Drug and Alcohol Review (March 2009), 28, 122–128
DOI: 10.1111/j.1465-3362.2008.00041.x

Views of Australian mental health stakeholders on clients' problematic drug and alcohol use

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Abstract

Introduction and Aims. *Substance misuse by people with a serious mental illness may exacerbate psychiatric symptoms and contribute to relapse. The aim of the study was to ascertain the views of a wide range of Australian mental health service providers on staff education and training, client contact and management, assessment, and treatment effectiveness and service delivery.* ***Design and Methods.*** *A survey was sent to a sample of 171 mental health stakeholders in Australia identified through internet searches, state and territory mental health departments and professional organisations.* ***Results.*** *Of the 66 respondents (39% response rate), the substances identified to be most problematic were alcohol and cannabis. Integrated service models of treatment were identified as the most preferable and effective. Barriers to treatment included client motivation to reduce substance use, poor communication and coordination between treatment services, and lack of specific services for dual diagnosis clients. Almost all indicated a need for further training in the area of dual diagnosis.* ***Discussion and Conclusions.*** *Dual diagnosis is common and the reality is that this vulnerable clientele will continue to challenge service providers and treatment approaches into the foreseeable future. Issues include the organization and delivery of treatment services, education and training, resource allocation, collaboration between treatment agencies and clinically relevant research evaluating the effectiveness of practice. It is thus surprising that with so much investment in this area the majority of stakeholders are still dissatisfied with access to and the level of care for dual diagnosis clients.* [Cleary M, Hunt GE, Matheson S, Walter G. Views of Australian mental health stakeholders on clients' problematic drug and alcohol use. *Drug Alcohol Rev* 2009;28:122–128]

Key words: dual diagnosis, mental health staff, substance misuse, survey, severe mental illness.

Introduction

Comorbid substance misuse by people with a psychiatric disorder ('dual diagnosis') is highly prevalent and associated with poor treatment outcomes and increased utilisation of in-patient services [1–5]. People with a co-occurring disorder often have complex social and health-care needs and present staff with many challenges because they are often difficult to motivate and engage in treatment. Health-care providers have an important role in the early detection, ongoing assessment, provision and coordination of treatment. Failure to provide effective early treatment not only results in poorer short-term outcomes, but might lead to more social, physical or psychological impairment in the long term [6,7].

Recent reviews have assessed the merits of various psychosocial interventions (integrated care models, cognitive behavioural therapy, motivational interviewing, etc) and pharmacological treatments for reducing drug use in patients with a serious mental illness [8–11]. In reality, most of the treatment options are not available for patients with a dual diagnosis because of the high cost of offering integrated assertive care, or they might be limited to special need groups, such as homeless people, or those with severe drug dependence

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Received 14 November 2007; accepted for publication 4 March 2008.

who are frequent users of in-patient services [12,13]. There is also disagreement among treatment providers as to which treatments are the most effective. Recent surveys of substance misuse and mental health treatment providers in the USA [14], UK [12] and Australia [15] reported divergent views about treatment approaches between administrators and clinical staff, and also between treatment providers.

Irrespective of the approach used, clinical staff need to feel knowledgeable and confident to deliver effective treatments, and systems need to be in place that overcome barriers and assist with treatment integration. For this to happen, education and training with appropriate clinical support is required. Previous surveys of stakeholders in Australia and New Zealand have examined these issues. A staff survey of mental health and drug services in Queensland identified a need for increased facilities and services and improved coordination of client care across services [15]. Interviews with service providers in rural NSW, the ACT [16] and Victoria [17] showed services failing to respond to co-morbid mental health and substance use problems. Moreover, marked regional variation in treatment approaches was found across New Zealand, based on focus groups with consumers, caregivers and clinicians [18]. They identified several barriers to the delivery of optimal care for patients with a dual diagnosis that included problems with service provision (e.g. lack of regional planning, fragmentation of services, lack of resources, problems in rural areas), deficient clinical skills, lack of assertive follow-up and attitudes of staff (e.g. judgmental, insistence on abstinence and confrontation) [18]. In contrast, a survey of mental health professionals in Victoria found staff had positive views on treatment interventions and were optimistic that drug and alcohol dependence are treatable illnesses [19].

People with a dual diagnosis are not a homogenous group and different types/patterns of illicit drugs (e.g. methamphetamine) are also emerging, posing different problems with new opportunities for responsive and flexible services [20]. Despite the increased attention by policy makers, administrators, researchers and clinicians, the impact on treatment outcome is yet to be realised [6] and further research is required to see how emerging trends in substance use and treatment are being incorporated into service delivery. In view of these factors, it is considered timely to ascertain the opinions of a wide range of Australian mental health service providers on staff education and training, client contact and management, assessment, treatment effectiveness and service delivery. Thus, the aim of the study was to conduct a survey of Australian mental health staff working in different settings to identify areas of need and effective treatment programs for clients with a dual diagnosis.

Methods

Ethics approval was obtained from the Area Mental Health Research Advisory Committee and the Sydney South West Ethics Review Committee.

Setting

Surveys were mailed to mental health service providers and mental health non-government organisations in urban, regional and remote areas across Australia.

Design

A cross-sectional mail-out survey was undertaken.

Participants section

In August 2007, a survey was sent to 171 mental health stakeholders identified through Internet searches of state and territory mental health departments and professional organisations. The sample comprised of public mental health service directors, in-patient and community teams and non-government agencies affiliated with mental health. Accompanying each survey was a self-addressed stamped envelope and a letter of invitation requesting that if the recipient was unable to complete the survey, they forward this to the relevant person(s) within their service. If a questionnaire was not returned, reminders were unable to be sent as the survey was anonymous.

Measures

The researchers constructed a 42-item questionnaire. Participants were asked their professional designation and other demographics regarding their work place, number of years working in mental health, and to describe any previous training they received specific to managing drug and alcohol clients. Respondents were also asked to rate their exposure to patients' substance misuse in their workplace and their views were sought about the effectiveness of the different treatment options for reducing substance use (e.g. *very effective, moderately effective, slightly effective, not effective*). Further questions explored the respondents' use of assessment tools and opinions on current service provision. Views regarding the perceived state of provision of services, as well as further education and training, were also surveyed. Participants could also provide additional written comments related to the above questions.

Statistical methods

Data were analysed using the Statistical Package for the Social Sciences (SPSS) version 13 and are mostly pre-

sented as observed rates and simple frequencies. Because of the small sample size, only two comparisons were made between respondent groups (e.g. professional background and urban vs. non-urban settings), and categories were merged to reduce low cell numbers. For categorical variables, chi-squared tests were used to determine if there were significant group differences between respondents.

Results

The overall response rate was 39% ($n = 66$). Characteristics of respondents are shown in Table 1.

Table 1. *Profile of survey respondents*

	n	%
Number of surveys sent	171	
Number of surveys returned	66	39
States and territories—sent (received)		
New South Wales	43 (19)	44
Western Australia	45 (16)	36
South Australia	26 (8)	31
Victoria	18 (7)	39
Queensland	16 (6)	38
Northern Territory	8 (5)	63
Australian Capital Territory	8 (2)	25
Tasmania	7 (3)	43
Professional background		
Registered nurse	33	50
Psychiatrist	12	18
Social worker	7	11
Psychologist	4	6
Consumer representative	2	3
Other	8	12
Years working in the health sector		
Less than 5 years	2	3
5–10 years	7	11
More than 10 years	57	86
Sector employed		
Public	53	80
Private (non-government organisation or private practice)	6	9
Mixed public/private	7	11
Primary area		
Mental Health	59	89
Other	7	11
Primary role		
Clinical	36	55
Management/administration	17	26
Project style/research	5	7
Other	8	12
Workplace setting		
Hospital	13	20
Community/outpatient	23	35
Both	27	41
Other	3	4
Type of work setting		
Urban or metropolitan (e.g. Sydney, Melbourne, Canberra)	37	56
Regional centres (e.g. Tamworth, Bendigo, Adelaide Hills)	17	26
Remote area (e.g. Port Lincoln, Charters Towers)	12	18

Previous experience and training

Forty-five (68%) respondents had undertaken specific training in the drug and alcohol field. This was mainly through participation in in-services (38; 58%) and workshops (30; 46%). A total of 18% ($n = 12$) had completed specific tertiary D&A qualifications. This participation in formal training had occurred in the last 2 years (24; 53%), 2–5 years ago (12; 27%) or more than 5 years ago (9; 20%). About three-quarters of participants (48; 73%) considered current dual diagnosis training to be inadequate and almost all respondents (64; 97%) indicated a need for further staff training.

Client contact and management of clients with a dual diagnosis

The majority of staff (42; 64%) reported that more than 50% of clients they work with also misuse drugs and/or alcohol. From a list of options, respondents identified the following drugs to be commonly used by dual diagnosis clients: alcohol and cannabis (63; 95%), amphetamines (42; 64%), methamphetamines (37; 56%), heroin (11; 17%) and cocaine (5; 8%).

A total of 17% ($n = 11$) of respondents perceived that mental health professionals adequately understand substance misuse treatment for dual diagnosis clients (45; 68% 'no' and 10; 15% were 'unsure'). Similarly, only 10 (15%) perceived that substance misuse professionals understand mental health treatments for dual diagnosis clients (47; 71% 'no' and 9; 14% 'unsure').

Assessment, history-taking and treatment effectiveness

Over 85% of staff believed they had a role in the assessment, management and referral of clients with dual diagnosis (See Table 2). When taking a history from clients, the majority of respondents claimed that they 'always' or 'usually' asked their clients about their alcohol consumption (62; 94%), cannabis use (61; 92%), benzodiazepine use (58; 88%), smoking tobacco (56; 85%), psychostimulant use (54; 82%), methamphetamine use (54; 82%), use of party drugs (52; 79%), opiate and methadone use (51; 77%) and use of other drugs (e.g. solvents, halluciogenics) (47; 71%). The following assessment methods were 'always' or 'usually' used by respondents: client interview (63; 95%), urinalysis/blood testing (23; 35%), screening tools, like AUDIT, specifically for alcohol use (16; 24%) and

Table 2. *The role of the mental health professional*

As a mental health professional, do you see yourself as having a role in:	Yes	No/unsure
The referral of clients with drug and alcohol problems.	60 (91%)	6 (9%)
The assessment of clients with drug and alcohol problems.	56 (85%)	10 (15%)
The management of clients with drug and alcohol problems.	57 (86%)	9 (14%)
Educating and providing information to clients with drug and alcohol problems	59 (89%)	7 (11%)

screening tools, such as the DAS, for drug use (11; 17%).

Staff views on the perceived effectiveness of the various treatment options for reducing substance use by dual diagnosis clients are shown in Table 3.

Staff attitudes to client management, service delivery and resources

Over two-thirds of respondents (45; 68%) admitted to finding dealing with clients who have both a major mental illness and a substance use disorder more difficult than dealing with other clients with either a mental illness or substance misuse alone (21; 32% 'the same').

Almost two-thirds (40; 61%) indicated that there was a problem in their work area with clients bringing prohibited substances onto the ward or clinic, or being under the influence at appointments. Most respondents (52; 81%) believed that both gradual managed reduction and complete reduction had a role in treating substance use, depending on the nature of substance use. Only 14% ($n = 9$) thought clients with a major mental illness were sufficiently motivated to reduce or cease their substance use when they sought psychiatric treatment (44; 67% 'no', 13; 20% 'unsure'). One-third (21; 32%) believed that patients with a major mental illness were sufficiently aware of the increased social and health risks associated with their substance use (36; 54% 'no' and 9; 14% 'unsure').

With regard to service delivery, most (50; 78%) thought that the same service provider should offer treatment simultaneously, and 17% ($n = 11$) felt they should be given in parallel by separate service providers. Other survey options were to treat the mental health disorder first, then the drug and alcohol disorder (2; 3%) or to treat the drug and alcohol disorder first, then the mental disorder (1; 2%).

A total of 82% ($n = 54$) of staff believed that dual diagnosis patients in their area had experienced barriers to accessing drug and alcohol treatment services. Reasons identified included difficulties engaging drug and alcohol services (39; 59%), shortage of drug and alcohol treatment places (33; 50%), paucity of detoxification places (29; 44%) and drug and alcohol services not knowing how to treat the mental illness (28; 42%). Similarly, 76% ($n = 50$) of staff perceived that dual diagnosis patients experienced barriers to accessing mental health services. Reasons identified included lack of communication/cooperation between the two services (30; 46%), mental health services not knowing how to treat the substance misuse (28; 42%), shortage of in-patient mental health treatment places (27; 41%) and shortage of public outpatient mental health treatment places (25; 38%).

Table 4 shows the attitudes of respondents on treatment options for dual diagnosis clients. There were no significant differences between response attributes and professional background (Psychiatrists, RNs and other) or work setting (urban vs. non-urban).

Discussion

This Australia-wide study showed that almost all respondents have regular contact with people with a dual diagnosis. Respondents were fairly evenly distributed between urban and other areas, and most identified themselves as mental health staff working in mental health. Alcohol, cannabis and amphetamines were commonly used and, perhaps because of high frequency of use, these substances were deemed the most problematic. Growth in the use of illicit drugs is noted elsewhere [21,22], reflecting a need to update management and treatment options to incorporate emerging trends in substances used including the issue of clients bringing prohibited substances into treatment settings.

This high frequency of contact with people with a co-occurring disorder does not ensure satisfactory care. Consistent with previous research, current workplace training was perceived as inadequate. Many thought that mental health professionals needed to more fully understand substance misuse treatment options and, conversely, that substance misuse health professions needed more understanding of the various mental health treatments [14,23]. It is probably safe to assume that many staff have not been exposed to new treatment models [24] or perhaps standardised assessment tools to detect substance use disorders, instead preferring the clinical interview. Less that one-quarter of the respondents formally assessed substance use using standardised screening instruments. This might in part be attributed to a lack of confidence or training in using these instruments. Further research could explore why interviews are more common than using standardised

Table 3. *Perceived effectiveness of treatment options for reducing substance use by dual diagnosis clients (rank ordered)*

Treatment option	Very effective (%)	Moderately effective (%)	Only a little effective (%)	Not effective (%)
Motivational Interviewing	33.3	47.6	15.9	3.2
Assertive Outreach	28.1	51.6	18.8	1.6
Case management	25.4	54.0	19.0	1.6
Residential treatment	25.4	52.4	21.2	0
Opioid maintenance therapy (e.g. methadone)	21.0	48.4	27.4	3.2
Family education	16.9	53.8	29.2	0
Skills training	14.3	60.3	25.4	0
Cognitive Behavioural Therapy	14.3	57.1	27.0	1.6
Education/information regarding the effects of substance misuse	14.1	57.8	25.0	3.1
Twelve step recovery (e.g. Alcoholics Anonymous)	11.1	46.0	39.7	3.2
Group therapy	11.3	40.3	43.5	4.8

Table 4. *Treatment options and attitudes for dual diagnosis (DD) clients*

	Yes	No/unsure
Are specific services available in your area for DD clients, offering integrated care in one setting?	29 (44%)	37 (56%)
Are Mental Health agencies currently coordinating care with D&A services in your area?	32 (49%)	34 (51%)
Are D&A services currently coordinating care with mental health agencies in your area?	35 (53%)	31 (47%)
Do you see any problems offering simultaneous treatment to DD clients by your service?	25 (38%)	41 (62%)
Are you satisfied with the level of care DD clients are currently receiving?	7 (11%)	59 (89%)
Do you think there is a need for further training of staff treating DD clients?	64 (97%)	2 (3%)
Are you aware of past or present research into DD being conducted in your local area?	19 (29%)	47 (71%)

methods of assessment and how this might affect the detection of substance abuse and dependence. It is important that clinicians do identify substance use disorders, irrespective of whether they themselves provide the treatment or refer to other providers [25]. Broad training is necessary to develop shared perspectives, although it is unknown whether these educational efforts actually result in improved clinical care and outcomes [26].

Many respondents felt an integrated approach to treatment is necessary, with most supporting managed reduction working towards complete abstinence. Focus groups with clinicians in the USA also reported abstinence as the preferred goal, consistent with harm reduction principles [24]. In our study, half of the respondents indicated that services were coordinated in their area and were offered simultaneously by the same service provider or in the same setting, although most were dissatisfied with the current level of care. As an integrated approach depends on staff possessing both substance use and mental health knowledge, this might again reflect a lack of cross training between these areas.

There is general consensus that an integrated approach avoids the patient having to negotiate two separate treatment systems with differing philosophies and staff training [27]. The vast majority of respondents said that dual diagnosis clients in their area had experienced barriers to accessing drug and alcohol services as well as mental health services. Evidence suggests that high-quality dual diagnosis services are rare in mental health, with program barriers, such as the absence of clear service models, deficiencies in organisational culture, a lack of preventative approaches absence of integrated education or philosophy and an experienced and skilled workforce [23,24,28]. Effective partnerships are therefore essential to overcome clinical and systems barriers, and where different treatment philosophies and programs prevail services should work towards cross-training, policies and enhanced relationship [26]. Drake and colleagues [23] also caution that the term 'dual diagnosis' is misleading as they might require multiple services (e.g. family or forensic services) to adequately address their needs [29].

Respondents noted that clients with a dual diagnosis are not usually motivated enough to reduce or cease substance using. The majority of respondents identified motivational interviewing as an effective treatment option and skills training, psychoeducation, cognitive behavioural therapy, opioid management and family education were also thought to be effective, although to

a lesser degree. Twelve-step recovery and group therapy were not rated as highly. Assertive outreach, case management and residential programs were nominated as being very or moderately effective treatment options and this positive attitude towards the effectiveness of long-term integrated treatments is consistent with research [10,30]. There is a need for more research on how best to disseminate and implement evidence-based interventions into the different settings [28].

Although the evidence regarding interventions and treatment models is not conclusive, it does suggest that many people with a dual diagnosis are not engaged in treatment programs, and few are in remission or recovery [10,30,31]. There is no doubt that this group is difficult to engage and over two-thirds of respondents admitted that working with these clients was more difficult than working with those without a dual diagnosis. Similar findings are reported elsewhere [32] and, given this difficulty, it is perhaps unrealistic to expect patients to attend different services for their various problems [13]. This might in part be attributed to their higher levels of social, physical and psychological impairment [6], and the interactive and cyclical nature of the disorders [26,29]. The social facilitation associated with substance misuse can also be reinforcing, in particular for those with social skills deficits [24].

It was encouraging to see so many respondents suggesting ways to improve clinical care and nominating ideas for further research. If services are to improve, a number of steps need to be undertaken. Recommendations mirrored those already published in the literature, concerning cross-training of staff and supervision, recognition of cognitive, social and environmental limitations, institutional support for integrated treatment programs and assessing the efficacy of different treatment approaches [9,24,33].

Finally, this study is not without limitations. Limitations regarding the representativeness of the sample in terms of the professional background, years of experience, type of sector (rural, urban) and setting type (alcohol and other drugs, mental health) also need acknowledgement. Given the majority of surveys were sent to senior staff, it is to be expected that the sample would comprise mostly experienced staff. Furthermore, the respondents consisted mainly of registered nurses and few medical or allied health professionals, given that nurses comprise the largest workforce and are often in key roles this again is not surprising. Although a higher response rate would have been welcome, the rate of 39% is typical for anonymous surveys [15]. Metropolitan, regional centres and remote areas from all states and territories were surveyed and findings show consistency across these. Surveys were not tracked so personalised reminder letters could not be sent, which might have increased the response rate.

Conclusions

This survey reports the views of a group of Australian mental health stakeholders clients' drug and alcohol use and provides some direction for improving best practice for this patient group. This study provides an interesting addition to the dual diagnosis literature by ascertaining health professionals' views on how they assess and manage these patients. Dual diagnosis is common and the reality is that this vulnerable clientele will continue to challenge service providers and treatment approaches into the foreseeable future. Current issues include the organisation and delivery of treatment services, education and training, resource allocation, collaboration between treatment agencies and clinically relevant research evaluating the effectiveness of practice. Findings also suggest it is extremely challenging for mental health service providers to engage clients with a dual diagnosis in treatment and to determine which programmes work best for them. It is thus surprising that with so much investment in this area that the majority of stakeholders are still dissatisfied with access to and the level of care for dual diagnosis clients. Future research could include a similar survey of alcohol and other drug workers and examine the impact of training and using formal assessment tools for detecting substance use and dependence in different clinical settings.

Acknowledgements

We wish to thank Pfizer Australia for funding this study and Dr Jan Horsfall for her helpful comments on the draft survey.

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