Comorbidity should be expected, not considered an exception. Consequently, the family therapy or significant family/parental involvement in treatment should be a whenever possible, component of treatment. The adolescent’s family should be engaged/involved in treatment and parent management/training should be a component of the treatment plan. The adolescent’s family should be engaged/involved in treatment and parent management/training should be a component of the treatment plan.

Developments in the treatment of adolescents with co-occurring psychiatric and substance use disorders differ in important ways from adults and developmental differences may impact expectancies, response to interventions, adherence, and treatment outcomes (Dean et al., 2000). Systems of care for adolescent substance use disorders should take into account the developmental stage of the individual, strengths, and weaknesses. Developmental differences exist in pharmacodynamics and treatment outcomes. It is important to consider the adolescent’s developmental stage, strengths, and weaknesses when developing treatment plans.

We conducted a series of English-language medical literature searches using PubMed and PsycINFO using the search terms “adolescent,” “youth,” “adult,” “systems of care,” “best practices,” “guidelines,” “substance abuse,” “substance dependence,” “substance use disorder,” “adolescent,” “psychiatric disorders,” and “co-occurring psychiatric and substance use disorders,” “dual diagnosis.” We manually searched reference lists of pertinent original research articles, review articles, and textbooks for relevant citations that we searched missed. Articles were selected if they provided guidelines or best practices (1) for the development and implementation of a co-occurring psychiatric and substance use disorder system of care and (2) for assessment, treatment, and psychopharmacological interventions for individuals with co-occurring psychiatric and substance use disorders.

System of Care Practice Guidelines

1. Comorbidity should be expected, not considered an exception. Consequently, the whole system must be designed to be welcoming and accessible to patients with all types of dual diagnoses.
2. Psychiatric and substance use disorders should be regarded as primary disorders, when they occur, requiring specific and appropriate interventions, diagnosis, and treatment, in accordance with established practice guidelines.
3. Severe psychiatric and substance use disorders are chronic, relapsing illnesses that can be conceptualized using a disease and recovery model, with phases of treatment or recovery.
4. The system should promote a longitudinal perspective on the treatment of patients with dual diagnoses, diagnosing the value of continuous relationships with patients and their families.
5. Whenever possible, treatment of persons with complex comorbid disorders should be provided by teams, or programs with expertise in mental health and substance use disorders.
6. The system should address the interdependencies of patients with similar conditions, engaging patients and their families in the selection of interventions and treatment outcomes.
7. Adherence should not be designed to prevent recidivism from resolving services that cannot fit the needs of the patient, but with patients who are in the process of treatment. When possible, treatment of patients with dual diagnoses should be provided by teams, or programs with expertise in mental health and substance use disorders.