Crises shrink.** Fewer emergencies and hospitalizations when symptoms are managed inside the program.
- **Recovery holds.** Sobriety built alongside mental health care survives stress that would break it standing alone.
- **Staff burn less.** Clear roles and shared plans replace the frustration of 'nothing works with this client.'

Section 12: Who does what on an integrated team

Integration is a team sport with clear positions.

- **Counselors.** Screen, build the plan with the client, deliver SUD treatment, and weave mental health goals in.
- **Nurses & prescribers.** Manage medications for both disorders and watch for interactions and side effects.
- **Directors & supervisors.** Build the policies, training, consultation pathways, and culture that make integration possible.

Section 13: Attitudes that make integration work

Philosophy shows up in how you talk and act.

- **Person-first.** Say 'a person with a substance use disorder' — the disorder is what they have, not what they are.
- **Recovery is expected.** People recover from both disorders every day. Treat every client as someone who can.
- **Symptoms aren't choices.** Depression isn't laziness; anxiety isn't resistance. Respond to illness as illness.
- **Meet them where they are.** Motivation is yours to help build — not a prerequisite the client must bring.

Section 14: Your role — and its limits

Integration doesn't mean everyone does everything.

- **Notice & document.** Observe changes in mood, thinking, and behavior — and record facts, not diagnoses.
- **Screen & refer.** Use approved screening tools and connect positive screens to qualified assessors.
- **Never diagnose alone.** Mental health diagnosis belongs to mental health professionals — consultation exists for a reason.
- **In your lane, loudly.** Working within scope isn't passivity: raise concerns, consult, and follow up.

Apply It — Scenarios

Scenario 1: The 'motivation problem'
A counselor vents about a client: 'He sleeps through morning group, contributes nothing, and I don't think

he wants recovery.' You know he screened positive for depression at intake — but no one followed up.
The right response: → Reframe it: sleeping through group and flat participation are textbook depression symptoms. → Follow up on the positive screen — a referral for assessment should have happened, and still can. → Raise it through your supervisor or consultation pathway rather than letting 'unmotivated' stand. → Document observations — facts about sleep and participation, never labels or diagnoses.

Scenario 2: Two providers, two stories
A client sees an outside therapist for PTSD. The therapist wants to process trauma now; her counselor fears it's destabilizing early recovery. The client is stuck in the middle, hearing two different plans.
The right response: → This is parallel care splitting — the fix is coordination, not picking a winner. → Get a release signed so the counselor and the therapist can actually talk. → Bring both providers to one shared plan for pacing trauma work alongside recovery. → Keep the client's voice at the center — it's her plan, built with her, not around her.

Key Terms

Term	What it means
Co-occurring disorders	A mental health disorder and a substance use disorder active in the same person.
Integrated treatment	One team treating both disorders in one coordinated plan.
Parallel treatment	Separate providers treating each disorder at the same time.
Sequential treatment	Treating one disorder first and the other later — the weakest approach.
No wrong door	Every entry point connects a client to help for both disorders.
Both primary	Neither disorder waits; each gets treatment from the start.
Dimension 3	The ASAM dimension covering emotional, behavioral, and cognitive conditions.
Scope of practice	The boundaries of what your license and training allow you to do.

Check Your Understanding

7. Why does co-occurring competence matter for every clinical staff member at a 245G program?
8. Under Minnesota's rule, who must have at least 12 hours of co-occurring disorders training?
9. When does a sequential approach genuinely fit?
10. Which of these is part of what integration takes to build?
11. What does 'no wrong door' mean in practice?
12. Which outcome is a payoff of integrated care?
13. What does 'in your lane, loudly' mean?

Looking ahead
Next, COD-02: Recognizing Mental Health Disorders — what depression, anxiety, PTSD, and more look like in treatment.

References

Minn. Stat. 245G.13, subd. 2(f) (12-hour co-occurring training requirement); Minn. Stat. ch. 245G (SUD program licensing).

Content current as of July 2026.