INTRODUCTION

Approximately five million adults in the United States have co-occurring disorders (Substance Abuse and Mental Health and Human Services Administration [SAMSHA], 2006). “Co-occurring disorders” denotes the simultaneous diagnosis of a substance use disorder and a serious mental illness. An individual with co-occurring disorders may have one or more substance use disorder in addition to one or more serious mental illness (SAMHSA, 2006). A substance use disorder includes abuse or dependence on alcohol or other drugs as classified in the Diagnostic and Statistical Manual of Mental Disorders 4th edition Text Revision [DSM-IV-TR] [American Psychiatric Association [APA], 2000]. A serious mental illness includes a mental, behavioral or emotional disorder that an individual is currently presenting or has presented within the last year. A serious mental illness also meets criteria specified in the DSM-IV-TR (APA, 2000; Center for Substance Abuse Treatment [CSAT], 2007a) resulting in functional impairment that substantially interferes with or limits one or more major life activities including self care, mobility, social and family life, educational and vocational performance, and community participation (CSAT, 2007a; Kessler et al., 2003).

Co-occurring disorders affect both men and women and can vary with regard to the combination and number of disorders, severity, chronicity, disability, and degree of impairment in functioning. (CSAT, 2005). However, SAMHSA (2006) reports that co-occurring disorders are almost twice as prevalent among women as men, 54% and 28% respectively. Further, studies have noted patterns in the presentation of co-occurring disorders among women, who are likely to have distinct presenting problems, reasons for seeking treatment, patterns of engagement, and treatment needs (DiNitto, Webb, & Rubin, 2002; Nicholson et al., 2006; CSAT, 2005). This fact sheet highlights some of these patterns and describes challenges and best practices in assessing, screening, and treating women with co-occurring disorders.

UNDERSTANDING WOMEN WITH CO-OCCURRING DISORDERS

Presenting Problems and History

In comparison to men, women with co-occurring disorders display greater substance use severity, engage in more polysubstance use, and are more likely to use primary substances on a daily basis (Mangrum, Spence, & Steinley-Bumgarner, 2006). Studies also show that women with co-occurring disorders have problems in multiple contexts of life (DiNitto et al., 2002; Office of Applied Studies [OAS], 2004c; Mangrum et al., 2006). They are more likely than men to be poor, possess fewer job skills, receive public assistance, report more relatives with alcohol and drug problems, care for more dependents, and report more psychosocial problems. (Alexander, 1996; DiNitto et al., 2002; Mangrum...
et al., 2006). Additionally, women with substance use disorders are also more likely than men to have low self esteem and mood, anxiety, eating and personality disorders (CSAT, 2005; Stromwall & Larson, 2004).

These women are likely to have a history of victimization, homelessness, and have experienced violence (Clark & Power, 2005; Nicholson et al., 2006). In their review of the literature, Cohen and Hien (2006) found that 30 - 59 percent of women with substance use disorders have co-occurring post traumatic stress disorder (PTSD). Clark & Power (2005) note that “Sexual abuse and physical abuse...and other forms of interpersonal violence disproportionately affect women and intertwine with the development of both substance abuse and mental health problems” (pp.1).

Another study suggests that women with co-occurring disorders experience a greater frequency of medical problems and emergency room visits than men (Mangrum et al., 2006). Specifically it has been found that women with co-occurring disorders have a high prevalence of musculoskeletal problems, respiratory diseases, hepatitis, circulatory system diseases, and HIV/AIDS (Larson et al., 2005; Becker et al., 2005). Finally, women with co-occurring disorders are more likely to have more episodes of treatment for substance abuse (OAS, 2002) and have higher rates of relapse and hospitalization (Drake et al., 2001) compared with women with either mental illness or substance use disorders alone.

**Help-seeking and Treatment Demographics**

Many women with co-occurring disorders do not receive treatment designed to address both mental health and substance abuse problems (CSAT, 2005; Epstein, Barker, Vorburger, & Murtha, 2004; OAS, 2004c). According to the OAS, in 2005, 38.4 percent of adults in the United States with co-occurring mental health and substance abuse disorders sought either mental health or substance abuse treatment, while only 8.5 percent of this group received both types of services (SAMHSA, 2006). A study by Watkins (2004) found that 50 percent of adults screened at outpatient substance abuse treatment programs showed indicators of a probable mental health disorder, and that the majority of these were women. Thus, it may not come as a surprise that women with co-occurring disorders are more likely than men to receive mental health services (Epstein et al., 2004; National Survey on Drug Use and Health [NSDUH], 2004); and that these services are often provided through substance abuse treatment facilities, particularly residential and rehabilitative settings (OAS, 2004a).

In 2001, a majority of the adults with co-occurring disorders who sought treatment in substance abuse treatment facilities were White (74%), 15% were Black, and 7% were Hispanic (OAS, 2004a). This represents a sharp contrast from the racial/ethnic distribution of all other substance abuse treatment admissions, which were 57% White, 23% Black and 7% Hispanic (OAS, 2004a). However, OAS (2004a) does not provide any additional information to explain these admission demographics.

**Treatment Challenges**

Women with co-occurring disorders can be difficult to engage, successfully treat, and retain in treatment (Nicholson et al., 2006). Barriers to treatment include long waiting lists, lack of available services, lack of knowledge of where to access services, complicated admission procedures, and being treated poorly (Becker et al., 2005). Caring for dependent children also represents one of the
most significant barriers for women in treatment (CSAT, 2001; Nicholson et al., 2006). In addition, a variety of philosophical, administrative, financial, policy, family and consumer barriers can encumber women with co-occurring disorders (Drake et al., 2001; SAMHSA, 2002; Mangrum et al., 2006). For many years women who have sought treatment for either substance abuse or mental health problems have been told to come back when their other problem is under control (Drake et al., 2001). In addition, separate and distinct professional training, and vastly different federal policies and funding for each system, continue to make treatment fragmented and difficult for consumers to utilize (Becker et al., 2005; Drake et al., 2001). Although much work needs to be done, federal agencies such as SAMHSA are working to help reduce barriers to treatment for individuals with co-occurring disorders through the “no wrong door” approach (CSAT, 2007d). This approach makes treatment available at multiple points of entry through various service systems. In addition, SAMHSA is providing training and education, and promoting provider accountability, flexibility and responsiveness directed toward increasing service capacity, improving integration, efficiency and access to treatment for co-occurring disorders.

SCREENING AND ASSESSMENT

Screening

A CSAT (2007c) publication states that the process of screening “determines the likelihood that a client has co-occurring substance use and mental disorders or that his or her presenting signs, symptoms, or behaviors may be influenced by co-occurring issues” (pp. 1). A comprehensive screening process also explores a variety of service needs that can include medical, housing, victimization, and trauma needs, among others. Because many individuals with co-occurring disorders are unable to navigate fragmented health, mental health, and substance abuse treatment systems and often feel rejected when attempting to access help, screening for problems in all areas is the first step toward effective treatment outcomes (Drake et al., 2001; SAMHSA, 2001; CSAT, 2007c).

Integrated screening helps providers identify multiple areas of need and plan treatment accordingly (CSAT, 2007c). Screening is particularly effective when it is implemented with a “no wrong door” approach, where an evaluation of needs occurs anywhere that a woman with co-occurring disorders presents for treatment (CSAT, 2007e). When consistently delivered across treatment systems, this approach ensures that a woman can be treated, or referred for treatment, whether she initially seeks help for a substance abuse problem, mental illness, or a general medical condition (SAMHSA, 2006). To support this approach, screening needs need to be offered in the health and human services context, criminal justice system, in homeless services, educational systems and all other settings in which women receive care (CSAT, 2007c).

Although no screening technique is foolproof, several brief, self report instruments have been clinically useful to alert professionals in multiple settings of potential health and mental health problems, and drug and alcohol abuse or dependence (Sacks, 2007). Examples of these screening tools include The Mental Health Screening Form-III [MHF-III] (Carroll & McGinley, 2001), the Modified Dartmouth Assessment of Lifestyle- 14 items [Modified DALI-14] (Alexander et al., 2006), Global Appraisal of Individual Needs- Short Screener [GSS] (Chestnut Health Systems, 2005; Dennis, Chan, & Funk, 2006), and the Psychiatric Diagnostic Screening Questionnaire [PDSQ] (Zimmerman and Mattia, 2001).
Assessment

Conducting a thorough and timely assessment represents a critical component in the process of recovery for women with co-occurring disorders (SAMHSA, 2002). The process of assessment can include a variety of information gathering methods such as assessment instruments, in-depth clinical interviews, review of social and treatment history, review of medical and psychiatric records, a physical examination, laboratory tests, interviews with collaterals, and interviews with friends and family (Sacks, 2006; CSAT, 2007c). At the most basic level, assessment for co-occurring disorders provides a foundation for treatment when it includes the establishment of a formal diagnosis, limitations and strengths in the level of functioning, and motivation for treatment (CSAT, 2005; CSAT, 2007c). In addition, other cultural, gender-specific and legal issues need to be explored (CSAT, 2005; Sacks, 2006; CSAT, 2007c). Numerous tools are available to help mental health and substance abuse treatment providers in the assessment process (CSAT, 2005; Sacks, 2006).

TREATING WOMEN WITH CO-OCCURRING DISORDERS

Expert consensus and empirical evidence have uncovered a number of best practices for treating co-occurring disorders in women (CSAT, 2005). In comprehensive reviews of the literature, Drake et al. (2001) and CSAT (2007g) agreed that effective treatment for individuals with co-occurring disorders incorporates the following program level components and specific therapeutic approaches: a long term approach to recovery; integrated mental health and substance abuse treatment; comprehensive focus; modified therapeutic communities; stagewise treatment; motivational interventions; contingency management, attention to women’s relationships; assertive outreach; and cognitive behavioral interventions. Following is a brief overview of each of these approaches.

Long-term Approach to Recovery

The presence of co-occurring disorders strongly influences the duration of treatment provided (Cohen & Hein, 2006). Specifically, women with co-occurring disorders are not likely to achieve stability and functional improvements quickly (Drake et al., 2001). For this reason, Cohen & Hein (2006) state that longer treatment than that typically used in substance abuse treatment alone may lead to improved outcomes. In fact, effective programs have used a long term recovery approach to help clients achieve stability longer after treatment (Drake et al., 2001). In a study comparing treatment outcomes with length of stay in two types of residential programs with clients who had not responded to previous outpatient treatment, Brunette, Drake, Woods, and Harnett (2001) found that the clients in the long-term program for an average of 624.9 days were more effectively able to reduce or eliminate active substance use compared with those in short-term treatment for an average of 66 days. Individuals in the long term program group also were less likely to experience homelessness post-treatment compared with the short-term group (Brunette et al., 2001).

Integrated Treatment

Integrated treatment can be defined as coordinated substance abuse treatment and mental health treatment delivered by the same clinician or teams of clinicians (El-Guebaly, 2004; Kranzler & Tinsley, 2004; Mueser et al., 2003; SAMHSA 2006). Mental Health and substance abuse services are also offered in separate settings (i.e., parallel treatment) or for the more acute disorder first (i.e.,
sequential treatment) (Mueser et al., 2003; Kranzler & Tinsley, 2004). However, expert consensus and emerging empirical evidence indicate that integrated services are the preferred method of service delivery (CSAT, 2005), particularly because clients with co-occurring disorders frequently have difficulty navigating multiple treatment systems (CSAT, 2007d).

Mueser et al. (2003) and CSAT (2007e) document that integrated treatment has several advantages. It eliminates organizational and administrative lapses because no coordination is required between different service providers; clinical problems that may arise by treating one disorder before another is avoided; conflicting philosophical perspectives of mental health and substance abuse professionals on treating dual disorders is minimized; access to services on behalf of consumers is improved; and clients experience an improved adherence to treatment plans because substance abuse and mental health interventions are supported (Mueser et al., 2003; CSAT, 2007e).

As mental health and substance abuse treatment systems join together, treatment providers in both fields can use a conceptual model, a four-quadrant framework, to provide and appropriate level of integrated services (Minkoff, 2005). Although a full discussion of this model is not possible here, this four-quadrant framework outlines substance use and mental health symptom severity and level of service system coordination (Minkoff, 2005). It also highlights a range of service possibilities from consultation and collaboration to integration (SAMHSA, 2002). In this context, consultation includes referrals and requests for exchange of information from an agency designed to treat only one disorder to an agency focused on treating the other disorder (CSAT, 2005). Consultation is important during identification, prevention, or early intervention with individuals with less severe co-occurring disorders (CSAT, 2005). Collaboration is necessary when a woman can be treated at an agency designed to treat primarily either mental illness or substance abuse. When this occurs, providers can share written releases and delineate formal roles in the treatment relationship (CSAT, 2005). Individuals with severe mental illness and substance abuse symptoms need to be treated in a program that offers a range of mental health and substance abuse treatments at a single site. Programs with fully integrated services combine the contributions of mental health and substance abuse treatment staff or cross-trained clinicians and incorporate treatments for mental health and substance abuse into a single treatment plan (CSAT, 2005).

**Comprehensive Focus**

For many women with co-occurring disorders, effective treatment often requires addressing multiple aspects of life as simultaneously as possible (Becker et al., 2005; SAMHSA, 2002; Savage et al., 2007). These women commonly need assistance managing both mental illness and substance use disorders while also pursuing functional goals related to housing, income, education and parenting (SAMHSA, 2002). Drake and colleagues (2001) reported that programs, which do offer a full continuum of services, often do so through linkage with other organizations and, together, provide effective services.

**Modified Therapeutic Communities**

Modified Therapeutic Communities have proven effective in modifying drug abuse behavior and reducing psychological symptoms (Stohler & Rossler, 2005). Studies have reported that individuals receiving services from Modified Therapeutic Communities demonstrate reduced frequency of drug
use, decreased criminality, increased employment, reduced HIV risk (De Leon, Sacks, Staines, & McKendrick, 2000), improved mental health, and improved access to housing (Sacks, Banks, McKendrick, & Sacks, 2008).

In order to best serve the needs of women with co-occurring disorders, several considerations may be taken into account when delivering services through therapeutic communities. Essential to women with co-occurring disorders is empowering and providing for self determination by involving them in the development of treatment plans and maximizing their choice in group treatment (Savage et al., 2007). Mixed-gender programs have successfully integrated women into their services by incorporating strong policies related to sexual harassment and safety, and by having a strong presence of female staff (CSAT, 2005). However, Stromwall and Larson (2004) state that if group treatment is used, it should be gender-specific in order to more successfully develop trust among the women. It also is critical to provide culturally sensitive interventions (Drake et al., 2001; Watkins et al., 2001), and offer or connect clients with modified 12-step self help groups (Evans & Sullivan, 2001; Mueser et al., 2003; SAMHSA, 2002).

**Stagewise Treatment**

Drake et al. (2001) and SAMHSA (2002) note that staged interventions have been an effective and valuable tool to help clinicians engage and retain clients in treatment by matching treatment approaches to each client’s stage of motivation and treatment engagement. Two models have been created to help clinicians effectively target treatment interventions to people with co-occurring disorders (SAMHSA, 2002). One conceptual model suggests that individuals progress through four stages with separate clinical tasks (Drake et al., 2001; Mueser et al., 2003). During the engagement phase, clinicians give explicit attention to forming a trusting client-clinician relationship. In the persuasion phase, a practitioner’s task is to help a client develop motivation to engage in treatment. During active treatment, clients work to acquire skills and functional support for achieving goals. In the fourth stage, clients can use strategies for maintain recovery and preventing relapse (Mueser et al., 2003).

Prochaska and DiClemente (1992) developed a similar five-stage model for clients in substance abuse treatment, that has been adapted for use with individuals with co-occurring disorders (Mueser et al., 2003; Smith, 2007). This model suggests that clients experience different phases of motivation in treatment referred to as precontemplation, contemplation, determination, action, maintenance, and relapse prevention as they progress to healthy recovery (Prochaska & DiClemente, 1992). Movement between stages and regression to earlier stages is common but clinicians can use both these models to appropriately adapt treatment strategies to a client’s stage of treatment engagement (Drake et al., 2001).

**Motivational Interviewing**

Motivational interviewing, also known as motivational enhancement, is a specific technique based on theories of change (Miller & Rollnick, 2002; Prochaska & DiClemente, 1992). This technique is used with individuals with co-occurring disorders to enhance intrinsic motivation, explore and resolve ambivalence, and develop strategies for change (Mueser et al., 2003; Smith, 2007). Key elements of
this technique include expressing empathy, developing discrepancy, rolling with resistance, and supporting self efficacy (Miller and Rollnick, 2002). Mueser et al. (2003) adds another element to this technique: establishing personal goals. Evidence suggests that motivational interviewing is a promising approach to enhance treatment engagement and improve outcomes (Caroll, 2004). In fact, programs have effectively used this technique with women with co-occurring disorders to improve participation in substance abuse treatment; reduce consumption of substances; and increase abstinence rates, social adjustment, and successful referrals to mental health treatment (SAMHSA, 2002).

**Contingency Management**

Contingency management approaches provide incentives or rewards for clients who evidence target behaviors or reach treatment goals (Carroll, 2004). These rewards may include vouchers for goods and services among other rewards (Carroll, 2004; Evans & Sullivan, 2001). Several studies have demonstrated that contingency management can reduce substance use (Carroll, Ball, Nich, O’Conner, Eagan, Frankforter, Triffleman, Shi, & Roussaville, 2001; Roll, Chermack, & Chuddzynski, 2004), increase treatment retention (Carroll et al., 2001), and improve adherence to medication (Rigsby, Rosen, Beavais, Cramer, Rainey, O’Malley, Dieckhaus, & Rounsaville, 2000).

**Attention to Women’s Relationships**

Relationships are an important component of the engagement and healing process for women with co-occurring disorders (CSAT, 2005; Tracy & Johnson, 2007). Because many women have experienced trauma and previous victimization (Cohen & Hien, 2006; Nicholson et al., 2006; Savage et al., 2007), positive, healthy and empathetic relationships and bonding among women are critical. In addition, treatment providers need to address the role of relationships in initiating and maintaining women’s substance use (CSAT, 2005; Tracy & Johnson, 2007), as well as the importance of relationships with children as a source of motivation for treatment (CSAT, 2005; Nicholson et al., 2006). Research also suggests that relationships with staff are critical in engaging and retaining clients (Becker et al., 2005).

Treatment providers can take several steps to enhance women’s relationships. When feasible, providers can support the mother-child relationship by offering onsite childcare and allowing children to accompany their parent in residential treatment (CSAT, 2001; CSAT, 2005). In addition, clinicians can explore the link between substance use and past and current relationships (CSAT, 2005; Tracy & Johnson, 2007). Because support networks are also crucial for maintenance of change after treatment, providers can foster re-integration among family members and promote positive ties among extended families, kinship networks and friends as an explicit component of treatment (CSAT, 2005; Tracy & Johnson, 2007).

**Assertive Outreach**

Assertive outreach, also known as Assertive Community Treatment (ACT), has been adapted from traditional case management methods for individuals with co-occurring disorders to help engage clients in treatment (Mueser et al., 2003; SAMHSA, 2002). Assertive outreach has also proven effective in monitoring and assisting in improving the course of dual disorders (Mueser et al., 2003). Common elements of this approach include extensive outreach, small case loads, an increased frequency of contacts with clients, assistance with basic needs (e.g., housing), a multidisciplinary team approach,
provision of substance abuse treatment and mental health services within the same team, and strong focus on the interrelationship between mental health and substance abuse (CSAT, 2005; SAMHS, 2002). In a review of the literature, Mueser et al. (2003) suggest that ACT can increase adherence to prescribed medication, reduce hospitalizations, decrease symptom severity, and improve quality of life.

**Cognitive-Behavioral Interventions**

Cognitive Behavioral Therapy (CBT) has been used successfully with individuals with co-occurring disorders to identify and replace self-defeating beliefs and actions with thoughts and behaviors oriented towards coping (CSAT, 2005; SAMHS, 2002; Smith, 2007). For example, CBT has been used to help individuals with co-occurring disorders to avoid high risk situations for substance abuse, challenge faulty beliefs around substance abuse, learn new coping skills (e.g. assertiveness) and management of feelings (e.g. relaxation skills), and change the consequences for the behavior (Evans & Sullivan, 2001). This is achieved through psychoeducation, role playing, imagery exercises and homework assignments (Evans & Sullivan, 2001; Smith, 2007).

CBT is commonly delivered through an individual or group modality, and several approaches are being tested and continually refined for individuals with co-occurring disorders (CSAT, 2005; SAMSHA, 2002). One CBT-based intervention model for women with PTSD and substance use disorders may be particularly promising (Najavits, 2002). This model, called Seeking Safety, has been shown to reduce symptoms of PTSD and substance use in a controlled clinical trial (Hein, Cohen, Miele, Litt, & Capstick, 2004). Seeking Safety teaches women coping skills, techniques to detach from emotional pain, self care, and exploring old ways of thinking and changing self-talk (Najavits, 2002). In addition, Weis, Najavits and Greenfield (1999) have developed a 20 session CBT relapse prevention group for people with co-occurring bipolar and substance use disorders. This group uses two trained therapists who use non-confrontational methods to help clients gain skills in avoiding high-risk situations that commonly lead to relapse. This program also helps clients to address ambivalence about treatment and develop life-style modifications to enhance self-care and self-monitoring (Weis et al., 1999). Relapse Prevention Therapy (Marlatt, 1985) has also been used with CBT to help individuals with co-occurring disorders recognize cues and change the relapse process and plan a roadmap for recovery (SAMHSA, 2002; Whitten, 2005).

**OTHER TREATMENT CONSIDERATIONS**

**Psychotropic Medications**

Psychotropic medications have proven to be beneficial in the treatment for many people with co-occurring disorders (Mueser et al., 2003; SAMHSA, 2006). Although a trained psychiatrist or medical doctor should manage the effects of these medications and complications with drugs, alcohol and other substances, other clinicians need to be aware of several important aspects of treatment (SAMSHA, 2002). The literature demonstrates that people who suffer from co-occurring disorders are at a significant risk for poor medication compliance (Magura et al., 2002; Mueser et al., 2003; SAMHSA, 2002; Torrey et al., 2001). When clinicians or practitioners are treating women with co-occurring disorders, they can play a vital role in medication monitoring by taking 5-10 minutes...
every few weeks to ask several simple and straightforward questions to facilitate and improve medication compliance (Baehni, 2004).

Pregnancy

Pregnancy may also present a challenge for women with co-occurring disorders. Mental illness is shown to be associated with physical pregnancy problems such as hyperemesis, ectopic pregnancy, and spontaneous abortion (Seng et al., 2001). Substance use disorders may impair a woman’s ability to obtain proper nutrition and prenatal care (American Psychiatric Association, 2006). Thus, women with dual diagnosis are at risk for adverse pregnancy outcomes (Kelly et al., 2002). Seng et al. (2001) point toward the importance of screening pregnant women for mental illness and substance use and providing early treatment. CSAT (2005) noted that it also is important to prepare women with co-occurring disorders to care for their newborns by working to ensure that these women receive a constellation of family-centered and coordinated services from social workers, child welfare workers, and, if indicated, the foster care system (American Psychiatric Association, 2006; CSAT, 2005).

TREATMENT COST

Providing separate and independent treatment for mental illness and substance disorders for individuals with co-occurring disorders is ineffective and costly. For instance, mental health service providers expend twice as much for consumers with co-occurring disorders than for consumers with single disorders [SAMHSA, 2003]. Yet, an integrated treatment approach not only provides for dual recovery, but ultimately reduces the overall costs of treatment (SAMHSA, 2003). Specifically, 12-step recovery programs, case management, and behavioral skills training have been found to reduce the costs of treating co-occurring disorders (SAMHSA, 2002). Additionally, the Women, Co-occurring Disorders, and Violence Study suggested that the following combined interventions are a more clinically efficient use of resources for treating women with co-occurring disorders: psychoeducational group counseling, resource coordination, and advocacy (Domino, Morrissey, Chung, Huntington, Larson, & Russell, 2005). That is, although there is no immediate reduction in cost for this bundle of services, the effectiveness of the intervention ultimately results in cost savings.

CONCLUSION

Women with co-occurring disorders typically have multiple risk factors and bring many challenges to treatment (Mangrum et al., 2006; Becker et al., 2005; DiNitto et al., 2002). A comprehensive screening process at the point of entry into any system enables providers to explore a variety of service needs and makes possible the process of referral and entry to appropriate resources and treatment recommendations [CSAT, 2007c]. A thorough, multi-faceted assessment provides the foundation for an integrated treatment plan. Empirical studies show that positive treatment outcomes are associated with the following programmatic and therapeutic approaches: a long-term approach to recovery, integrated mental health and substance abuse treatment, a comprehensive focus, stagewise treatment, motivational interventions, attention to women’s relationships, assertive outreach, and cognitive behavioral interventions (Drake et al., 2001; SAMHSA, 2002). Culturally relevant interventions,
modified 12-step self help groups, pharmacological interventions, and consumer advocacy also play important roles in treatment (Drake et al., 2001; Evans & Sullivan, 2001; Mueser et al., 2003; SAMHSA, 2002; Watkins et al., 2001). Finally, despite high costs of treating individuals with co-occurring disorders, integrated treatment can be a cost-effective solution (SAMHSA, 2002 & 2003).

REFERENCES


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