

TREATMENT OF CO-OCCURRING DISORDERS: ELEMENTS OF QUALITY TREATMENT

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There is an emerging consensus that better integrated systems of care will benefit substance abuse and mental health services for all people seeking care, not just those with co-occurring disorders (Osher, 1996). Currently, however, substance abuse and mental health services are largely provided in separate treatment systems with separate funding sources and reporting requirements. Within this current framework, appropriate care can be administered by either substance abuse or mental health treatment centers as long as sufficient attention is given to the unique needs of individuals with co-occurring disorders.

Integrated treatment may be defined as simultaneous treatment of all disorders and it can be provided appropriately in many different contexts. Integrated treatment may be provided by a single, dually-trained clinician, or by a coordinated team of service providers whose membership is competent in the treatment of co-occurring disorders. Ideally, team members should work within a single agency, but where necessary multiple agencies may collaborate as a unified team. This integrated team then has the charge to develop an integrated, coordinated treatment plan that addresses the interconnectedness and complexity of psychiatric and substance-related illnesses.

Several panels of experts have suggested general elements comprising quality treatment for persons with co-occurring disorders. In 1997, SAMHSA convened a national advisory panel to develop a report on services for individuals with co-occurring disorders. That same year, NIDA produced a research monograph (#172) written by national experts to address issues related to dual diagnosis¹. Key elements of treatment from these panel reports are summarized as follows:

- Staff must be cross-trained in the treatment of co-occurring disorders. Continuity in treatment is critical to avoid sending “mixed” messages to patients.
- Motivational enhancement techniques are used to facilitate engagement of patients, encourage progress toward abstinence by re-framing maladaptive behavior and building self-efficacy.
- Behavioral intervention strategies may also be quite valuable in addressing fundamental training in social skills, symptom management, and behavior change.
- Case management is used to attend to the range of clinical, housing, social, or other needs that may be affected by either substance abuse or mental health problems.
- Treatments must be appropriate and sensitive across culture, ethnicity, and gender.
- Treatment programs must take a long-term perspective that identifies and treats patients across stages of treatment, relapse, and recovery. This includes the recognition that treatment and recovery are not linear. Relapse is an inherent characteristic of chronic episodic disorders,

1. Treatment of drug-dependent individuals with comorbid mental disorders, National Institute on Drug Abuse, 1997

and it is an expected feature in recovery from serious mental illnesses and substance use disorders.

- Specific interventions should be tailored to the patient's stage of recovery: engagement, persuasion, active treatment, or relapse prevention.
- Group interventions are used to provide peer support, persuade patients to address substance abuse behavior, and to share coping strategies. Psychoeducation is a critical part of this process, wherein patients can learn about their psychiatric disorders, the effects of substance abuse, and the interactive relationship of substance abuse and mental illness.
- Self-help groups serve a key role in encouraging recovery through peer relationships and mutual support. Self-help groups must be sensitive to issues of dual diagnosis (e.g., Dual Recovery Anonymous).
- Where possible, treatment should involve the patient's social network and/or family members to address factors that maintain substance use, help patients progress toward personal goals, and bolster resistance to relapse.
- Treatment models should be based on rehabilitation and recovery concepts, as well as appropriate medical interventions, and which eschew judgmental and moralistic overlays.
- The development and use of therapeutic alliance to foster patient engagement in the treatment process, patient consistency in treatment, and positive treatment outcomes.
- A sense of optimism among staff. Data support the effectiveness of treatment for co-occurring disorders, with integrated approaches demonstrating the highest degree of effectiveness.
- The recognition that a small percentage of patients will require a high level of intensive treatment and related services, and that most patients/patients will respond to integrated services.

Available online at

<http://www.state.tn.us/mental/mhs/3680TraingManual.pdf>