Journal of Substance Abuse Treatment 144 (2023) 108899

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

Implementing clinical guidelines for co-occurring substance use and major mental disorders in Swedish forensic psychiatry: An exploratory, qualitative interview study with mental health care staff

J. Green [a,b,*], A.S. Lindqvist Bagge [a,b], S. Olausson [b], P. Andiné [a,c,d], M. Wallinius [a,e,f], M. Hildebrand Karlén [a,b,c]

[a] Centre for Ethics, Law and Mental Health, Department of Psychiatry and Neurochemistry, Institute of Neuroscience and Physiology, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden
[b] Department of Psychology, University of Gothenburg, Gothenburg, Sweden
[c] Department of Forensic Psychiatry, National Board of Forensic Medicine, Gothenburg, Sweden
[d] Forensic Psychiatric Clinic, Sahlgrenska University Hospital, Gothenburg, Sweden
[e] Child and Adolescent Psychiatry, Department of Clinical Sciences Lund, Lund University, Lund, Sweden
[f] Research Department, Regional Forensic Psychiatric Clinic, Växjö, Sweden

ARTICLE INFO

Keywords:
Substance use disorder
Co-occurring diagnoses
Implementation
Clinical guidelines
Community reinforcement approach
Thematic analysis

ABSTRACT

Introduction: Patients with substance use disorders (SUD) and co-occurring mental disorders (COD) within forensic psychiatric care often suffer poor treatment outcomes and high rates of criminal recidivism, substance use, and psychiatric problems. This study aimed to describe the conditions for, and mental health care staff's experiences with, implementing integrated SUD-focused clinical guidelines, including assessment and treatment for patients with COD at a high-security forensic mental health services (FMHS) facility in Sweden.

Methods: Study staff conducted nineteen semi-structured interviews with health care staff experienced in administering the new SUD assessment and treatment. The study conducted a thematic analysis to describe the health care staff's experiences with these guidelines and suggestions for improvement.

Results: Most participants reported appreciation for the implementation of clinical guidelines with an SUD focus, an area they considered to have previously been neglected, but also noted the need for more practical guidance in the administration of the assessments. Participants reported the dual roles of caregiver and warden as difficult to reconcile and a similar, hindering division was also present in the health care staff's attitudes toward SUD. Participants' reports also described an imbalance prior to the implementation, whereby SUD was rarely assessed but treatment was still initiated. One year after the implementation, an imbalance still existed, but in reverse: SUD was more frequently assessed, but treatment was difficult to initiate.

Conclusions: Despite indications of some ambivalence among staff regarding the necessity of the assessment and treatment guidelines, many participants considered it helpful to have a structured way to assess and treat SUD in this patient group. The imbalance between frequent assessment and infrequent treatment may have been due to difficulties transitioning patients across the "gap" between assessment and treatment. To bridge this gap, mental health services should make efforts to increase patients' insight concerning their SUD, flexibility in the administration of treatment, and the motivational skills of the health care staff working with this patient group. Participants considered important for enhancing treatment quality a shared knowledge base regarding SUD, and increased collaboration between different professions and between in- and outpatient services.

1. Introduction

Substance use disorders (SUD) significantly increase the risk that patients with psychiatric disorders will commit, and recidivate into, violent crimes (Baillargeon et al., 2009; Fazel et al., 2009; Lund et al., 2012). Treatment efficacy, retention, and outcome are worse for patients

* Corresponding author at: Department of Psychology, University of Gothenburg, Haraldsgatan 1, Box 500, S-405 30 Gothenburg, Sweden.
E-mail address: johan.green@psy.gu.se (J. Green).

https://doi.org/10.1016/j.jsat.2022.108899
Received 4 March 2022; Received in revised form 4 July 2022; Accepted 10 October 2022
Available online 12 October 2022

with SUD and one or more co-occurring mental disorders (henceforth COD; see Substance Abuse and Mental Health Services Administration (SAMHSA), 2020) (Choi et al., 2013). Forensic mental health services (FMHS) have an urgent need to integrate SUD treatment into clinical practice (Eagle et al., 2019; Jaffe et al., 2011; Kelly et al., 2011) Recently, clinical guidelines including SUD assessment and treatment for COD patients were implemented at a high-security FMHS facility in Sweden. The successful implementation of interventions in clinical settings requires sustained efforts from staff and continuous support from management. The purpose of the current study was to describe health care staff's experiences with the implementation of the SUD-focused clinical guidelines, directly following its launch and one year later.

1.1. Importance of treating SUD among forensic inpatients

1.1.1. Prevalence

The issue of SUD among forensic psychiatric patients has elicited increased attention in recent decades (e.g., Eagle et al., 2019). Lifetime SUD prevalence rates in the US general population have been estimated at 17 %, but at 48 % among patients with co-occurring schizophrenia and as much as 56 % for patients with bipolar disorder (Regier et al., 1990). Similar prevalence rates have been found in many epidemiological surveys (Grant et al., 2015; Grant et al., 2016; Kessler et al., 2005), with some studies suggesting a significant increase in recent years (Substance Abuse and Mental Health Services Administration (SAMHSA), 2021). SUD among Swedish forensic psychiatric patients has been estimated at between 20 and 30 % (The Swedish National Board of Health and Welfare, 2008). In 2020, 52 % of women and 71 % of men admitted to FMHS in Sweden had a history of addiction (Swedish National Forensic Psychiatric Register, 2020).

1.1.2. Problem areas

The COD patient group is highly stigmatized and often disregarded in both general mental health and addiction services (Ford et al., 2021; Lindqvist, 2007). These patients suffer adverse effects in several domains: high mortality rates due to SUD (Steingrímsson et al., 2015); high rates of suicide attempts (Aharonovich et al., 2002); increased rates of hospitalization (Schmidt et al., 2011) and homelessness (Substance Abuse and Mental Health Services Administration (SAMHSA), 2013); and poorer psychosocial functioning and retention of medical treatment (Baker et al., 2007). SUD also elevates the risk of violent behavior, and many studies suggest that comorbid SUD is the critical deciding factor behind violence perpetrated by individuals with mental disorders (Lund et al., 2013; Steadman et al., 1998; Stuart, 2003; van der Kraan et al., 2014).

1.1.3. Special requirements for treatment

Clinical practice research has shown that SUD interrelates reciprocally with psychiatric disorders, and that patients' prognoses are poor in both domains if treatment interventions do not target both conditions simultaneously (Boden & Moos, 2009; Flynn & Brown, 2008; Kola & Kruszynski, 2010). The integration of SUD treatment in FMHS has shown some ambiguous yet promising reductions in reoffending and substance use rates, as well as improvements in patients' quality of life (Brunette et al., 2001; Hesse, 2009; Pott et al., 2022). Implementing such interventions, however, has often been found to be poorly sustained or short-lived (Drake et al., 1998; Drake et al., 2001; Drake & Bond, 2010; Hunter et al., 2017; Sacks et al., 2013), warranting further studies on which context-specific factors need consideration when implementing such interventions.

1.2. Implementing clinical guidelines in FMHS

1.2.1. Gap between need for and delivery of treatment

Research has recognized the need to implement integrated COD treatment globally (Domingo-Salvany et al., 2016; Sacks et al., 2009; Substance Abuse and Mental Health Services Administration (SAMHSA), 2020). However, a considerable gap exists between recognizing the need for integrated COD treatment and the actual delivery of treatment (Belenko & Peugh, 2005; Compton et al., 2007; Sacks et al., 2013). In a sample of 256 health care programs in the United States, 18 % of addiction treatment and only 9 % of mental health programs were capable of providing integrated COD treatment (McGovern et al., 2012). Less than one third of individuals with COD report having access to integrated care (Novak et al., 2019), and only 5.7 % report actually receiving such treatment (Substance Abuse and Mental Health Services Administration (SAMHSA), 2021).

1.2.2. Challenges in implementation

The implementation of new, evidence-based interventions in clinical settings often fails and, as a result, patients do not receive optimal treatment or suffer iatrogenic harm (Grimshaw et al., 2012; Klein & Knight, 2005; Powell et al., 2009a). Efforts to improve the implementation of interventions in FMHS settings have yielded insights into commonly encountered implementation barriers and facilitators. A lack of funding, time, managerial support, training, and learning opportunities leads to comparatively little attention being paid to SUDs, or even to staff avoiding diagnosing an SUD for fear of interference with the treatment of other psychiatric disorders or clinic funding (Drake et al., 2001). When health care staff lack knowledge concerning the intervention, or lack an empathetic perspective toward addiction, they are at risk of compassion fatigue and burnout and can pose an additional barrier to overcome for their colleagues working for a successful implementation (Brown & Lewis, 2015; Davies et al., 2007). Comorbid SUD in particular can be difficult to diagnose, and health care staff often lack sufficient knowledge of integrated treatment, assess and treat SUD insufficiently, and have negative attitudes toward the patient group (Adams, 2008; Morojele et al., 2012; Wadell & Skärsäter, 2007). Facilitating factors for the successful implementation of integrated COD treatment—such as administrative leadership, supervision, training, and feedback—are all vital for sustained implementation (Brunette et al., 2008; Ford et al., 2021; Powell et al., 2009b). Having a team, or clinic "champions", responsible for propagating the implementation alongside external consultants and establishing relationships with community partners are also advisable for increasing leadership, learning opportunities, and lasting change (McGovern et al., 2006; McGovern et al., 2010; McKee et al., 2013). Implementing clinical guidelines for the complex and stigmatized patient group treated within FMHS requires sustained efforts and continuous monitoring (Fixsen et al., 2009; McAlearney et al., 2016), and we need more knowledge about health care staff's experiences of the implementation process.

1.3. Study aims

The aim of the current study was to describe health care staff's experiences with implementing clinical guidelines, including SUD assessment and treatment for patients with COD, at a high-security FMHS facility in Sweden. The specific research aims were to describe mental health care staff's:

a) experiences of pre-existing enabling and hindering factors in the implementation of the clinical guidelines at the start of the implementation process; and.
b) experiences of the implementation process for the clinical guidelines directly following their launch and one year thereafter.

2. Method

This study was part of a research project (FOR-SATA) investigating SUD assessment and treatment among forensic psychiatric patients diagnosed with an SUD, within a larger research program (FOR-Evidence) aiming to improve the evidence base of Swedish forensic

psychiatry. The Swedish Ethical Review Authority approved the project (2019-03042).

2.1. The intervention

In 2019, all wards of the FMHS clinic in question implemented the clinical guidelines, with the aim to improve SUD assessment and treatment. The clinical guidelines included instruments for assessing SUD and the Community Reinforcement Approach treatment method (CRA; Smith et al., 2001). The assessment instruments included the Addiction Severity Index (ASI; Cacciola et al., 2011; McLellan et al., 1980), Extended Alcohol Use Disorders Identification Test (AUDIT-E; Babor & Robaina, 2016), Extended Drug Use Disorders Identification Test (DUDIT-E; Berman et al., 2007), Alcohol Effects Questionnaire (AEFQ; Rohsenow, 1983), Structural Analysis of Social Behaviour (SASB; Pincus et al., 1998), and NORC Diagnostic Screen for Gambling Disorders (NODS; Hodgins, 2004). In the CRA, interventions are combined to target the patient's substance use problems and problems related to their social situation. The method has strong empirical support (Smith et al., 2001), and is recommended for COD by national health agencies, including The Swedish National Board of Health and Welfare (2019).

2.2. Participants and setting

The current study is based on interviews with health care staff working with recently implemented clinical guidelines for SUD treatment at a large, high-security FMHS in Sweden.

The staff who were eligible for participation in this study were those with previous experience of administering the SUD assessments and CRA treatment at the clinic. The clinic's policy required a minimum of 120 higher education credits for staff to be eligible to administer the SUD assessments and treatment, as such all participants in the study met the same criteria. The majority of participants were registered nurses or treatment assistants, but behavioral scientists and social workers were also represented. Two sets of interviews were held to explore the progression of the implementation process during the first year: at the start of implementation and one year thereafter. At the start of implementation (November 2019), the study interviewed six women and six men ($n = 12$, labelled A1–12), aged 24–39 years ($m = 31.25$), and their professional experience ranged from less than one year to 14 years ($m = 4.83$). One year later (November 2020), five women and two men were interviewed ($n = 7$, labelled B1–7), aged 27–50 years ($m = 35.14$), and their professional experience ranged from less than one year to 15 years ($m = 6.93$). Of these seven participants interviewed in 2020, three had also been interviewed in 2019 (i.e., repeated interviews) while the remaining four were interviewed for the first time in November 2020.

By the first set of interviews, immediately following the start of the implementation, all participants had received training in how to administer CRA. Regarding training in administering the SUD assessment instruments, all staff eligible according to the clinic's policy (see above) were invited to a one-day lecture and workshop prior to the launch of the implementation, and six workshop opportunities focusing on challenges in administration throughout the year. Initially, all participants were to be interviewed on both occasions, but due to COVID-19 restrictions, health care quarantine rules, and increased clinical workload this was not possible.

The FMHS facility had several inpatient wards and one outpatient ward. Clinic staff from both in- and outpatient wards participated in the study, which provided representation from all stages of treatment. The inpatient wards varied to some extent regarding patient characteristics, some having more heterogeneous patient groups while others were more specialized in the treatment of psychoses, with one ward specifically treating SUD and personality disorders.

2.3. Procedure

Prior to each set of interviews (during November 2019 and November 2020), a list of all eligible participants was compiled by a research assistant at the clinic. The researchers e-mailed information about the study, including informed consent, for full initial disclosure of the study's terms to all eligible participants ($N = 60$ in 2019, $N = 82$ in 2020). Following each recruitment attempt, the study sent a reminder e-mail, ultimately resulting in twelve participants for the 2019 set of interviews and seven for the 2020 set (a recruitment rate of 20 % in 2019 and 8.54 % in 2020). No attrition of participants occurred.

Health care staff who chose to participate were instructed to reply to an e-mail address and received a time for their interview. Before the interview started, study staff gave oral and written information about the study to participants. All participants were reminded that their involvement was voluntary and that their decision to participate would not impact their employment in any way. All participants then signed the written consent form. When study staff did not conduct interviews in person, these forms were put in a mailbox at the clinic and later collected by the researchers. The study conducted the first set of interviews, in 2019, in person at the clinic. The second set, in 2020, was held via video link or telephone due to COVID-19 restrictions. All interviews were recorded using voice recorders.

2.4. Interviews

Both sets of interviews were semi-structured and developed by clinical researchers with experience with SUD assessment/treatment within FMHS (MHK) and COD care (SO). The interview guide was divided into three parts: 1) the current structure of COD care; 2) the staff's attitudes toward SUD; and 3) structured interventions against, and attitudes toward, SUD relapse at the ward. During the second set of interviews (2020), the interview guide also contained questions regarding any perceived changes in the assessment and treatment of COD during the past year. All questions were open-ended, and the interview guide contained suggestions for follow-up questions if participants answered vaguely or nonexhaustively. The semi-structured interview format allowed researchers to dynamically follow participants' responses, expand on particularly relevant or information-dense replies, or omit questions that they considered to have been sufficiently covered earlier in the interview. The interviews were conducted by researcher MHK and ALB, who are both clinical psychologists and researchers with experience from forensic psychiatric assessment and care. The authors' professional experience from FMHS allowed the interviews to explore clinically relevant issues in greater depth. The first set of interviews (2019) ranged in length between 37 and 78 min ($M = 52$ min) and the second set (2020) between 19 and 81 min ($M = 51$ min). All interviews were recorded and transcribed verbatim by the first author (JG).

2.5. Analysis

This study was inductive and explorative but built on generalizable findings from previous studies on implementing interventions in clinical settings (e.g., Drake et al., 2001; Grimshaw et al., 2012). The study team conducted an inductive, thematic analysis on the interview data (Braun & Clarke, 2006). The first author (JG) read the transcripts and extracted all data relevant to the research questions, while refraining from attempts to fit data to pre-existing findings and noting ideas on possible structures. Subsequently, the first author re-read all transcripts, and extracted preliminary codes. We then input all material into and organized it in the software NVivo (R1, v.1.4.1). The team structured codes and possible themes in the software. The research team reviewed all data to extract quotes that best captured the essence of each theme. Once preliminary themes had been identified and structured, all authors (JG, SO, ALB, and MHK) reviewed the results. After thorough discussion and minor reviews, the team defined a unified set of themes.

The researcher who conducted the majority of the analysis (JG) had comparatively limited experience with clinical psychiatry but had analogous experience from Sweden's prison and probation system. Although a lack of clinical experience might have led to the omission of certain nuances in the data, the current explorative study considered an unbiased and inductive position preferable not to accept potentially common conventions at face value. Furthermore, results were continuously discussed with more experienced co-authors (MHK, ALB, SO, PA, and MW), diminishing the risk that the study had not considered important terminological nuances. Throughout the analysis process, the first author (JG) kept a reflexive logbook containing presuppositions and personal characteristics that might limit credibility of the analysis. For instance, the first author noted, during the initial analysis, the use of an unnecessarily critical and skeptical perspective in relation to participants' description of their work. This insight was discussed with the co-authors and measures were taken to adjust for it during the subsequent thematic analysis.

3. Results

Table 1 lists themes. The first theme concerned preconditions for implementation, the second described participants' experiences with the implementation of the clinical guidelines one year into the implementation process, and the last aggregated participants' recommendations for the continued implementation of the clinical guidelines. Fig. 1 presents a visual representation of the thematic structure.

3.1. Theme 1: preconditions for implementing the new clinical guidelines

The study team extracted from the data various enabling and hindering conditions for implementing SUD interventions. The staff's attitudes toward SUD varied, and disparate attitudes were considered problematic for work team efficiency and morale. Many participants discussed the position of SUD in contrast to other mental disorders and the question of responsibility. Participants also described certain dilemmas or paradoxes.

3.1.1. Disparate attitudes

Many participants discussed two distinct attitudes toward SUD. The first, and most often reported, was an attitude involving psychoeducation; flexibility; and a tolerant, explorative mindset, focusing on adapting interventions to the individual:

> *That the patient isn't afraid to come to us if they feel like using again, and you actually go through, thoroughly, what happened? //So that the patient isn't afraid to talk to us later on.*
>
> (A9)

Staff pointed out that this open and explorative mindset was critical for initiating treatment, as patients were often reluctant to bring up SUD-related symptoms and cravings for fear of legal reprisal and regression of the treatment progress. Several participants mentioned that not shying away from SUD-related conversation topics out of fear of "awakening" cravings among patients was an effective way of encouraging them to communicate about SUD. Most participants considered relapses to be a natural and expected part of the treatment process, and felt they should be viewed as opportunities for exploring patients' "triggers" for substance use. This open mindset and tolerant attitude toward SUD-related symptoms was reported to be surprising to some patients, and could open channels of communication and access points into underlying psychological mechanisms. Many reports stated that an important part of this explorative, patient-centered attitude involved maintaining a high degree of flexibility in treatment administration:

> *And all patients might not fit into this format and that format might be doomed to fail, so maybe you have to try something new. Since many fail in this standardised format my recommendation is to dare to think outside the box.*
>
> (A5)

Staff also reported effectiveness of treatment to be dependent on patients' stability. Therefore, participants reported that treatment required flexibility to effectively follow the fluctuating nature of patient motivation. Reports also stated that pushing treatment engagement when the patient was not motivated damaged the treatment alliance between patient and health care staff:

> *In some cases, it's like bashing your head bloody against a wall. //And then [when the patient is motivated] you have to strike while the iron's hot.*
>
> (B4)

In contrast to the explorative attitude prevalent in most of the participants' interviews, some participants frequently reported that other staff members possessed a penalizing attitude, even a year after the launch of the implementation. This penalizing attitude involved a belief that restrictions after a relapse were necessary to ensure the patient's well-being and that they were not a danger to others. Some participants, however, reported that a few staff members also saw these restrictions as serving as a punitive consequence with the intent of conditioning patients with negative feelings regarding relapse. The effect of this punitive perspective was considered by all who discussed it to be ultimately detrimental to the patient's well-being and treatment progress:

> *Relapses happen to most of them but so many [staff members] are still in the old mindset where you're meant to punish failure instead of elevating success.*
>
> (A2)

Some participants stated that the patient's privileges within the clinic (ground privileges, such as unsupervised walks within the clinic area or visits to the activity center) were also restricted after a substance use relapse. Some also reported that therapeutic interventions, such as meetings with occupational therapists, were restricted. This penalizing perspective on consequences for SUD relapses, some reported, was harmful to the patient because it meant withholding treatment. Some participants stated that, prior to the implementation of the new clinical guidelines, this consequential approach was the main source of "treatment" for SUD:

> *By and large, you release patients untreated and more or less wait for a relapse but there's no treatment involved more than inhibition, so to say, where some sort of consequence mentality is meant to teach patients that it's going to be negative if you relapse. And that's meant to be some sort of treatment? Not very effective in my opinion. //It's bothered me that the only treatment has really been consequence mentality.*
>
> (A5)

Many participants stated that most patients experienced a great deal of shame following a relapse and felt as if they had let the caregivers

Table 1
Main themes and subthemes.

Main theme	Subtheme
Theme 1. Preconditions for implementing the new clinical guidelines	1.1 Disparate attitudes 1.2 SUD prioritization 1.3 Paradoxes in forensic mental health services
Theme 2. Mixed reception	2.1 Effective assessment but misplaced efforts 2.2 Effective treatment but demanding 2.3 Confusion and resistance, mostly overcome
Theme 3. Future recommendations	3.1 Unify knowledge and attitudes 3.2 Operational improvements

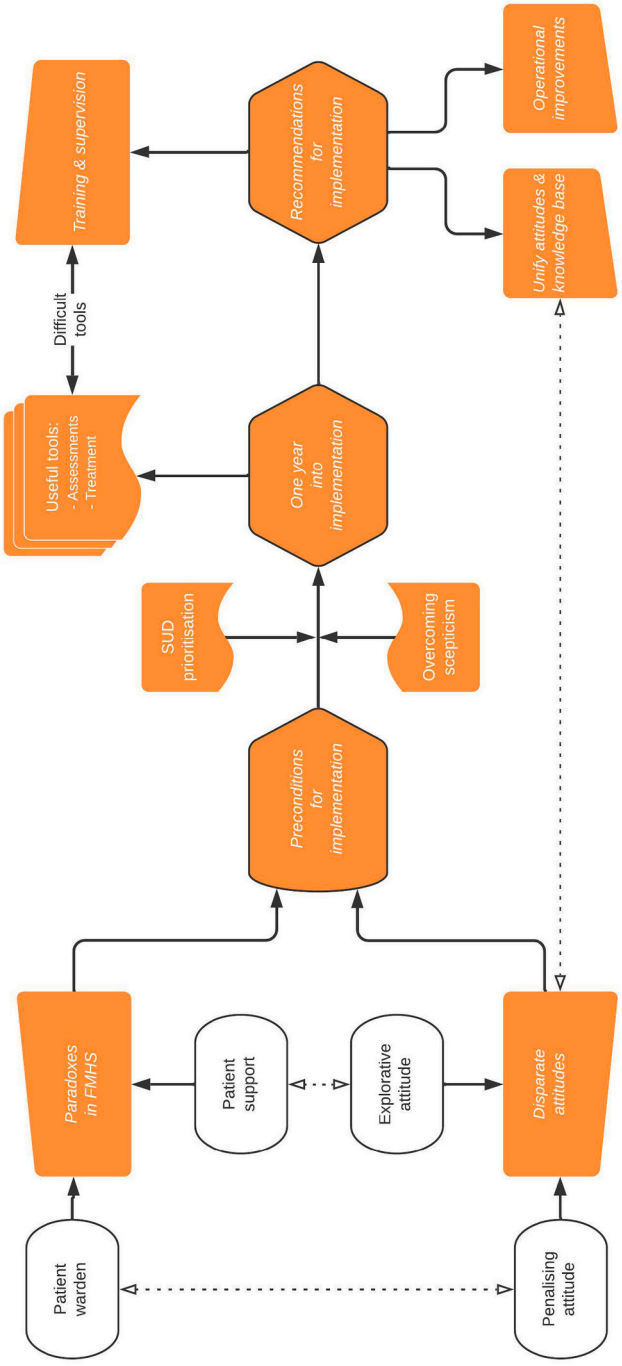

Fig. 1. Thematic structure of mental healthcare staffs' experiences with implementing COD treatment guidelines. FMHS = forensic mental health services, SUD = substance use disorder.

down. They also reported that this penalizing attitude exacerbated patients' feelings of shame and pointlessness, created a distance to staff, and embittered the patients. One participant also reflected that the main purpose of this penalizing mentality may have been related to staff's own needs rather than the patient's treatment.

3.1.2. SUD prioritization

The debate over whether SUD is to be considered a mental disorder on par with other mental disorders permeated many participants' reports. The debate does not have a simple answer, and varied perspectives were represented in the reports in both sets of interviews. Some participants stated that substance use was the patient's own choice, and that certain staff members claimed it was incongruent with effective care to focus on SUD-related problems. Others reported the disposition that SUD was as much a mental disorder as any other and should thus be treated as such:

> *But I consider it an active choice to start using substances, while a psychotic illness isn't something you choose. //[Some SUD patients] have had an awful upbringing with foster care and abuse, substance abuse in the family, and you can see that any other outcome would have been strange. But they've still made a choice. There are 'dandelion kids', after all, who have managed fine.*
>
> (B4)

> *It's not something you choose. There isn't a person on earth who would choose to hit rock bottom and develop a severe addiction.*
>
> (A2)

Many participants were conflicted regarding this dilemma and reported that they indeed considered SUD a mental disorder on par with others, but simultaneously assigned blame to the patient and considered the patient to be responsible for their condition. Directly following the implementation's launch in 2019, some participants reported that colleagues sometimes demonstrated exceedingly negative attitudes toward SUD in comparison to other mental disorders. Some participants who had SUD treatment as their primary care task reported that they were working "against" their colleagues and that they had to defend the patients:

> *But there are a lot who are just, what's the use? And I sometimes feel like I'm working with a headwind, against others. //It's still my job. And you can feel like others are thinking, rolling their eyes at me and, sigh, why is she putting so much effort into this*?
>
> (A2)

Many participants also reported that no staff members had time in their schedule dedicated to working with SUD assessment or treatment, and that other staff members did not consider SUD treatment to be part of their job description and were therefore uninterested in SUD-related work tasks. Participants reported that practical everyday activities were often prioritized over SUD interventions. A year after the implementation of the clinical guidelines, those whose primary assignment at the ward was SUD assessment and treatment reported that they had had to struggle for their work to be prioritized by other staff and supervisors:

> *…other work, that is to say everyday tasks, stand in the way of these screening instruments. //I've had to work hard to get my way. It hasn't been easy. So there's been some resistance, like certain people consider it more important for a patient to do other things than to talk with me about past alcohol habits, for example. It hasn't been entirely easy, let me tell you.*
>
> (B5)

In both sets of interviews, some participants advocated for increased professional integrity for SUD treatment, and for SUD treatment to become an integrated part of COD treatment. They reported that this increased legitimacy must be recognized both by the managerial staff, in terms of dedicated work hours for SUD treatment, and by fellow staff

members in terms of attitudes toward SUD-related tasks. Although a slight majority of participants reported that SUD lost out to other mental disorders in terms of priority, many also reported that it had received more attention following the implementation of the guidelines.

3.1.3. Paradoxes in forensic mental health services

Among conditions for successful implementation, the study also gathered certain paradoxical perspectives. Many participants reported a prior lack of treatment options for SUD and a lack of prioritization of SUD, and some voiced concern that patients' SUD was left untreated even up to the moment of discharge from the clinic. When asked at which phases of a patient's treatment process SUD was considered, the majority of participants responded that SUD was often assessed upon arrival at the clinic (or shortly after, when the acute phase of their disorder had subsided) and then again in proximity to discharge, implying that active and long-term SUD interventions were not a priority, or were only attended to in other treatment modalities, e.g., psychotherapy. Many participants also reported a disposition among health care staff that forced abstinence due to confinement was an effective, if not the only, intervention for combatting SUD among patients. The participants who had noted this attitude among staff members also stated that this disposition was anathema to successful treatment and that patients instead needed to be offered substitute activities to invest in, to maintain their motivation for refraining from drug use. The same participants also stated that patients' reactions to this punitive disposition were mainly irritation and increased desire to use again, given the opportunity. Several participants stated that boredom and the long-spanning treatment periods, perceivably void of effective treatment or meaningful activities, were a potential source of relapse among their patients:

> *…when you experience pointlessness, when you don't have anything to do, no activities, no future prospects, when there's no point to anything, at that point [relapse] is almost a guarantee.*
>
> (A5)

The dual roles of motivating patients for treatment engagement and instilling hope while simultaneously punishing them following relapse by forcing them to regress or stagger in treatment progression were also mentioned as a difficult-to-reconcile duality:

> *We're both police and at the same time are meant to help [patients] progress. But then they make a mistake, and we push them back and then we're meant to progress again. It's pretty complex.*
>
> (B4)

Some participants reflected on these dual roles, saying that if SUD is treated as a mental disorder, relapses are per definition the responsibility of the caregiver. In stark contrast to this, some staff members were described by the participants as seemingly experiencing "incredible joy" at discovering illegal substances in patients' rooms and at the prospect of "busting them".

3.2. Theme 2: mixed reception

The new assessment instruments and the CRA treatment intervention were largely received positively by participants, but participants did raise some criticisms. The assessments offered health care staff new insight into SUDs and new means with which to communicate with patients concerning their disorder. Participants raised some issues about the administration of the assessments. The introduction of CRA was met with a sense of relief, but participants noted an enduring gap in the treatment process in relation to SUD interventions.

3.2.1. Effective assessment but misplaced efforts

Overall, participants were positive regarding the potential of the new assessment instruments and could, directly following implementation, notice certain benefits. Participants reported that, while previous instances in the chain of FMHS had assessed the patient, administering the assessment instruments at their ward provided new and important information on SUDs. Many participants noted that, in the past, they might have relied too heavily on the assessments made upon arrival and that treatment interventions therefore might have been initiated based on outdated assessments. A large number of participants also noted relief that the new assessment instruments provided a more extensive foundation upon which to adapt patient treatment:

> *…then they have the information they need in order to provide help for him. The right help is accessible. Thanks to the new assessment.*
>
> (A3)

Many also reported that the new assessment, while exhaustive and at times exhausting, provided them with previously inaccessible keys to patient engagement and to a dialogue with the patient that could ultimately lead to increased motivation. Similarly, the process of working with and coming to understand the new instruments had led to an increased awareness among the staff members concerning the prevalence of SUD in the COD patient group and the importance of treating it.

A few participants, however, considered certain aspects of the assessment instruments to be a poor match for the COD patient group. Many reports described the patient group in question as particularly hard to motivate and as often lacking the cognitive resources to cope with complex questions or self-scrutiny. Participants mentioned that some of the instruments contained a considerable number of questions, that it could be exhausting for the patient to complete, and that patients could not always identify nuances in questions that were similar or that contained multiple statements. Reportedly, some patients reacted adversely to the repeated administration of the instruments:

> *You've administered it to those who've been here for a while, and it's required a lot of motivation for them to comply. Because they think that, yeah, this is meaningless. And maybe they're tired…*
>
> (A2)

Participants reported a desire for more flexibility in the administration of the assessments to meet the patient group's often limited cognitive capacity, limited attention span, and low levels of motivation. Participants also reported that the frequency with which these instruments were expected to be administered was incompatible with the timeframe of the FMHS and the low rate at which the patients' mental health progressed. They mentioned that subsequent administrations following the first were met with increasing resistance from patients. Some participants pointed out that not much changed between assessment sessions, and that repeated administrations of assessments were misplaced efforts. In rare cases, overly frequent administration served to demonstrate to the patient how little progress they had made, and was ultimately detrimental to patient motivation and instilled hopelessness. Furthermore, some reports stated that patients were hard to motivate concerning recurring assessment due to an often-cited opinion that, since confinement, they had abstained from drug use and therefore no longer met the diagnostic criteria of an SUD.

3.2.2. Effective treatment but demanding

Participants often reported a positive reaction to the CRA treatment. A majority of participants reported that, prior to the implementation of the clinical guidelines, no systematic treatment options for SUD had been available. Some stated that they had had a "homemade" treatment method, designed by experienced health care staff but lacking empirical basis. Still others reported that the CRA treatment had been available to them previously, but had rarely been utilized. A large number of participants also noted that they had recognized the need for SUD treatment in their patient group prior to this implementation and, although the implementation process had meant a significant amount of work, had experienced relief at finally benefitting from an effective and empirically founded treatment option such as the CRA:

…we had that dream. What if we could have a treatment option for it? We could do something, we could do something structured, following a format. //…I mean, this [the new treatment] is what we've been working towards. Now we start reaping the rewards.

(B7)

CRA was especially appreciated for its flexibility and broad coverage of problematic areas. Many participants reported a dissipation of their frustration at recognizing a patient's need for treatment but having nowhere to turn:

…you've assessed and ended up with nothing to do or not knowing what to do. So now the structure is in place, and we start from the beginning. It feels easier.

(A8)

Several participants noted a gap between the identification of SUD in COD patients and the engagement in treatment programs. Judging by the reports of most participants, this gap persisted even after the new clinical guidelines had been implemented. Some participants reported that identifying SUD, prior to the implemented guidelines, had been met with little interest. They mentioned having communicated SUD issues to colleagues and to the ward's physician, but that they had received little feedback and that the issue was largely disregarded. Interventions were often initiated based on limited or outdated assessments. While the SUD intervention guidelines had made a potent treatment method available, participants noted that it was the only option available and that it was demanding in terms of requiring a relatively high level of cognitive capacity and motivation from the patient. This difficulty in patient engagement and treatment administration was reported both in proximity to the start of the implementation and still one year later. A large number of patients for whom the participants provided care were considered to lack the necessary requirements for the CRA treatment to be successful; and if CRA were deemed an unfit treatment, the options were limited:

If I administer, say, an AUDIT on someone and identify severe alcohol dependence for example, then it stops there, I feel. [The new treatment] requires a person to be motivated to be able to perform it, and if not, then it's impossible. And then, what's there after that? And that's when it stops. There are no other options.

(B5)

The most commonly reported intervention for SUD at the clinic, in both sets of interviews, was motivational interventions. This finding implies that the assessments are efficient, and the treatment is readily available, but that bridging the gap between the two is challenging. Due to the demanding nature of SUD treatment, a considerable degree of responsibility was reportedly placed on the patients. Some participants reported that the patient was responsible for initiating treatment. Some also stated that if caregivers were too intrusive with requests for treatment engagement, they risked being seen as "pushy" or bothersome, and that such behavior would ultimately alienate the patient and make them difficult to reach. Many participants also reported a lack of skill and education in effective motivational techniques. Some reported the need to elevate the motivational skills of staff members working "on the floor", who spent the majority of their time with the patients, to effectively transition the patients across this gap from assessment to treatment.

3.2.3. Confusion and resistance, mostly overcome

Some participants noted that, simultaneously, the number of new instruments that were implemented was overwhelming, and they felt they had been somewhat poorly prepared for the significant change this implementation entailed:

…I mean, it's a lot at once and we haven't been fully prepared, I guess. Maybe there could have been more information and maybe more follow-up and more practical guidance?

(B2)

Participants described several of the assessments as difficult to administer, and their results as difficult to interpret. A number of participants mentioned the need for more practical guidance concerning the instruments. Some mentioned that a sequential implementation would have been preferable, to mitigate the sheer volume of new instruments included in the clinical guidelines.

Participants also reported some confusion concerning the division of responsibility. Some participants stated that conducting these new assessments was a central part of their work but that, even a year after the implementation launch, their colleagues still lacked insight into their function and purpose. Participants also reported that some staff members were hesitant about the new interventions because their application was not part of their responsibility; that they considered the patients to be responsible for their disorder; or that attempts to help patients manage substance dependence, withdrawal, and cravings were in vain or a waste of time. Communicating the results from the assessments to fellow health care staff, deliberating on ambiguous data, and formulating treatment plans were considered to have been hampered by this reluctance and diffusion of responsibility.

Some participants also reported that the initial hesitance toward the new interventions might have been due to a collective lack of understanding, regarding both the interpretation of the assessment instruments but also the overarching purpose of the clinical guidelines being implemented. Some participants also disclosed an initial fear of making mistakes when they had first used the assessment instruments together with a patient. A year following the launch of the implementation, participants noted that they had largely overcome this initial fear and hesitance and that the new instruments had become integrated into their everyday clinical work:

…there was some initial resistance, we thought it was hard, complicated, we were afraid of making mistakes. But now, we're past that, and we can really see the benefits of it.

(B7)

Many participants also reported a gradually more positive attitude toward SUD treatment in their work teams and a greater degree of recognition of SUDs in the COD patient group, and staff members working primarily with SUD treatment reported feelings of increased respect for their work:

But I do think people have started to be more respectful towards those at the ward who do them [the assessments], and that they're effective and important. So, I find that very positive, for the year that I've been here.

(B5)

3.3. Theme 3: future recommendations

Many of the participants reported recommendations and suggestions for the improvement of, and future changes to, continued implementation efforts. Several participants reported the benefits of improving the staff's empathetic disposition, and unifying them in terms of attitude and shared knowledge. Participants also mentioned structural limitations or possible organizational improvements that would be of benefit to SUD care for COD patients or that would otherwise benefit the staff's ability to administer such care.

3.3.1. Unify attitudes and knowledge base

A significant number of participants reasoned that there were potential gains for SUD treatment through unifying staff members' attitudes and empathetic perspective toward SUD. The majority reported an empathetic and explorative perspective, but many also noted that all

staff members did not share this attitude. A desire for a more non-judgmental, non-threatening, open-minded attitude was stated by many participants, with the desired outcomes of minimizing patients' fear of penalization and improved communication with patients. Another important recommendation for propagating empathetic attitudes was to increase staff members' knowledge and understanding of SUD, addiction, and relapse. Some participants noted that not all staff members shared the same educational level or knowledge of SUD research, and that this discrepancy created intra-staff barriers when administering the new SUD interventions:

> …*they [colleagues] might have worked there for a long time, they've been around the block many times, year in, year out. And they might not have the same knowledge about past addiction, substances, they haven't worked with it before. And now they might consider this unnecessary work. Why do we need to do these new things? Why can we not just keep doing what we've always done? I think that might be one of the major problems, why certain staff members are uninterested and don't care or think this is unnecessary*.
>
> (B5)

Many participants reported that a lack of understanding of SUD and its psychological mechanisms might account for the custodial, penalizing mentality that some staff members held. They stated that simply considering an SUD patient an "addict" and failing to "see the person behind the patient" led to low motivation to treat the disorder. Increased knowledge and understanding could, reportedly, improve not only the quality of care but also the morale of the staff, as poor insight into SUD mechanisms and the rehabilitation process might lead to negative attitudes and the depletion of hope among staff following a patient's relapse:

> A9: …*and the understanding, simply what an addiction is or what substance use is, what it does to you, needs to improve*.
>
> Interviewer: *Such a lack of understanding, what could it lead to*?
>
> A9: …*that you become judgmental. And for some, empathetic fatigue*.

Several participants offered suggestions for how to increase knowledge. They mentioned courses, lectures, a checklist of observable, clinical symptoms preceding relapse, and addressing the psychology of SUD as a reoccurring topic at their monthly staff meetings. They also pointed out the need for continuous practical supervision, as knowledge was often lost in translation from theory to practice.

Participants also reported that it was important that staff create a jointly held perspective on long-term, realistic outcomes for successful SUD treatment. Considering the complex, multifaceted problems for the COD patient group, participants recommended maintaining flexibility in long-term treatment goals:

> *These are often severely ill, severely disabled individuals. The goal has to be to offer them the greatest degree of autonomy and freedom as possible. And considering that these are patients with COD, with extremely complex problems, it would be great if we could [upon the patient's return after relapse] have him live in assisted housing for 29 days a month and have him spend one night with us and then return – if he's psychologically stable and manages medication and other treatment*.
>
> (A5)

Some participants noted that a lifestyle entirely free from relapse may be an unrealistic goal for their patients, and that insisting on this may be counterproductive. They stated that structure flexibility would be beneficial and that many patients are in fact responsible when entrusted.

3.3.2. Operational improvements

Besides the recommended unity of knowledge and attitudes regarding SUD and treatment outcomes, some participants also suggested practical and operational improvements. Many participants, in both sets of interviews, reported that more clearly structured scheduling that allowed for the dedicated administration of SUD assessments and treatment would assist their work. SUD-related tasks were often overshadowed by practical necessities, which hindered the development of the skills required for successful SUD treatment:

> …*sometimes I have to work the kitchen as well. And I know some treatment assistants at other wards who are new; they get placed there a lot as well. It severely inhibits the development for the treatment assistants, that they can't develop their skills in a meaningful way*.
>
> (B5)

Many reported that communication with physicians and some of the psychologists was difficult. Some psychologists reportedly lacked the time to spend with patients to fully comprehend the information the nursing staff relayed:

> …*I mean, that's what you lack at a large clinic, that psychologists and vocational trainers and others never have the time to be down at the ward. They have overly large groups, too many patients. You would have preferred for them to get to know the patients, and for the patients to see them, that they're there for them and don't just pop in, have a session for an hour, take some notes and then they're done*.
>
> (A8)

Many participants also reported benefits from the intervention of increased collaboration between different professional roles. Participants reported that some physicians were uninterested in SUD, and that issues raised relating to SUD were often ignored. Several participants reported the need for greater engagement from psychologists and physicians, advocating for greater collaboration within and across the professional teams responsible for the patients. This desire for improved cooperation was also reported on a higher organizational level within the FMHS in Sweden. Many participants saw a need for collaboration across municipalities, with other institutions, and with the patient's social network. This elevation in collaboration was considered especially important, as many patients frequently transitioned between clinics during the often extensive care period within FMHS.

Many of these suggestions required increased staff resources, which participants also explicitly mentioned as a suggested improvement. Some recommended that staff members spend more of their time with the patients, to physically "be where the patients are" at the ward. Many participants recommended that staff develop a deeper understanding of the patient as a person. Participants reported that the best way to predict an oncoming relapse was to get to know the patient well and learn their unique indicators for a worsened psychological state.

4. Discussion

Clinical guidelines focusing on SUD (incl. assessment and treatment) for patients with COD were implemented at a high-security FMHS facility in Sweden. The aim of this study was to describe health care staff's experiences of factors that enabled and hindered the implementation, and the implementation process, at two time points: directly following its launch (November 2019) and one year thereafter (November 2020).

Consistent with results from previous studies examining barriers to implementing integrated COD treatment in FMHS settings (Graham, 2004; Morojele et al., 2012), the reports from health care staff in this study indicated a division in attitude among staff members concerning SUD and addiction in general. Most participants reported having an explorative and tolerant attitude toward SUD, addiction, and relapse, but also noted the hindering presence of a penalizing, consequential mindset among other staff members. Results also indicated a lingering resistance among some of the staff members toward the new interventions and an unenthusiastic approach to administering them. The participants suggested that this resistance might be due to a lack of knowledge concerning SUD and addiction in general. These findings are

in line with previous studies on implementation processes in various clinical settings (Davies et al., 2007), and stress the value of educational investments in the health care setting. The results also observed a persistent, yet reversed, imbalance between administered assessment and treatment at the clinic. Staff had substantially increased the assessment of SUD one year into implementation, but reported difficulties in engaging patients in the implemented treatment (e.g., patients were not deemed eligible for CRA or considered motivated to initiate treatment). This gap between recognition of need and administration of treatment for patients with COD has been reported in previous studies (e.g., Novak et al., 2019). Such a gap is a prevalent issue in psychiatric treatment that needs to be addressed.

4.1. Enabling and hindering preconditions

Various clinical settings have identified health care staff's attitudes as a cornerstone of the successful implementation of new interventions (e.g., Eagle et al., 2019; Ford et al., 2021; Graham, 2004). One prominent aspect of the results in this study involved the two distinct attitudes reported by the health care staff. Their dual roles of supporting caregiver and restricting warden, alongside the complex heterogeneity of mental disorders among COD patients, may have given rise to this division in attitudes—a division that has been discussed in previous reviews of mental health nursing staff's attitudes toward patients with COD (Adams, 2008). The attitude held by a majority of the health care staff in this study was explorative of patients' psychological mechanisms, regarded relapses as a natural and inevitable part of the treatment process, and saw relapses as offering valuable opportunities for exploring triggers and increasing patients' motivation for treatment. Participants regarded refraining from talking about patients' SUD for fear of awakening cravings as a barrier to SUD treatment, a disposition that has been found in a previous Swedish study of nursing staff's experiences of working with COD patients (Wadell & Skärsäter, 2007). Many participants recognized the negative feelings patients often experienced in association with relapse, and felt it was their responsibility to support these patients by imparting optimism and hope rather than penalizing them through negative consequences after relapses. Considering the multifaceted complexities and poor treatment retention of the COD patient group (Drake et al., 2001; Drake et al., 2008; Lyons et al., 2021), this attitude is a highly beneficial presence at the clinic and steps should be taken to convey it to all staff members.

Reports also revealed the presence of a penalizing attitude, which participants regarded as the “old mindset”. Some of the clinic's staff believed that, in lieu of empirically founded treatment options, conditioning patients through negative associations to substance use by penalizing relapse was an effective treatment for SUD. Previous research suggests that mental health care staff often possess negative, stigmatizing attitudes toward patients with COD (Avery et al., 2013; Avery et al., 2015; Kulesza et al., 2016). Such negative attitudes may worsen the psychological distress of, and lead to inadequate treatment for, COD patients (Adams, 2008; Schulze, 2007; van Boekel et al., 2013). Reports indicated that the issue of SUD, prior to the implementation, was perpetually postponed until patients were to be discharged from FMHS. A lack of treatment interventions or meaningful activities and boredom—in combination with some staff's stigmatizing attitudes, which elicited animosity from patients and exacerbated negative feelings—suggest the existence of a relapse-inducing structure. To improve the sustainability of the implemented intervention, penalizing or stigmatizing attitudes toward SUD should be eliminated. Some participants noted that this penalizing mentality was more commonly held by senior staff members. Research has hypothesized that multiple negative experiences with SUD patients induce and worsen negative attitudes among staff over time (Avery et al., 2017) but that these attitudes can be improved by training and education (Pinderup, 2016). Maintaining positivity and empathy and recognizing that SUD management is an arduous process in which relapses are commonplace are important for mitigating health care staff's empathy fatigue. Some participants reported that the negativity and fatigue of other staff members served as an additional and unnecessary obstacle in working toward the implementation of COD treatment. Previous research has found degeneration of health care staff's morale and clinical team cohesion to be a critical barrier to the implementation of COD treatment (Brown & Lewis, 2015), and seems to be a current challenge for the participants in this study as well. Health care staff's empathy is key to a successful patient-caretaker alliance and can be problematic to maintain without training (McLeod et al., 2002). Investments in improving staff morale, peer support, and communication are therefore likely to support implementation efforts and reduce health care staff's risk of burnout.

4.2. Experiences of the implementation process at launch and one year later

Reports one year following the implementation's launch indicated that the process of improving staff's attitudes toward SUD might be well underway, as participants observed that the penalizing attitude was less prevalent. A Danish study by Pinderup (2018) found that attitudes toward COD had improved as a result of the implementation process, and that health care staff had started to react when other staff expressed negative attitudes toward COD. The notion of improved attitudes due to implementation fidelity is supported by this study, but further studies on long-term implementation fidelity and changes in attitudes should confirm this.

At the launch of the implementation, some participants reported being overwhelmed by the scope of the clinical guidelines and many requested more practical guidance in how to administer and interpret the assessments. A year after implementation patients still reported this need, albeit to a lower degree. The low treatment rate for the COD patient group is due partly to underdiagnosis (Rumpf et al., 2001) and partly to the use of inappropriate assessment approaches (Morojele et al., 2012). Research highly recommends that administrative leadership, ongoing learning opportunities, and feedback be sustained for two to four years (Fixsen et al., 2009). Due to the complex treatment needs of the COD patient group, sustained educational efforts are especially valuable in the FMHS setting. Another critical component in implementing SUD-focused clinical guidelines is that staff members recognize the significance of SUD in COD patients' treatment. At the start of the implementation, a majority of participants were positive toward implementing SUD assessments, suggesting that some, if not most, of them recognized the importance of SUD interventions for the patient group. They also noted, however, that not all staff members shared this view and that some questioned the value of investing time and resources in SUD interventions. Health care staff in general experience a multitude of new interventions, and implementation research has shown that some may be reluctant to divert their attention from what they consider to be qualitative care to invest in “transient fads” (Davies et al., 2007). While the link between severe mental disorders and violence is not yet fully understood, co-occurring SUD is a potent predictor of violent reoffending (Fazel et al., 2009; Gumpert et al., 2010; Van Dorn et al., 2011). Treatment staff should convey the value and veracity of empirical research to health care staff. In clinical settings, when implementing new interventions, an administrative support structure should be established that can sustain the implementation process and clinics must not rely solely on a select few individuals to singlehandedly carry the burden of sustaining the implementation. Some reports at the beginning of the implementation, in 2019, stated that participants who were responsible for administering the implemented assessment and treatment did not receive dedicated time in their schedule to perform these tasks and that practical tasks were often given priority. The initial skepticism regarding the value of the implemented interventions and the issue of prioritization were reported as having been mostly overcome one year into the implementation process, indicating that SUD had gained more recognition and that the importance of treating COD had

begun to be conveyed among staff. A mixed-method design study showed, however, that while self-report data from nursing staff indicated increased knowledge and capability in treating COD due to newly implemented interventions, objective measurements challenged this point (Pinderup, 2018).

4.3. Bridging the gap

Another important result in this study was the health care staff's reports concerning the gap between assessment and treatment. Prior to the implemented clinical guidelines containing both the assessment and treatment of SUD, an imbalance existed. While little attention was given to SUD assessment, treatment—often lacking adequate empirical support and long-term effectiveness—was still initiated. One year into the implementation of the guidelines an imbalance still existed, but in the reverse: Assessments were frequently conducted, but engaging patients in treatment was considered difficult. This gap between the assessment and treatment of SUD, and the reported difficulties in transitioning patients across it, are not uncommon for the COD patient group (McKee, 2017; Novak et al., 2019; Sacks et al., 2013). To improve quality of care for COD patients, FMHS must bridge this gap. Participants claimed that patients were often deemed unfit for the implemented treatment approach due to their lack of insight into their SUD diagnosis. One important component in bridging the treatment gap, then, is to augment the perceived relevance of treatment by increasing COD patients' insight concerning their SUD (Williams et al., 2015). Many participants also advocated for a more flexible treatment administration that allowed for treatment to be tailored according to patients' varying cognitive capacity, psychological issues, substance use history, and social situations. Therefore, another important component in transitioning COD patients from assessment to treatment could be a flexible adaptation of treatment that engages patients' social and personal resources with a long-term perspective (Beaulieu et al., 2021; Brunette et al., 2004; Kelly & Daley, 2013; Lubman et al., 2010; Warren et al., 2007). Assertively engaging, but not provoking, patients requires a fine balance and a skilled practitioner, and FMHS is a particularly challenging setting in this regard, with patients' motivation for treatment being low. Some participants experienced that, while treatment was available, patients themselves were expected to initiate, or signal their readiness to enroll in, treatment. Consequently, clinic investments to increase staff skills in more advanced motivational interventions (Barrowclough et al., 2001; Barrowclough et al., 2010; Drake et al., 2004) could be another important component to improving quality of care for COD patients in FMHS and bridging the gap between assessment and treatment.

5. Limitations

To explore the progression of the implementation process, the study held two sets of interviews, the first in 2019 and the second in 2020. However, the strained circumstances during the COVID-19 pandemic resulted in too few participants in the second set of interviews to conduct a separate analysis of repeated interviews. Therefore, the two sets of interviews were treated as one data corpus and the temporal aspect was only considered when participants' reports concerned noticeable changes at the clinic during the past year as a result of the implemented clinical guidelines. The study did not collect data concerning the extent of participants' experience with the newly implemented instruments save for years of professional experience. While all participants had received education, training, and some measure of supervision regarding the administration of CRA and the assessments, the extent of their familiarity with the instruments could have varied. Additionally, in the second set of interviews, one participant had only been employed at the clinic for six months. All other participants had had professional experience ranging from three to 15 years. While the interview with a participant with less experience and familiarity with the assessments than others could perceivably yield less information, it could yield unbiased insights pertaining to the prevalent attitudes toward SUD and addiction that would otherwise be hard to obtain. Furthermore, staff who consented to participate in the study were mostly positive regarding the integration of SUD-focused guidelines. Staff who were critical of the implementation efforts may not have participated; as such, their perspective may be absent. Participants often discussed other staff members, whose viewpoints could be regarded as being included as second-hand information. Implementation research suggests that an effort should be sustained for four years to observe lasting change (Fixsen et al., 2009); therefore, our exploring the implementation's status and consequences thereof only one year following its launch might have limited the possibility to observe change. Nevertheless, participants reported that some change indeed had occurred, suggesting that the implementation is progressing well.

6. Conclusion and clinical implications

The results from this study highlight the value of unifying health care staff's attitudes toward COD for the sustained implementation of interventions. One year after implementing the SUD-focused clinical guidelines, some of the initial resistance and skepticism regarding SUD had been overcome and the health care staff were starting to see its benefits. But successful implementation efforts take time, and many implementations in clinical settings fail due to low fidelity to sustained efforts (e.g., Drake & Bond, 2010). Without financial and organizational support, improvements following the implementation are likely to degrade. To improve implementation sustainability, the clinic must carefully plan and allocate long-term financial resources. FMHS should provide ongoing supervision and training, streamline documentation, and monitor changes to and the fidelity of the intervention implementation. Clinics should provide recurring education and workshops, where staff can deliberate on ambiguous results and discuss how to give patients feedback together with staff who have more assessment experience.

The gap between the assessment and treatment of SUD needs addressing. Efforts to increase patients' insight into their SUD, increase flexibility in the administration of treatment, and increase mental health care staff's skills in motivational work would aid in transitioning patients across the gap. Seminars and clinic-wide training opportunities concerning SUD, and addiction in general, and an empathetic perspective on SUD and relapses would be valuable investments. Participants considered having an SUD and patients' current SUD status as set points in meeting agendas to help to enhance an SUD perspective in the treatment of COD patients within FMHS. Providing health care staff, especially junior members, with a clearer forum to discuss SUD assessment and treatment would also aid in solidifying the status of SUD treatment as a critical component of FMHS.

CRediT authorship contribution statement

J. Green: Methodology, Validation, Formal analysis, Data curation, Writing – original draft, Writing – review & editing. **A.S. Lindqvist Bagge:** Validation, Investigation, Writing – review & editing, Supervision. **S. Olausson:** Methodology, Validation, Writing – review & editing. **P. Andiné:** Conceptualization, Validation, Writing – review & editing. **M. Wallinius:** Conceptualization, Validation, Writing – review & editing. **M. Hildebrand Karlén:** Conceptualization, Validation, Methodology, Investigation, Data curation, Writing – review & editing, Supervision.

Declaration of competing interest

The authors of the present manuscript have no conflicts of interest to declare.

Acknowledgements

This research was supported by the Swedish Research Council for Health, Working Life and Welfare (2018-01409). We thank all the employees at the clinic, particularly Ida Johansson, Isabelle Johansson, and Jimmi Andersson, without whose hard work and dedication the implemented SUD interventions would not be possible. We also acknowledge Christel Karlsson for her administrative support during the study.

References

Adams, M. (2008). Comorbidity of mental health and substance misuse problems: A review of workers' reported attitudes and perceptions. *Journal of Psychiatric and Mental Health Nursing, 15*(2), 101–108. https://doi.org/10.1111/j.1365-2850.2007.01210.x

Aharonovich, E., Liu, X., Nunes, E., & Hasin, D. S. (2002). Suicide attempts in substance abusers: Effects of major depression in relation to substance use disorders. *The American Journal of Psychiatry, 159*(9), 1600–1602. https://doi.org/10.1176/appi.ajp.159.9.1600

Avery, J., Dixon, L., Adler, D., Oslin, D., Hackman, A., First, M., Goldman, B., Koh, S., Nossel, I., & Siris, S. (2013). Psychiatrists' attitudes toward individuals with substance use disorders and serious mental illness. *Journal of Dual Diagnosis, 9*(4), 322–326. https://doi.org/10.1080/15504263.2013.835165

Avery, J., Han, B. H., Zerbo, E., Wu, G., Mauer, E., Avery, J., Ross, S., & Penzner, J. B. (2017). Changes in psychiatry residents' attitudes towards individuals with substance use disorders over the course of residency training. *The American Journal on Addictions, 26*(1), 75–79. https://doi.org/10.1111/ajad.12406

Avery, J., Zerbo, E., & Ross, S. (2015). Improving psychiatrists' attitudes towards individuals with psychotic disorders and co-occurring substance use disorders. *Academic Psychiatry, 40*(3), 520–522. https://doi.org/10.1007/s40596-015-0361-6

Babor, T., & Robaina, K. (2016). The alcohol use disorders identification test (AUDIT): A review of graded severity algorithms and national adaptations. *The International Journal of Alcohol and Drug Research, 5*(2), 17. https://doi.org/10.7895/ijadr.v5i2.222

Baillargeon, J., Penn, J., Knight, K., Harzke, A., Baillargeon, G., & Becker, E. (2009). Risk of reincarceration among prisoners with co-occurring severe mental illness and substance use disorders. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(4), 367–374. https://doi.org/10.1007/s10488-009-0252-9

Baker, K., Lubman, D., Cosgrave, E., Killackey, E., Pan Yuen, H., Hides, L., Baksheev, G., Buckby, J., & Yung, A. (2007). Impact of co-occurring substance use on 6-month outcomes for young people seeking mental health treatment. *Australian and New Zealand Journal of Psychiatry, 41*(11), 896–902. https://doi.org/10.1080/00048670701634986

Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S. W., Moring, J., O'Brien, R., Schofield, N., & McGovern, J. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *The American Journal of Psychiatry, 158*(10), 1706–1713. https://doi.org/10.1176/appi.ajp.158.10.1706

Barrowclough, C., Haddock, G., Wykes, T., Beardmore, R., Conrod, P., Craig, T., Davies, L., Dunn, G., Eisner, E., Lewis, S., Moring, J., Steel, C., & Tarrier, N. (2010). Integrated motivational interviewing and cognitive behavioural therapy for people with psychosis and comorbid substance misuse: Randomised controlled trial. *BMJ, 341*(7784), 26–1204. https://doi.org/10.1136/bmj.c6325

Beaulieu, M., Tremblay, J., Baudry, C., Pearson, J., & Bertrand, K. (2021). A systematic review and meta-analysis of the efficacy of the long-term treatment and support of substance use disorders. *Social Science & Medicine, 285*(1982), Article 114289.

Belenko, S., & Peugh, J. (2005). Estimating drug treatment needs among state prison inmates. *Drug and Alcohol Dependence, 77*(3), 269–281. https://doi.org/10.1016/j.drugalcdep.2004.08.023

Berman, A., Palmstierna, T., Källmén, H., & Bergman, H. (2007). The self-report drug use disorders identification test—Extended (DUDIT-E): Reliability, validity, and motivational index. *Journal of Substance Abuse Treatment, 32*(4), 357–369. https://doi.org/10.1016/j.jsat.2006.10.001

Boden, M., & Moos, R. (2009). Dually diagnosed patients' responses to substance use disorder treatment. *Journal of Substance Abuse Treatment, 37*(4), 335–345. https://doi.org/10.1016/j.jsat.2009.03.012

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brown, S., & Lewis, K. (2015). Hope for successful implementation of psychosocial/psychiatric rehabilitation in the forensic mental health setting. *Psychiatric Rehabilitation Journal, 38*(4), 365–370. https://doi.org/10.1037/prj0000086

Brunette, M., Asher, D., Whitley, R., Lutz, W., Wieder, B., Jones, A., & McHugo, G. (2008). Implementation of integrated dual disorders treatment: A qualitative analysis of facilitators and barriers. *Psychiatric Services, 59*(9), 989–995. https://doi.org/10.1176/ps.2008.59.9.989

Brunette, M., Drake, R. E., Woods, M., & Hartnett, T. (2001). A comparison of long-term and short-term residential treatment programs for dual-diagnosis patients. *Psychiatric Services (Washington, D.C.), 52*(4), 526–528. https://doi.org/10.1176/appi.ps.52.4.526

Brunette, M., Mueser, K., & Drake, R. (2004). A review of research on residential programs for people with severe mental illness and co-occurring substance use disorders. *Drug and Alcohol Review, 23*(4), 471–481. https://doi.org/10.1080/09595230412331324590

Cacciola, J., Alterman, A., Habing, B., & Thomas, M. (2011). Recent status scores for version 6 of the addiction severity index (ASI-6). *Addiction (Abingdon, England), 106*(9), 1588–1602. https://doi.org/10.1111/j.1360-0443.2011.03482.x

Choi, S., Adams, S., MacMaster, S., & Seiters, J. (2013). Predictors of residential treatment retention among individuals with co-occurring substance abuse and mental health disorders. *Journal of Psychoactive Drugs, 45*(2), 122–131. https://doi.org/10.1080/02791072.2013.785817

Swedish National Forensic Psychiatric Register, R. K.c. (2020). *Annual 2020*. Gothenburg: Swedish National Forensic Psychiatric Register.

Compton, W., Thomas, Y., Stinson, F., & Grant, B. (2007). Prevalence, correlates, disability, and comorbidity of DSM-IV drug abuse and dependence in the United States: Results from the National Epidemiologic Survey on alcohol and related conditions. *Archives of General Psychiatry, 64*(5), 566–576. https://doi.org/10.1001/archpsyc.64.5.566

Davies, H., Powell, A., & Rushmer, R. (2007). *Healthcare professionals' views on clinician engagement in quality improvement: A literature review*. Retrieved from. The Health Foundation https://www.health.org.uk/publications/.

Domingo-Salvany, A., Torrens, M., & Mestre-Pintó, J. (2016). Comorbidity of substance use and mental disorders in Europe. *European Monitoring Centre for Drugs and Drug Addiction, Publications Office.*. https://doi.org/10.2810/532790

Drake, R. E., & Bond, G. (2010). Implementing integrated mental health and substance abuse services. *Journal of Dual Diagnosis, 6*(3–4), 251–262. https://doi.org/10.1080/15504263.2010.540772

Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services (Washington, D.C.), 52*(4), 469–476. https://doi.org/10.1176/appi.ps.52.4.469

Drake, R. E., Mercer-McFadden, C., Mueser, K. T., McHugo, G. J., & Bond, G. R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin, 24*(4), 589–608. https://doi.org/10.1093/oxfordjournals.schbul.a033351

Drake, R. E., Mueser, K., Brunette, M., & McHugo, G. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal, 27*(4), 360–374. https://doi.org/10.2975/27.2004.360.374

Drake, R. E., O'Neal, E., & Wallach, M. (2008). A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. *Journal of Substance Abuse Treatment, 34*(1), 123–138. https://doi.org/10.1016/j.jsat.2007.01.011

Eagle, K., Ma, T., & Sinclair, B. (2019). Integrated substance use rehabilitation in a secure forensic facility. *Journal of Forensic Practice, 21*(1), 50–60. https://doi.org/10.1108/JFP-09-2018-0037

Fazel, S., Gulati, G., Linsell, L., Geddes, J., & Grann, M. (2009). Schizophrenia and violence: Systematic review and meta-analysis. *PLoS Medicine, 6*(8), 1–15. https://doi.org/10.1371/journal.pmed.1000120

Fixsen, D., Blase, K., Naoom, S., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*(5), 531–540. https://doi.org/10.1177/1049731509335549

Flynn, P., & Brown, B. (2008). Co-occurring disorders in substance abuse treatment: Issues and prospects. *Journal of Substance Abuse Treatment, 34*(1), 36–47. https://doi.org/10.1016/j.jsat.2006.11.013

Ford, J., Kaur, A., Rao, D., Gilson, A., Bolt, D., Garneau, H., Saldana, L., & McGovern, M. (2021). Improving medication access within integrated treatment for individuals with co-occurring disorders in substance use treatment agencies. *Implementation Research and Practice, 2*. https://doi.org/10.1177/26334895211033659, 263348952110336.

Graham, H. (2004). Implementing integrated treatment for co-existing substance use and severe mental health problems in assertive outreach teams: Training issues. *Drug and Alcohol Review, 23*(4), 463–470. https://doi.org/10.1080/09595230412331324581

Grant, B. F., Goldstein, R. B., Saha, T. D., Chou, S. P., Jung, J., Zhang, H., Pickering, R. P., Ruan, W. J., Smith, S. M., Huang, B., & Hasin, D. S. (2015). Epidemiology of DSM-5 alcohol use disorder: Results from the National Epidemiologic Survey on alcohol and related conditions III. *JAMA Psychiatry, 72*(8), 757–766. https://doi.org/10.1001/jamapsychiatry.2015.0584

Grant, B. F., Saha, T. D., Ruan, W. J., Goldstein, R. B., Chou, S. P., Jung, J., Zhang, H., Smith, S. M., Pickering, R. P., Huang, B., & Hasin, D. S. (2016). Epidemiology of DSM-5 drug use disorder: Results from the National Epidemiologic Survey on alcohol and related conditions-III. *JAMA Psychiatry, 73*(1), 39–47. https://doi.org/10.1001/jamapsychiatry.2015.2132

Grimshaw, J., Eccles, M. P., Lavis, J. N., Hill, S. J., & Squires, J. E. (2012). Knowledge translation of research findings. *Implementation Science: IS, 7*(1). https://doi.org/10.1186/1748-5908-7-50

Gumpert, C., Winerdal, U., Grundtman, M., Berman, A. H., Kristiansson, M., & Palmstierna, T. (2010). The relationship between substance abuse treatment and crime relapse among individuals with suspected mental disorder, substance abuse, and antisocial behavior: Findings from the MSAC study. *International Journal of Forensic Mental Health, 9*(2), 82–92. https://doi.org/10.1080/14999013.2010.499557

Hesse, M. (2009). Integrated psychological treatment for substance use and co-morbid anxiety or depression vs. treatment for substance use alone. A systematic review of the published literature. *BMC Psychiatry, 9*(1). https://doi.org/10.1186/1471-244X-9-6, 6-6.

Hodgins, D. C. (2004). Using the NORC DSM screen for gambling problems as an outcome measure for pathological gambling: Psychometric evaluation. *Addictive Behaviors, 29*(8), 1685–1690. https://doi.org/10.1016/j.addbeh.2004.03.017

Hunter, S. B., Han, B., Slaughter, M. E., Godley, S. H., & Garner, B. R. (2017). Predicting evidence-based treatment sustainment: Results from a longitudinal study of the adolescent-community reinforcement approach. *Implementation Science, 12*(1). https://doi.org/10.1186/s13012-017-0606-8, 75-75.

Jaffe, A., Du, J., Huang, D., & Hser, Y. (2011). Drug-abusing offenders with comorbid mental disorders: Problem severity, treatment participation, and recidivism. *Journal of Substance Abuse Treatment, 43*, 244–250. https://doi.org/10.1016/j.jsat.2011.12.002

Kelly, T., & Daley, D. (2013). Integrated treatment of substance use and psychiatric disorders. *Social Work in Public Health, 28*(3–4), 388–406. https://doi.org/10.1080/19371918.2013.774673

Kelly, T., Daley, D., & Douaihy, A. (2011). Treatment of substance abusing patients with comorbid psychiatric disorders. *Addictive Behaviors, 37*(1), 11–24. https://doi.org/10.1016/j.addbeh.2011.09.010

Kessler, R., Chiu, W., Demler, O., & Walters, E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627. https://doi.org/10.1001/archpsyc.62.6.617

Klein, K., & Knight, A. (2005). Innovation implementation: Overcoming the challenge. *Current Directions in Psychological Science, 14*(5), 243–246. http://www.jstor.org.ezproxy.ub.gu.se/stable/20183036.

Kola, L., & Kruszynski, R. (2010). Adapting the integrated dual-disorder treatment model for addiction services. *Alcoholism Treatment Quarterly, 28*(4), 437–450. https://doi.org/10.1080/07347324.2010.511067

Kulesza, M., Matsuda, M., Ramirez, J. J., Werntz, A. J., Teachman, B. A., & Lindgren, K. P. (2016). Towards greater understanding of addiction stigma: Intersectionality with race/ethnicity and gender. *Drug and Alcohol Dependence, 169*, 85–91. https://doi.org/10.1016/j.drugalcdep.2016.10.020

Lindqvist, P. (2007). Mental disorder, substance misuse and violent behaviour: The Swedish experience of caring for the triply troubled. *Criminal Behaviour and Mental Health, 17*(4), 242–249. https://doi.org/10.1002/cbm.658

Lubman, D., King, J., & Castle, D. (2010). Treating comorbid substance use disorders in schizophrenia. *International Review of Psychiatry, 22*(2), 191–201. https://doi.org/10.3109/09540261003689958

Lund, C., Forsman, A., Anckarsäter, H., & Nilsson, T. (2012). Early criminal recidivism among mentally disordered offenders. *International Journal of Offender Therapy and Comparative Criminology, 56*(5), 749–768. https://doi.org/10.1177/0306624X11411677

Lund, C., Hofvander, B., Forsman, A., Anckarsäter, H., & Nilsson, T. (2013). Violent criminal recidivism in mentally disordered offenders: A follow-up study of 13–20years through different sanctions. *International Journal of Law and Psychiatry, 36*(3–4), 250–257. https://doi.org/10.1016/j.ijlp.2013.04.015

Lyons, R., Panza, K. E., Helm, J., Angkaw, A. C., Straus, E., & Norman, S. B. (2021). Psychosocial functioning in integrated treatment of co-occurring posttraumatic stress disorder and alcohol use disorder. *Journal of Psychiatric Research, 142*, 40–47. https://doi.org/10.1016/j.jpsychires.2021.07.036

McAlearney, A. S., Walker, D., Livaudais-Toman, J., Parides, M., & Bickell, N. (2016). Challenges of implementation and implementation research: learning from an intervention study designed to improve tumor registry reporting. *SAGE Open Medicine, 4*. https://doi.org/10.1177/2050312116666215, 2050312116666215-2050312116666215.

McGovern, M., Lambert-Harris, C., Gotham, H. J., Claus, R. E., & Xie, H. (2012). Dual diagnosis capability in mental health and addiction treatment services: An assessment of programs across multiple state systems. *Adm. Policy Ment. Health Ment. Health Serv. Res., 41*(2), 205–214. https://doi.org/10.1007/s10488-012-0449-1

McGovern, M., Lambert-Harris, C., McHugo, G., Giard, J., & Mangrum, L. (2010). Improving the dual diagnosis capability of addiction and mental health treatment services: Implementation factors associated with program level changes. *Journal of Dual Diagnosis, 6*(3–4), 237–250. https://doi.org/10.1080/15504263.2010.537221

McGovern, M., Xie, H., Segal, S. R., Siembab, L., & Drake, R. E. (2006). Addiction treatment services and co-occurring disorders: Prevalence estimates, treatment practices, and barriers. *Journal of Substance Abuse Treatment, 31*(3), 267–275. https://doi.org/10.1016/j.jsat.2006.05.003

McKee, S. (2017). Concurrent substance use disorders and mental illness: Bridging the gap between research and treatment. *Canadian psychology =Psychologie Canadienne, 58*(1), 50–57. https://doi.org/10.1037/cap0000093

McKee, S., Harris, G., & Cormier, C. (2013). Implementing residential integrated treatment for co-occurring disorders. *Journal of Dual Diagnosis, 9*(3), 249–259. https://doi.org/10.1080/15504263.2013.807073

McLellan, T., Luborsky, L., Woody, G., & O'Brien, C. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The addiction severity index. *The Journal of Nervous and Mental Disease, 168*(1), 26–33. https://doi.org/10.1097/00005053-198001000-00006

McLeod, H., Deane, F., & Hogbin, B. (2002). Changing staff attitudes and empathy for working with people with psychosis. *Behavioural and Cognitive Psychotherapy, 30*(4), 459–470. https://doi.org/10.1017/S1352465802004071

Morojele, N., Saban, A., & Seedat, S. (2012). Clinical presentations and diagnostic issues in dual diagnosis disorders. *Current Opinion in Psychiatry, 25*(3), 181–186. https://doi.org/10.1097/YCO.0b013e328351a429

Novak, P., Feder, K., Ali, M., & Chen, J. (2019). Behavioral health treatment utilization among individuals with co-occurring opioid use disorder and mental illness: Evidence from a national survey. *Journal of Substance Abuse Treatment, 98*, 47–52. https://doi.org/10.1016/j.jsat.2018.12.006

Pincus, A., Gurtman, M., & Ruiz, M. (1998). Structural analysis of social behavior (SASB): Circumplex analyses and structural relations with the interpersonal circle and the five-factor model of personality. *Journal of Personality and Social Psychology, 74*(6), 1629–1645. https://doi.org/10.1037/0022-3514.74.6.1629

Pinderup, P. (2016). Training changes professionals' attitudes towards dual diagnosis. *International Journal of Mental Health and Addiction, 15*(1), 53–62. https://doi.org/10.1007/s11469-016-9649-3

Pinderup, P. (2018). Improving the knowledge, attitudes, and practices of mental health professionals regarding dual diagnosis treatment–A mixed methods study of an intervention. *Issues in Mental Health Nursing, 39*(4), 292–303. https://doi.org/10.1080/01612840.2017.1398791

Pott, S., Delgadillo, J., & Kellett, S. (2022). Is behavioral activation an effective and acceptable treatment for co-occurring depression and substance use disorders? A meta-analysis of randomized controlled trials. *Journal of Substance Abuse Treatment, 132*. https://doi.org/10.1016/j.jsat.2021.108478, 108478-108478.

Powell, A., Rushmer, R., & Davies, H. (2009a). Effective quality improvement: Recognising the challenges. *British Journal of Healthcare Management, 15*(1), 17–21. https://doi.org/10.12968/bjhc.2009.15.1.37893

Powell, A., Rushmer, R., & Davies, H. (2009b). Effective quality improvement: Some necessary conditions. *British Journal of Healthcare Management, 15*(2), 62–68. https://doi.org/10.12968/bjhc.2009.15.2.39168

Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. Results from the epidemiologic catchment area (ECA) study. *JAMA, 264*(19), 2511–2518. https://doi.org/10.1001/jama.1990.03450190043026

Rohsenow, D. (1983). Drinking habits and expectancies about alcohol's effects for self versus others. *Journal of Consulting and Clinical Psychology, 51*(5), 752–756. https://doi.org/10.1037/0022-006X.51.5.752

Rumpf, H., Bohlmann, J., Hill, A., Hapke, U., & John, U. (2001). Physicians' low detection rates of alcohol dependence or abuse: A matter of methodological shortcomings? *General Hospital Psychiatry, 23*(3), 133–137. https://doi.org/10.1016/S0163-8343(01)00134-7

Sacks, S., Chaple, M., Sirikantraporn, J., Sacks, J., Knickman, J., & Martinez, J. (2013). Improving the capability to provide integrated mental health and substance abuse services in a state system of outpatient care. *Journal of Substance Abuse Treatment, 44*(5), 488–493. https://doi.org/10.1016/j.jsat.2012.11.001

Sacks, S., Cleland, C. M., Melnick, G., Flynn, P. M., Knight, K., Friedmann, P. D., Prendergast, M. L., & Coen, C. (2009). Violent offenses associated with co-occurring substance use and mental health problems: Evidence from CJDATS. *Behavioral Sciences & the Law, 27*(1), 51–69. https://doi.org/10.1002/bsl.850

Schmidt, L., Hesse, M., & Lykke, J. (2011). The impact of substance use disorders on the course of schizophrenia-a 15-year follow-up study. Dual diagnosis over 15 years. *Schizophrenia Research, 130*(1–3), 228–233. https://doi.org/10.1016/j.schres.2011.04.011

Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry (Abingdon, England), 19*(2), 137–155. https://doi.org/10.1080/09540260701278929

Smith, J., Meyers, R., & Miller, W. (2001). The community reinforcement approach to the treatment of substance use disorders. *The American Journal on Addictions, 10*(Supplement 1), s51–s59. https://doi.org/10.1080/10550490150504137

Steadman, H., Mulvey, E., Monahan, J., Robbins, P., Appelbaum, P., Grisso, T., Roth, L., & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry, 55*(5), 393–401. https://doi.org/10.1001/archpsyc.55.5.393

Steingrímsson, S., Sigurdsson, M. I., Aspelund, T., Sigfússon, S., & Magnússon, A. (2015). Total population-based study of the impact of substance use disorders on the overall survival of psychiatric patients. *Nordic Journal of Psychiatry, 70*(3), 161–166. https://doi.org/10.3109/08039488.2015.1062143

Stuart, H. (2003). Violence and mental illness: An overview. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 2*(2), 121–124.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). *Behavioural Health Services for People Who are Homeless*. Retrieved from. U.S. Department of Health and Human Services https://www.samhsa.gov/data/.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). Substance abuse treatment for persons with co-occurring disorders. Retrieved from. In *Treatment Improvement Protocol*. U.S. Department of Health and Human Services https://www.samhsa.gov/data/.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Key Substance Use and Mental Health Indicators in the United States: Results From the 2020 National Survey on Drug Use and Health*. Retrieved from. U.S. Department of Health and Human Services https://www.samhsa.gov/data/.

The Swedish National Board of Health and Welfare. (2008). *Tvångsvården 2008. Sammanställning från inventeringen den 6 maj 2008* [*Compulsory care 2008. Compilation from the inventory 6th of May 2008*]. Stockholm: Swedish National Board of Health and Welfare, 2050312116666215-2050312116666215.

The Swedish National Board of Health and Welfare. (2019). *Nationella Riktlinjer för Vård och Stöd vid Missbruk och Beroende – Stöd för Styrning och Ledning* [*National Guidelines for Treatment and Care of Substance Abuse and Addiction – Support for Management and Directors*]. Stockholm: Swedish National Board of Health and Welfare.

van Boekel, L., Brouwers, E., van Weeghel, J., & Garretsen, H. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence, 131*(1), 23–35. https://doi.org/10.1016/j.drugalcdep.2013.02.018

van der Kraan, J., Verkes, R. J., Goethals, K., Vissers, A., Brazil, I., & Bulten, E. (2014). Substance use disorders in forensic psychiatric patients. *International Journal of Law and Psychiatry, 37*(2), 155–159. https://doi.org/10.1016/j.ijlp.2013.11.009

Van Dorn, R., Volavka, J., & Johnson, N. (2011). Mental disorder and violence: Is there a relationship beyond substance use? *Social Psychiatry and Psychiatric Epidemiology, 47*(3), 487–503. https://doi.org/10.1007/s00127-011-0356-x

Wadell, K., & Skärsäter, I. (2007). Nurses' experiences of caring for patients with a dual diagnosis of depression and alcohol abuse in a general psychiatric setting. *Issues in Mental Health Nursing, 28*(10), 1125–1140. https://doi.org/10.1080/01612840701581230

Warren, J., Stein, J., & Grella, C. (2007). Role of social support and self-efficacy in treatment outcomes among clients with co-occurring disorders. *Drug and Alcohol Dependence, 89*(2), 267–274. https://doi.org/10.1016/j.drugalcdep.2007.01.009

Williams, A., Olfson, M., & Galanter, M. (2015). Assessing and improving clinical insight among patients "in denial". *JAMA Psychiatry (Chicago, Ill.), 72*(4), 303–304. https://doi.org/10.1001/jamapsychiatry.2014.2684