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## Women with Co-Occurring Mental Illness and Substance Abuse

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### Introduction

“Co-occurring disorders” denotes the simultaneous diagnosis of a substance use disorder and a serious mental illness (Office of Applied Studies [OAS], 2004a). A substance use disorder includes abuse or dependence on alcohol or other drugs as classified in the Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition Text Revision (DSM-IV-TR) (American Psychiatric Association [APA], 2000). Serious mental illness includes a mental, behavioral, or emotional disorder that meets criteria listed in the *DSM-IV-TR* (APA, 2000; OAS, 2004b) resulting in functional impairment that substantially interferes with or limits one or more major life activities (OAS, 2004c) such as self-care, mobility, social and family life, productive activity, and community participation (Kessler et al., 2003).

Co-occurring disorders can occur in any combination and number. However, studies have noted patterns in the presentation of co-occurring disorders among women (Center for Substance Abuse Treatment [CSAT], 2005). According to a national study of substance abuse treatment admissions, females with co-occurring mental illness were most likely to have alcohol as their primary drug of choice (46 percent), followed by opiates (18 percent), cocaine (17 percent), marijuana (10 percent), stimulants (4 percent), and other drugs (4 percent) (OAS, 2002).

Although co-occurring disorders affect both men and women, women with co-occurring disorders are likely to have distinct presenting problems, reasons for seeking treatment, patterns of engagement, and treatment needs (Alexander, 1996; DiNitto, Webb, & Rubin, 2002; Mallouh, 1996). The following section highlights the demographic features of women with co-occurring disorders and describes a variety of additional psychosocial, health, and interpersonal problems that these women commonly bring to treatment.

### Understanding Women with Co-occurring Disorders *Demographics*

Approximately seven to ten million adults in the United States have co-occurring disorders at some point in their lives (U.S. Department of Health and Human Services,

1999). Women represent 48 percent of adults with co-occurring disorders (OAS, 2004c). Because women with co-occurring disorders can and do recover, fewer women experience co-occurring mental illness and substance use disorders in any given year, compared to the number of women who experience these disorders at some point in their lives (CSAT, 2005). More specifically, according to results from the 2002 National Survey on Drug Use and Health, two million women aged 18 or older had co-occurring serious mental illness and substance use disorders in that year (OAS, 2004c).

### *Help-seeking and treatment demographics*

Many women with co-occurring disorders do not attend treatment designed to treat both mental health and substance abuse problems (CSAT, 2005; Epstein Barker, Vorburger, & Murtha, 2004; OAS, 2004c). According to the results of Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health, 48 percent of adults in the United States with co-occurring mental health and substance use disorders sought either mental health or substance abuse treatment, while only 11.8 percent of this group received both types of services (Epstein et al., 2004).

Women with co-occurring disorders were more likely to receive mental health services compared with men (Epstein et al., 2004). However, many women with co-occurring disorders are treated at substance use treatment facilities, particularly residential and rehabilitative settings (OAS, 2004a). From 1995 to 2001, the number of admissions with co-occurring disorders at substance abuse treatment facilities increased from 12 to 16 percent of all admissions (OAS, 2004a).

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

admission demographics. Non-Hispanic White women were more likely to receive any type of treatment than African American, Latino, or other women (Epstein et al., 2004).

#### *Presenting problems and history*

Studies show that women with co-occurring disorders have problems in multiple contexts of life (Alexander, 1996; DiNitto et al., 2002; OAS, 2004c). Women with co-occurring disorders are more likely than men to be poor, complete fewer years of education, possess fewer job skills, receive public assistance, report more relatives with alcohol and drug problems, and care for more dependents (Alexander, 1996; DiNitto et al., 2002). Women with substance use disorders are also more likely than men to have mental disorders such as depression, anxiety, eating disorders, and lower self-esteem (CSAT, 2005).

These women are also likely to have a history of victimization, homelessness, and to have experienced violence (Alexander, 1996; Najavits, Weiss, & Shaw, 1997). In their review of the literature, Najavits, Weiss, and Shaw (1997) found that between 30-59 percent of women with substance use disorders have co-occurring posttraumatic stress disorder (PTSD). In a study of gender differences in 135 men and 37 women with co-occurring schizophrenia and substance use disorders, Brunette and Drake (1997) also found that women have a higher frequency of violent victimization compared with men.

Other studies suggest that women with co-occurring disorders experience a greater frequency of alcohol and drug related health problems as well as medical hospitalizations for conditions such as hepatitis, cirrhosis, fractures, anemia, and kidney and bladder ailments than women in the general population (Brunette & Drake, 1997; Mowbray, Ribisl, Solomon, Luke, & Kewson, 1997). 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.

#### *Barriers to seeking treatment*

Women with co-occurring disorders can be difficult to engage, successfully treat, and retain in treatment (Brown, Huba, & Melchior, 1995). In addition to the sheer intensity and number of presenting problems that women bring to treatment (Alexander, 1996), a variety of philosophical, administrative, financial, policy, family, and consumer barriers can encumber treatment for women with co-occurring disorders (Drake et al., 2001; SAMHSA, 2002). For example, during the last 15 years,

women who have sought treatment in either the substance abuse treatment or mental health system have been told to come back when their other problem is under control (Drake et al., 2001). When women with co-occurring disorders seek treatment for substance abuse, some programs have refused to allow these women to take psychotropic medication prescribed by the mental health system (Drake et al., 2001). In addition, separate and philosophically conflicting professional training and vastly different federal policies and funding for each system continue to make treatment more fragmented and difficult for consumers to utilize (Drake et al., 2001; Osher & Drake, 1996). Caring for dependent children also represents one of the most significant barriers for women in treatment (CSAT, 2001). Although much work remains to be done, federal agencies, such as SAMHSA, are working to help reduce barriers to treatment for individuals with co-occurring disorders by providing technical assistance and training, promoting provider accountability, and supporting state grants to increase service capacity and integrate substance abuse and mental health services (SAMHSA, 2002).

### **Screening and Assessment**

#### *Screening*

Since many women with co-occurring disorders are unable to navigate fragmented health, mental health, and substance abuse treatment systems, screening for problems in all these areas is the first step towards effective treatment outcomes (Drake et al., 2001; SAMHSA, 2002). In a report to Congress, SAMHSA (2002) noted that if a problem is identified, treatment providers can conduct a more thorough assessment and make appropriate referrals or treatment recommendations as needed.

Routine health, mental health, and substance abuse screening for women with co-occurring disorders is critical for several reasons. Women with co-occurring disorders who use even small quantities of psychoactive drugs are more likely to experience greater negative consequences associated with use compared with women who are not mentally ill (RachBeisel, Scott, & Dixon, 1999). Cuffel, Shumway, Chouljian, and Macdonald (1994) suggest that substance use in this population is particularly deleterious since substances further impair cognitive and behavioral mechanisms of impulse control and promote negative mood states. In addition, individuals with mental illness are likely to be confused about or unaware of the consequences of their substance use (RachBeisel et al., 1999).

Brief and routine screening has helped providers identify multiple areas of need and plan treatment accordingly (SAMHSA, 2002). Screening is particularly effective when it is implemented with a "no wrong door" approach,

where an evaluation of need occurs anywhere that a woman with co-occurring disorders presents for treatment (SAMHSA, 2002). 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, 2002). To support this approach, screening needs to be offered in emergency rooms, mental health clinics, drug treatment facilities, primary care offices, and all other settings where women seek care (Lehman, 1996; SAMHSA, 2002). Lehman (1996) maintains that organizations need to conduct comprehensive screenings even when they do not have the capacity to treat all the conditions identified.

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 (CSAT, 2005). Examples of these screening instruments include the Michigan Alcoholism Screening Test (MAST); the Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers (CAGE) questionnaire (Ewing, 1984); the Brief Symptom Inventory (Derogatis & Melisaratos, 1983); and the General Health Questionnaire (Goldberg, 1972). These screening instruments are most effective when combined with follow up laboratory tests and collateral reports (Lehman, 1996; RachBeisel et al., 1999).

#### *Assessment*

Conducting a thorough and timely assessment represents a critical component in the process of recovery for women with co-occurring disorders (Lehman, 1996; SAMHSA, 2002). The first steps in the assessment process include establishing rapport, using face-to-face interviews, assuring clients of confidentiality, and obtaining collateral information from multiple sources (RachBeisel et al., 1999). These steps help improve the validity of the information gathered, particularly when relying primarily upon self-report data (RachBeisel et al., 1999). At the most basic level, assessment for co-occurring disorders provides a foundation for treatment when it includes a synopsis of the individual's background; a diagnosis of the severity of illness; strengths and areas of concern; and motivation for treatment (CSAT, 2005; Kofoed, 1991). In addition, other medical, cultural, gender-specific, sexual orientation, and legal issues need to be explored and documented by the individual(s) conducting the assessment (CSAT, 2005; Lehman, 1996). Numerous assessment tools are available to help mental health and substance abuse treatment providers (CSAT, 2005).

### **Best Practices for Treating Women with Co-Occurring Disorders**

Expert consensus and empirical evidence have uncovered a number of best practices and treatments for treating co-occurring disorders in women (CSAT, 2005). Several treatment principles and modifications have been recommended to specifically address the needs of these women and their children (CSAT, 2005; Drake et al., 2001; RachBeisel et al., 1999; SAMHSA, 2002). Finkelstein, Kennedy, Thomas, and Kearns (1997) assert that women with co-occurring disorders are best served when programs build on women's strengths and use supportive rather than confrontational approaches. In addition, some programs have seen an increase in attendance at group treatment when offering women-only groups (CSAT, 2005). Women who attend these programs report that they are more willing to attend these groups because they feel more comfortable in addressing traumatic experiences (RachBeisel et al., 1999; Watkins, Shaner, & Sullivan, 1999). 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). These programs also address the needs of women through developing programming for both women and their children.

In comprehensive reviews of the literature, Drake et al. (2001), RachBeisel et al. (1999), and SAMHSA (2002) agreed that effective treatment for individuals with co-occurring disorders incorporates both program level components and specific therapeutic approaches with the following common elements: a long-term approach to recovery; integrated mental health and substance abuse treatment; comprehensive focus; stagewise treatment (i.e., treatment in stages); motivational interventions; attention to women's relationships; assertive outreach; and cognitive-behavioral interventions. The following section gives a brief overview of these treatment approaches.

#### *Programmatic features of successful treatment*

##### Long-term approach to recovery

Women with co-occurring disorders are not likely to achieve stability and functional improvements quickly (Drake et al., 2001). Based on this knowledge, effective programs have used a long-term recovery approach to help clients achieve stability over months and years in stable 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 were also 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 (Drake et al., 2001; RachBeisel et al., 1999; SAMHSA, 2002). Mental health and substance abuse services have historically been offered in separate service sectors (Osher, 1996; Osher & Drake, 1996). Currently, 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 (Osher & Drake, 1996; RachBeisel et al., 1999).

As mental health and substance abuse treatment systems begin to join together, treatment providers in both fields can use a conceptual model, a four-quadrant framework, developed jointly by mental health and substance abuse treatment fields to provide an appropriate level of integrated services (National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors, [NASMHPD/NASADAD] 1999; SAMHSA, 2002). Although a full discussion of this model is not possible here, this four-quadrant framework outlines symptom severity and level of service system coordination on a continuum from less severe to more severe mental health and substance abuse symptoms (NASMHPD/NASADAD, 1999).

This framework also highlights a range of service possibilities from consultation and collaboration to integration (NASMHPD/NASADAD, 1999; 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, permanent change often requires addressing multiple aspects of life (SAMHSA, 2002). These women commonly need assistance to develop and maintain supports to manage both mental illness and substance use disorders while pursuing functional goals (SAMHSA, 2002). Strategies used to help women gain these skills include money management, drug testing, vocational rehabilitation, housing, and linkages with other services to provide a coordinated continuum of care (Drake et al., 2001; SAMHSA, 2002; Zweben, 1996). Drake and colleagues (2001) reported that programs, which did not offer a full continuum of services, were able to link with other organizations and, together, provide effective services.

#### Therapeutic techniques

##### 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 mental health and substance use disorders (SAMHSA, 2002). One conceptual model, originally developed for mental health treatment (Osher & Kofoed, 1989), suggests that individuals progress in a non-linear fashion through four stages with separate clinical tasks (Drake et al., 2001; McHugo et al., 1995). 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 supports for goals, and treatment providers help a client control illness. In the fourth stage, clients can use strategies for maintaining recovery and preventing relapse (Osher & Kofoed, 1989).

Prochaska and DiClemente (1992) developed a similar five-stage model for clients in substance abuse treatment, called the Stages of Change or Stages of Readiness that has been adapted for use with individuals with co-occurring disorders (Bellack & DiClemente, 1999; Ziedonis & Trudeau, 1997). This model suggests that clients experience different phases of motivation in treatment referred to as precontemplation, contemplation, determination, action, maintenance, and relapse prevention as clients progress towards 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 interventions

Motivational interviewing, also known as motivational enhancement, is a specific technique based on theories of change (Miller & Rollnick, 1991; Prochaska & DiClemente, 1992). This technique has been used with individuals with co-occurring disorders to enhance intrinsic motivation, explore and resolve ambivalence, and develop strategies for change (Sciaccia, 1997). Motivational interviewing can also be used to help people engage in treatment (Miller & Rollnick, 1991). Key elements of this technique include expressing empathy, providing feedback, avoiding argumentation, refraining from directly confronting resistance, and encouraging an individuals' belief that he or she has the ability to change (Miller & Rollnick 1991). Evidence suggests that motivational interviewing is a promising approach to enhance treatment engagement. 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).

#### Attention to women's relationships

Women's relationships are an important component of the engagement and healing process for women with both mental illness and substance use disorders (CSAT, 2005; Watkins et al., 1999). Since many women with co-occurring disorders have experienced trauma and previous victimization (Najavits et al., 1997), empathic relationships and bonding among women are critical. In addition, treatment providers also need to address the role that women's relationships have provided in initiating women into substance use, as well as, the importance of relationships with children as a source of motivation for treatment (CSAT, 2005). Research also suggests that relationships with staff are another critical component in engaging and retaining clients (Drake et al., 2001; SAMHSA, 2002; Watkins et al., 1999).

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

#### 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 (SAMHSA, 2002). Common elements of this approach include extensive outreach, small caseloads, assistance with meeting basic needs (e.g., housing), a multidisciplinary team approach, provision of substance abuse treatment and mental health services within the same team, and a strong focus on the interrelationship between mental health and substance abuse (CSAT, 2005; SAMHSA, 2002). Programs have effectively used this approach to reduce noncompliance, dropout rates, and substance use over time (Clark et al., 1998; Drake et al., 2001; Meisler, Blankertz, Santos, & McKay, 1997).

#### Cognitive-behavioral interventions

Cognitive-Behavioral Therapy (CBT) has been successfully used with individuals with co-occurring disorders to identify and replace self-defeating beliefs and actions with thoughts and behavior oriented towards coping (CSAT, 2005; Drake et al., 2001; SAMHSA, 2002). For example, CBT has been used to help individuals with co-occurring disorders change self-talk from statements such as, "The only time I'm comfortable is when I'm high," to statements such as, "It's hard to learn to be comfortable socially without drugs, but people do it all the time," (CSAT, 1999).

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; SAMHSA, 2002). One CBT intervention for women with PTSD and substance use disorders may be particularly promising (Najavits, 2002). This therapy, 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 finding exploring old ways of thinking and changing self-talk (Najavits, 2002). In addition, Weiss, 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 address ambivalence about treatment and develop life-style modifications to enhance self-care and self-monitoring (Weiss et al., 1999). Relapse Prevention Therapy (Marlatt, 1985) has also been integrated with CBT to help individuals with co-occurring disorders recognize cues and change the relapse process and plan a roadmap for recovery (SAMHSA, 2002).

### **Other Treatment Considerations**

Psychotropic medications are now considered a vital aspect of treatment for many people with co-occurring disorders (SAMHSA, 2002). While 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 (SAMHSA, 2002). The literature demonstrates that people who suffer from co-occurring disorders are at a significant risk for poor medication compliance (Haywood, Kravitz, Grossman, Cavanaugh, Davis, & Lewis, 1995; Magura, Laudet, Mahmood, Rosenblum & Knight, 2002; SAMHSA, 2002; Torrey et al., 2001). When clinicians or practitioners are treating women with co-occurring disorders, clinicians 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 may also present a challenge for women with co-occurring disorders. Women's symptoms of mental illness may worsen, and psychotropic medications may affect women differently during pregnancy due to varying hormonal balances (Grella, 1997; Mallouh, 1996). Mallouh (1996) recommends that social service providers ensure that women are knowledgeable and able to access needed services by offering advocacy and case management. During this process, Mallouh (1996) also suggests that service providers need to be sensitive to a woman's potentially ambivalent emotions, including guilt, resentment, and anxiety around the decision of whether or not to continue taking medications during pregnancy. In addition, CSAT (2005) noted that it is important to prepare women with co-occurring disorders to care for their newborns. To support pregnant women with co-occurring disorders, treatment providers can help expectant mothers by working to ensure that these women receive a constellation of family-centered and coordinated services from social workers, child welfare workers, and the foster care system (CSAT, 2005).

Several other aspects of treatment for women with co-occurring disorders are also important to consider. Two of these components include explicitly providing culturally sensitive interventions (Drake et al., 2001), and offering or connecting clients with modified 12-step self-help groups (RachBeisel et al., 1999; SAMHSA, 2002). In addition, consumer involvement in service planning and design plays an important role in addressing stigma and improving service delivery (Drake & Wallach, 2000). SAMHSA (2002) notes that modified therapeutic communities have used consumer involvement to shape federal, state, and local policy initiatives.

### **Treatment Cost**

Although services for individuals with co-occurring disorders are associated with significantly increased cost compared with substance abuse treatment or mental health services alone (Dickey & Azeni, 1996; RachBeisel et al., 1999), several practices may decrease the financial cost for women with co-occurring disorders (Jerrell & Ridgely, 1995). Research shows that the majority of increased service cost is associated with acute psychiatric inpatient care (Dickey & Azeni, 1996), and several interventions have been shown to reduce service costs by decreasing the need for acute services.

For example, Jerrell and Ridgely (1996) compared the cost of service with treatment outcomes for 132 individuals with co-occurring disorders who were assigned to 12-18 months of CBT, ACT, or a 12-step intervention post-discharge from inpatient care or by referral through their outpatient mental health provider. This research showed that all three groups decreased the number of hospital and emergency room visits and increased their use of outpatient mental health services after treatment (Jerrell & Ridgely, 1995), thus lowering the cost of service compared with their prior histories.

CBT may be a particularly promising intervention since individuals demonstrated the greatest reduction in costs for acute mental health services, while also showing significant improvements in social adjustment and role functioning and reductions in substance use (Jerrell & Ridgely, 1995). ACT may be an additional cost-efficient treatment for individuals with co-occurring disorders (Clark et al., 1998). In a randomized controlled trial, Clark and colleagues (1998) compared the quantity of substance use and quality of life of 100 people with co-occurring disorders in ACT with 93 similar individuals in standard case management. These researchers found that while standard case management was more cost-effective during the first two years, ACT was more efficient in the third year since these participants had a lower cost for other outpatient services such as housing support, day treatment, and expenses related to arrests (Clark et al., 1998).

### **Conclusion**

Women with co-occurring disorders bring many challenges to treatment (Brown et al., 1995). Women with both mental illness and substance use disorders frequently come to treatment with a history of multiple risk factors (Alexander, 1996; DiNitto et al., 2002; Najavits et al., 1997; Watkins et al., 1999). During the treatment process, screening for these multiple risk factors, completing a thorough assessment, and providing appropriate referrals are critical to matching treatment with an individual's stage of recovery and stage of treatment engagement (Alexander, 1996; RachBeisel et

al., 1999). Multiple tools are available to assist clinicians in this process (McHugo et al., 1995; RachBeisel et al., 1999). Empirical studies have shown that programs that incorporate at least nine elements, including: a long-term approach to recovery, integrated mental health and substance abuse treatment, comprehensive focus, stagewise treatment, motivational interventions, attention to women's relationships, assertive outreach, and cognitive-behavioral interventions are associated with positive treatment outcomes (Drake et al., 2001; RachBeisel et al., 1999; SAMHSA, 2002). Culturally relevant interventions, modified 12-step self-help groups, pharmacological interventions, and consumer advocacy also play important roles in treatment (SAMHSA, 2002). Finally, despite the high cost of acute psychiatric care, ACT and CBT are promising interventions in terms of cost and outcome for individuals with co-occurring disorders (Clark et al., 1998; Jerrell & Ridgely, 1996; RachBeisel et al., 1999).

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### Resources

- Dual Recovery Anonymous (DRA), <http://www.draonline.org/>
- Foundations Associates - Dual Diagnosis Recovery Network, <http://www.dualdiagnosis.org>
- The National GAINS Center for People with Co-Occurring Disorders in the Justice System, <http://www.gainsctr.com/>
- Substance Abuse and Mental Health Services Administration (SAMHSA), <http://www.samhsa.gov/index.aspx>
- Center for Substance Abuse Prevention. <http://prevention.samhsa.gov/>
  - Center for Substance Abuse Treatment. <http://csat.samhsa.gov/>
  - Co-occurring dialogues electronic discussion list. <http://www.treatment.org/Topics/DualDialogues.html>
  - Substance Abuse and Mental Health Services Administration Co-Occurring Center for Excellence. <http://coce.samhsa.gov/>

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