MODELS OF CARE FOR INTEGRATED MENTAL HEALTH & AOD SERVICES

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Please find following a summary of a literature search and relevant results. All articles can be provided in full - email library@monashhealth.org for a list of the articles you require.

See the Appendix for the search methodology.

QUESTION

What models of care have been implemented in integrating Mental Health and AoD (Alcohol and other drugs) and what is the most effective model?

RESULTS

ONLINE RESOURCES (GREY LITERATURE)

GUIDELINES

Matilda Centre [AU]. (2022) **Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings, 3rd Ed**. Link.

- See section *B5: Coordinating care* from p. 145 onwards.
- See p. 158 onwards for *Models of care*, including integrated treatment.

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Substance Abuse and Mental Health Services Administration (SAMHSA) [USA]. (2020). **Substance Use Disorder Treatment for People With Co-Occurring Disorders: Updated 2020**. Link.

- Part of a Treatment Improvement Protocol series providing evidence-based guidance.
- See p. 183: *Chapter 7-Treatment models and settings for people with co-occurring disorders*.
- Integrated care discussed on p. 188.

National Institute for Health and Care Excellence [UK]. (2016). **Coexisting severe mental illness and substance misuse: Community health and social care services**. Link.

- Includes guidance on partnerships between relevant services, referral to secondary care mental health services, and improving service delivery.

EVIDENCE REVIEWS

Health Research Board & Georgia Health Policy Center. (2019). **Treatment Services for people with co-occurring substance use and mental health problems. A rapid realist synthesis**. Link.

- See p. 33 for section on *What existing models of care for adults with co-occurring substance use and mental health problems lead to positive treatment outcomes and successful service integration?*
- See pp. 51-52 for recommendations.

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National Collaborating Centre for Mental Health [UK]. (2016). **Review 4: Which service models for health, social care and voluntary and community sector organisations are cost-effective and fficient at meeting the needs of people with a severe mental illness who also misuse ubstances?** Link.

- See pp. 31-49 for summaries of the evidence on integrated treatment models, including outcomes and cost-analysis.

NSW Ministry of Health. (2015). **Effective models of care for comorbid mental illness and illicit substance use: Evidence check review**. Link.

- See pp. 12 – 17 for *Models of care*, outlining various models in place around the world.
- See pp. 18 – 21 for *Effectiveness outcomes*, comparing models and their success.

Agency for Healthcare Research and Quality [USA]. (2008). **Integration of mental health/substance abuse and primary care**. Link.

- See section 3 for *Integrating mental health into primary care*, including *Models of integration* and discussion of barriers to successful integration.
- See section 4 for detailed case studies with lessons learned.

TOOLKITS

Case Western Reserve University. (2011). **Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Toolkit, Version 4.0**. Link.

- Guides the assessment of dual diagnosis capability in mental health services, and provides enhancement suggestions drawn from real-life treatment providers.
- See other Dual Diagnosis Capability Resources.

SAMHSA [USA]. (2010). **Integrated Treatment for Co-Occurring Disorders: Evidence-Based Practices Toolkit.** Link to landing page.

- Building Your Program
- The Evidence
- Training Frontline Staff
- Evlauating Your Porgram

GOVERNMENT & INDUSTRY REPORTS

Victorian Alcohol and Drug Association. (2023). **Integration of Care in Practice.** Link.

- Victorian examples of models of care, tools and activities that promote integrated care for people experiencing mental illness and substance use or addiction.
- Three models: Multidisciplinary teams; Co-location and Care Co-ordination; Service delivery partnerships.

National Working Group for Dual Diagnosis [Ireland]. (2023). **Model of care for people with mental disorder and co-existing substance use disorder (dual diagnosis).** Link.

- See p. 19 onwards for literature review focusing on UK, Australia, USA, Europe, and others.
- See p. 37 onwards for *Suggestions for Future Provision of DD Services*.

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Victorian Government Department of Health. (2022). **Integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction Guidance for Victorian mental health and wellbeing and alcohol and other drug services**. Link.

- See p. 18 for *How Local and Area Services can configure themselves to deliver integrated treatment, care and support.*
- Related: Turning Point Statewide Specialist Clinical Services, integrated care provider.

Lee, N. et al. (2020) **Exploring the place of alcohol and other drug services in a successful mental health system**. Link.

- See pp. 25 – 35 for *Responding to comorbidity*, including *Should services be integrated?*
- *Models that support holistic care* discussed on pp. 36 – 42.
- See p. 50 for section discussing collaboration with primary care and other sectors.

PEER-REVIEWED LITERATURE – MOST RECENT FIRST

Articles are grouped as follows:

- Reviews of multiple models
- Guidelines & implementation
- Effectiveness of integrated care
- Integration with primary care
- Co-located services

Each article summary contains excerpts from the abstract and an online link.

REVIEWS OF MULTIPLE MODELS

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A. Richardson, et al. (2020). **A systematic scoping review of interventions to integrate physical and mental healthcare for people with serious mental illness and substance use disorders**. *Journal of Psychiatric Research*, *128*(jtj, 0376331), 52-67. Full-text.
The aim of this systematic scoping review was to describe empirical investigations of interventions designed to integrate physical, mental, and addiction healthcare for this population. A total of 28 eligible publications were identified, representing 25 unique studies. Over half of the included studies investigated the use of case managers to provide self-management skills or to coordinate mental and physical healthcare (n=14). Other interventions examined the co-location of services (n=9) and the implementation of screening and referral pathways to specialist treatment (n=2). Less than half of the included studies described a framework, theory or model that was underpinning the intervention tested. While some aspects of integrated care have been identified and addressed by interventions, other key dimensions have not been considered, such as shared decision-making. Identification of a comprehensive model of integrated care is recommended to inform the development and evaluation of future interventions for people with SMI/SUDs.

M. T. Assefa, et al. (2019). **Implementing integrated services in routine behavioral health care: primary outcomes from a cluster randomized controlled trial**. *BMC Health Services Research*, *19*(1), 749. Full-text.
We evaluated if the Network for the Improvement of Addiction Treatment (NIATx) implementation strategy was effective in increasing integrated services capacity among organizations treating persons with co-occurring disorders. METHODS: This study employed a cluster randomized waitlist control group design. Forty-nine addiction treatment organizations from the State of Washington were randomized into one of two study arms: (1) NIATx strategy (active implementation strategy), or (2) waitlist (control). The primary outcome was a standardized organizational measure of integrated

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service capability: the Dual Diagnosis in Addiction Treatment (DDCAT) Index. CONCLUSIONS: Overall, organizations in both study arms improved DDCAT Index scores over time. Organizations in the NIATx strategy arm with full adherence to the NIATx protocol had significantly greater improvements in the primary outcome measure of integrated service capacity for persons with co-occurring disorders.

M. Wiktorowicz, et al. (2019). **Models of Concurrent Disorder Service: Policy, Coordination, and Access to Care**. *Frontiers in Psychiatry*, *10*(101545006), 61. Full-text.
As different approaches to care for persons with concurrent disorders emerge, a limited understanding of current models prevails. The goal of this paper is to explore these challenges along with promising models of coordinated care across Canadian provinces. Materials and methods: A scoping review of policies, service coordination and access issues was undertaken involving a review of the formal and gray literature from 2000 to 2018. The scoping review was triangulated by an analysis of provincial auditor general reports. Conclusion: Emergent models of coordinated care were found to include collaborative care, regional networks with centralized access to care, clinical information-sharing, cross-training, improved scope of care to include psychologists and alignment of physician incentives with patient needs to better support patient care.

B. Hobden, et al. (2018). **Finding the optimal treatment model: A systematic review of treatment for co-occurring alcohol misuse and depression**. *The Australian and New Zealand Journal of Psychiatry*, *52*(8), 737-750. Full-text.
This systematic review determined the: (i) methodological quality of publications examining psychosocial treatment of co-occurring alcohol misuse and depression using a sequential, parallel or integrated treatment model; and (ii) effectiveness of each dual treatment model compared to single treatment for those with co-occurring alcohol misuse and depression. RESULTS: Seven studies met inclusion criteria. None were categorised as low risk on the risk of bias criteria. No studies examined a sequential model of treatment, three examined a parallel model and four examined an integrated model of dual-focussed treatment. The studies examining the parallel model and two out of four studies examining the effectiveness of an integrated model demonstrated greater improvement for alcohol or depression outcomes compared to control conditions. CONCLUSION: Evidence for the psychosocial treatment of co-occurring alcohol misuse and depression is limited to a handful of studies. The evidence has several methodological limitations.

GUIDELINES & IMPLEMENTATION

J. Harris, et al. (2023). **Achieving integrated treatment: a realist synthesis of service models and systems for co-existing serious mental health and substance use conditions.** *The Lancet Psychiatry*, *10*(8), 632-643. Full-text.
Approximately 30–50% of people with serious mental illness have co-existing drug or alcohol problems (COSMHAD), associated with adverse health and social care outcomes. UK guidelines advocate both co-occurring needs being met within mental health services, but uncertainty remains about how to operationalise this to improve outcomes. Various unevaluated service configurations exist in the UK. A realist synthesis was done to identify, test, and refine programme theories of how context shapes the mechanisms through which UK service models for COSMHAD work, for whom, and in what circumstances. Structured and iterative realist searches of seven databases identified 5099 records. A two-stage screening process identified 132 papers. Three broad contextual factors shaped COSMHAD services across 11 programme theories: committed leadership, clear expectations regarding COSMHAD from mental health and substance use workforces, and clear care-coordination processes.

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E. Machavariani, et al. (2023). **Design, implementation and preliminary results of a type-2 hybrid cluster-randomized trial of integrating screening and treatment for major depressive disorder into specialty clinics providing opioid agonist therapies in Ukraine**. *Contemporary Clinical Trials*, *131*(101242342), 107248. Full-text.
In Ukraine, treatment for substance use (SUD) is delivered in specialized substance use clinics, without providing any other medical services for comorbidities, including major depressive disorder (MDD). Here we present the protocol, along the with the preliminary results of the MEDIUM project, including observations over the first 6 months. METHODS: A cluster-randomized type-2 hybrid trial was conducted to integrate MDD treatment into specialty clinics providing opioid agonist therapies (OAT) in Ukraine. PRELIMINARY RESULTS: For service delivery outcomes, 4421 patients enrolled on OAT across all sites were assessed for MDD for screening (76.7%), evaluation with diagnosis (43.5%) and treatment (30.7%) for MDD; 13.8% continued treatment at least for 6 months.

C. Minshall, et al. (2021). **What should guide cross-sector collaborations between mental health and alcohol and other drug services? A scoping review**. *Advances in Mental Health*, *19*(1), 29-39. Request full-text.
Recent workforce strategies require mental health workers to collaborate across sectors. This scoping review aims to identify the theoretical principles (e.g. frameworks, models, strategies) that inform the implementation of cross-sector initiatives on a workforce level, with an emphasis on the role of leadership. Results: In total 10 publications were included. Five key themes were identified: (i) mental health; (ii) alcohol and other drugs; (iii) recovery orientated; (iv) lived experience workforce; these impact the structure, sector and workforce, including lived experience workforce. Literature addressing leadership was dearth. Discussion: Existing models of cross-sector collaboration often fail to address factors important to mental health and alcohol and other drug service delivery (e.g. recovery, consumer and carer participation). Future models should emphasise workforce development, including the emerging role of the lived experience workforce.

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R. Alsuhaibani, et al. (2021). **Scope, quality and inclusivity of international clinical guidelines on mental health and substance abuse in relation to dual diagnosis, social and community outcomes: a systematic review**. *BMC Psychiatry*, *21*(1), 209. Full-text.
The aim of this systematic review was to explore the scope, quality and inclusivity of international clinical guidelines on mental health and/or substance abuse in relation to diagnosis and treatment of co-existing disorders and considerations for wider social and contextual factors in treatment recommendations. RESULT: Three of the included guidelines were related to coexisting disorders, 11 related to severe mental illness (SMI), and 7 guidelines were related to substance use disorder (SUD). Seven (out of 18) single disorder guidelines did not adequately recommend the importance of diagnosis or treatment of concurrent disorders despite their high co-prevalence. The majority of the guidelines (n = 15) lacked recommendations for medicines optimisation in accordance with concurrent disorders (SMI or SUD) such as in the context of drug interactions.

C. Fantuzzi, et al. (2020). **Dual diagnosis: A systematic review of the organization of community health services**. *The International Journal of Social Psychiatry*, *66*(3), 300-310. Request full-text.
This review analyzed 48 studies in order to verify the state of the art regarding the organization of community health services for dual diagnosis (DD) treatment. RESULTS: Four macro-themes have been identified: service organization, critical issues, assessment tools and evidence-based interventions. An effective service recognizes the complexity of DD, promotes a common staff culture, and tailors the organization to local needs. The main critical issues in its implementation include the lack of specific staff training, the poor management of resources and the need for greater personalization of care plans, with attention to psychosocial interventions. Integrated service assessment tools can be used as a benchmark measure at the program level for implementation planning and at the national level to affect policy change. The integrated treatment

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model for DD should also aim to improve access to care and offer treatments based on scientific evidence. It is also evident that the integration of services can improve outcomes but it is not a guarantee for it.

M. Savic, et al. (2017). **Strategies to facilitate integrated care for people with alcohol and other drug problems: a systematic review**. *Substance Abuse Treatment, Prevention, and Policy*, *12*(1). Full-text.
We synthesised the existing evidence on strategies to improve integrated care in an AOD treatment context by conducting a systematic review of the literature. RESULTS: We identified a number of interconnected strategies at the funding, organisational, service delivery and clinical levels. Ensuring that integrated care is included within service specifications of commissioning bodies and is adequately funded was found to be critical in effective integration. Cultivating positive inter-agency relationships underpinned and enabled the implementation of most strategies identified. Staff training in identifying and responding to needs beyond clinicians' primary area of expertise was considered important at a service level. Sharing of client information (subject to informed consent) was critical for most integrated care strategies. Case-management was found to be a particularly good approach to responding to the needs of clients with multiple and complex needs. At the clinical level, screening in areas beyond a clinician's primary area of practice was a common strategy for facilitating referral and integrated care, as was joint care planning.

EFFECTIVENESS OF INTEGRATED CARE

A. Chetty, et al. (2023). **Integrated vs non-integrated treatment outcomes in dual diagnosis disorders: A systematic review**. *Health SA = SA Gesondheid*, *28*(101213385), 2094. Full-text.
This study aimed to examine current literature on the treatment outcomes for patients with DD. Method: A systematic review of randomised controlled trials (RCTs) published between 2009 and 2018 was conducted for two broad intervention categories identified by the literature: non-integrated and integrated treatment. Results: The search generated a total of 743 studies, of which 11 satisfied the inclusion criteria. These studies were thematically synthesised into two main analytical themes: 'treatment outcomes' and 'reported strengths and limitations of DD treatment'. Specifically, integrated treatment held an advantage over non-integrated treatment in significantly improving psychiatric symptomatology. However, no significant benefits were found between integrated and non-integrated treatment regarding substance misuse and treatment retention.

V. Karapareddy. (2019). **A Review of Integrated Care for Concurrent Disorders: Cost Effectiveness and Clinical Outcomes**. *Journal of Dual Diagnosis*, *15*(1), 56-66. Request full-text.
The objectives of this study are to determine whether existing service models are effective in treating combined mental health and substance use disorders and to examine whether an integrated model of service delivery should be recommended to policy makers. The following two research questions are the focus of this paper: (1) Are the existing service models effective at treating mental health and substance use disorders? (2) How are existing service models effective at treating mental health and substance use disorders? Models were considered effective if they are found to be cost-effective and significantly improve clinical and social outcomes. Conclusions: Given the limited number of studies in relation to service delivery for concurrent disorders, it is too early to make a strong evidence-based recommendation to policy makers and service providers as to the superiority of one approach over the others. However, the available evidence suggests that integrated care models for concurrent disorders are the most effective models for patient care.

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G. E. Hunt, et al. (2019). **Psychosocial interventions for people with both severe mental illness and substance misuse**. *The Cochrane Database of Systematic Reviews*, *12*(100909747), CD001088. Full-text.

OBJECTIVES: To assess the effects of psychosocial interventions for reduction in substance use in people with a serious mental illness compared with standard care. MAIN RESULTS: Our review now includes 41 trials with a total of 4024 participants. We have identified nine comparisons within the included trials and present a summary of our main findings for seven of these below. … 1. Integrated models of care versus standard care (36 months): No clear differences were found between treatment groups for loss to treatment, death, alcohol use, substance use (drug), global assessment of functioning (GAF) scores, or general life satisfaction (QOLI) scores. 2. Non-integrated models of care versus standard care: There was no clear difference between treatment groups for numbers lost to treatment at 12 months. AUTHORS' CONCLUSIONS: We included 41 RCTs but were unable to use much data for analyses. There is currently no high-quality evidence to support any one psychosocial treatment over standard care for important outcomes such as remaining in treatment, reduction in substance use or improving mental or global state in people with serious mental illnesses and substance misuse.

M. W. Battersby, et al. (2013). **A randomised controlled trial of the Flinders Program TM of chronic condition management in Vietnam veterans with co-morbid alcohol misuse, and psychiatric and medical conditions**. *The Australian and New Zealand journal of psychiatry*, *47*(5), 451-62. Request full-text.

OBJECTIVE: To evaluate the efficacy of the Flinders Program TM of chronic condition management on alcohol use, psychosocial well-being and quality of life in Vietnam veterans with alcohol misuse. METHOD: This 9-month wait-list, randomised controlled trial used the Alcohol Use Disorders Identification Test (AUDIT) score >= 8 as the entry criterion. Intervention veterans received the Flinders Program plus usual care and controls received usual care. RESULTS: Randomisation resulted in 46 intervention and 31 control participants. CONCLUSIONS: Use of the Flinders Program in addition to usual care resulted in reduced alcohol use, reduced alcohol dependence, and global clinical improvement in Vietnam veterans with risky alcohol behaviours and chronic mental health problems. The findings demonstrate that the Flinders Program provides a structured framework for delivering self-management support, case management and coordinated care for people with chronic conditions. This clinical approach has the potential to bridge the gap between physical and mental illness service delivery for people with long-term conditions in Australia.

S. J. Schulte, et al. (2011). **Dual diagnosis clients' treatment satisfaction - a systematic review**. *BMC Psychiatry*, *11*(100968559), 64. Full-text.
We examined satisfaction with treatment received, variations in satisfaction levels by type of treatment intervention and by diagnosis (i.e. DD clients vs. single diagnosis clients), and the influence of factors other than treatment type on satisfaction. Peer-reviewed studies published in English since 1970 were identified by searching electronic databases using pre-defined search strings. RESULTS: Across the 27 studies that met inclusion criteria, high average satisfaction scores were found. In most studies, integrated DD treatment yielded greater client satisfaction than standard treatment without explicit DD focus. In standard treatment without DD focus, DD clients tended to be less satisfied than single diagnosis clients. CONCLUSIONS: High satisfaction levels with current treatment provision, especially among those in integrated treatment, should enhance therapeutic optimism among practitioners dealing with DD clients.

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M. Hesse. (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*(100968559), 6. Full-text.
METHODS: Based on a systematic search of MedLine and PsychInfo, 9 trials of integrated treatment for depression or anxiety plus substance use disorder were identified. Where possible, meta-analyses were carried out, using random effects models. CONCLUSION: Psychotherapeutic treatment for co-morbid depression and substance use disorders is a promising approach, but is not sufficiently empirically supported at this point. Psychotherapeutic treatment for co-morbid anxiety and substance use disorders is not empirically supported. There is a need for more trials to replicate the findings from studies of integrated treatment for depression and substance use disorders, and for the development of new treatment options for co-morbid anxiety and substance use disorders.

INTEGRATION WITH PRIMARY CARE

S. Park, et al. (2023). **Integrating Depression and Alcohol Use Care Into Primary Care in Low- and Middle-Income Countries: A Meta-Analysis**. *Psychiatric Services*, *74*(9), 950-962. Full-text.
Evaluation of the effectiveness of integration of depression and alcohol use disorder care into primary health care in low- and middle-income countries (LMICs) is limited. The authors aimed to quantify the effectiveness of integrating mental health care into primary care by examining depression and alcohol use disorder outcomes. The study updates a previous systematic review summarizing research on care integration in LMICs. CONCLUSIONS: Integration of mental health care into primary health care in LMICs was found to improve depression and alcohol use disorder outcomes.

J. D. McLeigh, et al. (2022). **Paediatric integrated care in the primary care setting: A scoping review of populations served, models used and outcomes measured**. *Child: care, health and development*, *48*(5), 869-879. Request full-text.
Paediatric integrated care (PIC), which involves primary care and behavioural health clinicians working together with patients and families, has been promoted as a best practice in the provision of care. In this context, behavioural health includes behavioural elements in the care of mental health and substance abuse conditions, chronic illness and physical symptoms associated with stress, and addressing health behaviours. Models of and contexts in which PIC has been applied vary, as do the outcomes and measures used to determine its value. RESULTS: Overall, acceptability of PIC appears to be high for patients and providers, with access, screening and engagement generally increasing. However, several gaps in the knowledge base on PIC were uncovered, and for some studies, ascertaining which models of integrated care were being implemented proved difficult.

S. J. Bartels, et al. (2004). **Improving access to geriatric mental health services: a randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use**. *The American journal of psychiatry*, *161*(8), 1455-62. Full-text.
The authors sought to determine whether integrated mental health services or enhanced referral to specialty mental health clinics results in greater engagement in mental health/substance abuse services by older primary care patients. METHOD: This multisite randomized trial included 10 sites consisting of primary care and specialty mental health/substance abuse clinics. Primary care patients 65 years old or older (N=24,930) were screened. The final study group consisted of 2,022 patients (mean age=73.5 years; 26% female; 48% ethnic minority) with depression (N=1,390), anxiety (N=70), at-risk alcohol use (N=414), or dual diagnosis (N=148) who were randomly assigned to integrated care (mental health and substance abuse providers co-located in primary care; N=999) or enhanced referral to specialty mental health/substance abuse clinics (i.e., facilitated scheduling, transportation, payment; N=1,023). CONCLUSIONS: Older primary care patients are more likely to

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accept collaborative mental health treatment within primary care than in mental health/substance abuse clinics.

CO-LOCATED SERVICES

C. Glover-Wright, et al. (2023). **Health outcomes and service use patterns associated with co-located outpatient mental health care and alcohol and other drug specialist treatment: A systematic review**. *Drug and Alcohol Review*, *42*(5), 1195-1219. Full-text.
Despite long-standing recommendations to integrate mental health care and alcohol and other drug (AOD) treatment, no prior study has synthesised evidence on the impact of physically co-locating these specialist services on health outcomes. KEY FINDINGS: Twenty-eight studies met our inclusion criteria. We found provisional evidence that integrated care that includes co-located mental health care and AOD specialist treatment is associated with reductions in substance use and related harms and mental health symptom severity, improved quality of life, decreased emergency department presentations/hospital admissions and reduced health system expenditure. Many studies had a relatively high risk of bias and it was not possible to disaggregate the independent effect of physical co-location from other common aspects of integrated care models such as care coordination and the integration of service processes. CONCLUSION: Integrated care that includes the co-location of mental health care and AOD specialist treatment may yield health and economic benefits.

A. Kidorf, et al.(2013). **Reinforcing integrated psychiatric service attendance in an opioid-agonist program: a randomized and controlled trial.** *Drug & Alcohol Dependence* , *133*(1), 30-36. Full-text.
The benefits of integrating substance abuse and psychiatric care may be limited by poor service utilization. This randomized clinical trial evaluated the efficacy of using contingency management to improve utilization of psychiatric services co-located and integrated within a community-based methadone maintenance treatment program. METHODS: Opioid-dependent outpatients (n=125) with any current psychiatric disorder were randomly assigned to: (1) reinforced on-site integrated care (ROIC), with vouchers (worth $25.00) contingent on full adherence to each week of scheduled psychiatric services; or (2) standard on-site integrated care (SOIC). All participants received access to the same schedule of psychiatrist and mental health counseling sessions for 12-weeks. RESULTS: ROIC participants attended more overall psychiatric sessions at month 1 (M=7.53 vs. 3.97, p<.001), month 2 (M=6.31 vs. 2.81, p<.001), and month 3 (M=5.71 vs. 2.44, p<.001). Both conditions evidenced reductions in psychiatric distress (p<.001) and similar rates of drug-positive urine samples. No differences in study retention were observed.

R. K. Brooner, et al. (2013). **Managing psychiatric comorbidity within versus outside of methadone treatment settings: a randomized and controlled evaluation**. *Addiction*, *108*(11), 1942-51. Full-text.
This study evaluates the efficacy of on-site and integrated psychiatric service delivery in an opioid-agonist treatment program on psychiatric and substance use outcomes. DESIGN: Participants at the Addiction Treatment Services (ATS) were assigned randomly to receive on-site and integrated substance abuse and psychiatric care (on-site: n = 160) versus off-site and non-integrated substance abuse and psychiatric care (off-site: n = 156), and observed for 1 year. On-site participants received all psychiatric care within the substance abuse program by the same group of treatment providers. The same type and schedule of psychiatric services were available to off-site participants at a community psychiatry program. CONCLUSIONS: On-site and integrated psychiatric and substance misuse services in a methadone treatment setting might improve psychiatric outcomes compared with off-site and non-integrated substance misuse and psychiatric care. However, this might not translate into improved substance misuse outcomes.

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APPENDIX

SEARCH METHODOLOGY

A systematic search was conducted for literature. The results were screened using Covidence.

SEARCH LIMITS

- English-language only.
- Study designs: systematic reviews, meta-analyses, and randomised controlled trials. Relevant peer-reviewed scoping reviews and realist syntheses were also included.

DATABASES SEARCHED

- Medline – index of peer reviewed articles across health sciences and medicine.
- APA PsycInfo – index of literature spanning the behavioural and social sciences.
- Embase – index of biomed and pharmacological peer reviewed journal articles.
- Emcare – index of nursing, allied health, critical-care medicine and more.
- Cochrane Library – collection of databases containing high-quality independent evidence.
- Grey literature – Google, Google Scholar, Trip database, Biomed Central Proceedings.

SEARCH TERMS

Concept	MeSH headings	Keywords
Model of care	Models, Theoretical/, Models, Organizational/	Model(s) or structure(s/d) or organis(z)ation(s/al) or delivery or system(s/atic) or framework(s) or pathway(s) + care or service(s).
Mental health	exp Mental Health Services/, exp Mental Disorders/therapy	Mental health(care) or mental disorder(s) or psych(ological/iatric) or behav(ioural) or depress(ion/ed) + service(s) or program(s) or care or treat(ed/ment/s) or intervention(s).
Substance use / alcohol and other drugs	Substance Abuse Treatment Centers/, exp Substance-Related Disorders/therapy	Alcohol(ic) or drug(s) or substance(s) + service(s) or program(s) or care or treat(ed/ment/s) or intervention(s). AODU or AODE or AOD + service(s) or program(s) or care or treat(ed/ment/s) or intervention(s).
Integrated care	"Delivery of Health Care, Integrated"/	Integrat(e/d/ing) or coordinat(e/d/ion) or co-ordinat(e/d/ion) or dual diagnosis or collaborat(ive/ing/e) or co-locat(ed/ion) or colocat(ed/ion) + care or service(s) or program(s) or treat(ed/ment/s) or intervention(s) or system(s) or delivery or model(s) or structure(s) or framework(s) or pathway(s).

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MEDLINE SEARCH STRATEGY

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1 Models, Theoretical/ or *Models, Organizational/ 169018
2 ((model* or structure* or organi?ation* or delivery or system* or framework* or pathway*) adj3 (care or service*)).ti,ab,kf. 227600
3 1 or 2 391548
4 exp Mental Health Services/ or exp Mental Disorders/th 284437
5 ((mental health* or mental disorder* or psych* or behav* or depress*) adj4 (service* or program* or care or treat* or intervention*)).ti,ab,kf. 322849
6 4 or 5 529052
7 Substance Abuse Treatment Centers/ or exp Substance-Related Disorders/th 35246
8 ((alcohol* or drug* or substance*) adj4 (service* or program* or care or treat* or intervention*)).ti,ab,kf. 256845
9 ((AODU or AODE or AOD) adj3 (service* or program* or care or treat* or intervention*)).ti,ab,kf. 367
10 7 or 8 or 9 278559
11 "Delivery of Health Care, Integrated"/ 14343
12 ((integrat* or coordinat* or co-ordinat* or dual diagnosis) adj2 (care or service* or program* or treat* or intervention* or system* or delivery or model* or structure* or framework* or pathway*)).mp. 134812
13 11 or 12 134812
16 3 and 6 and 10 and 13 470

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Please note:

- Validated database filters – published by Canada's Drug and Health Technology Agency – were applied to narrow the search results to the target study designs.
- The search strategy was multifaceted, employing multiple variations on the above search.
- For more information contact the Monash Health Library team.

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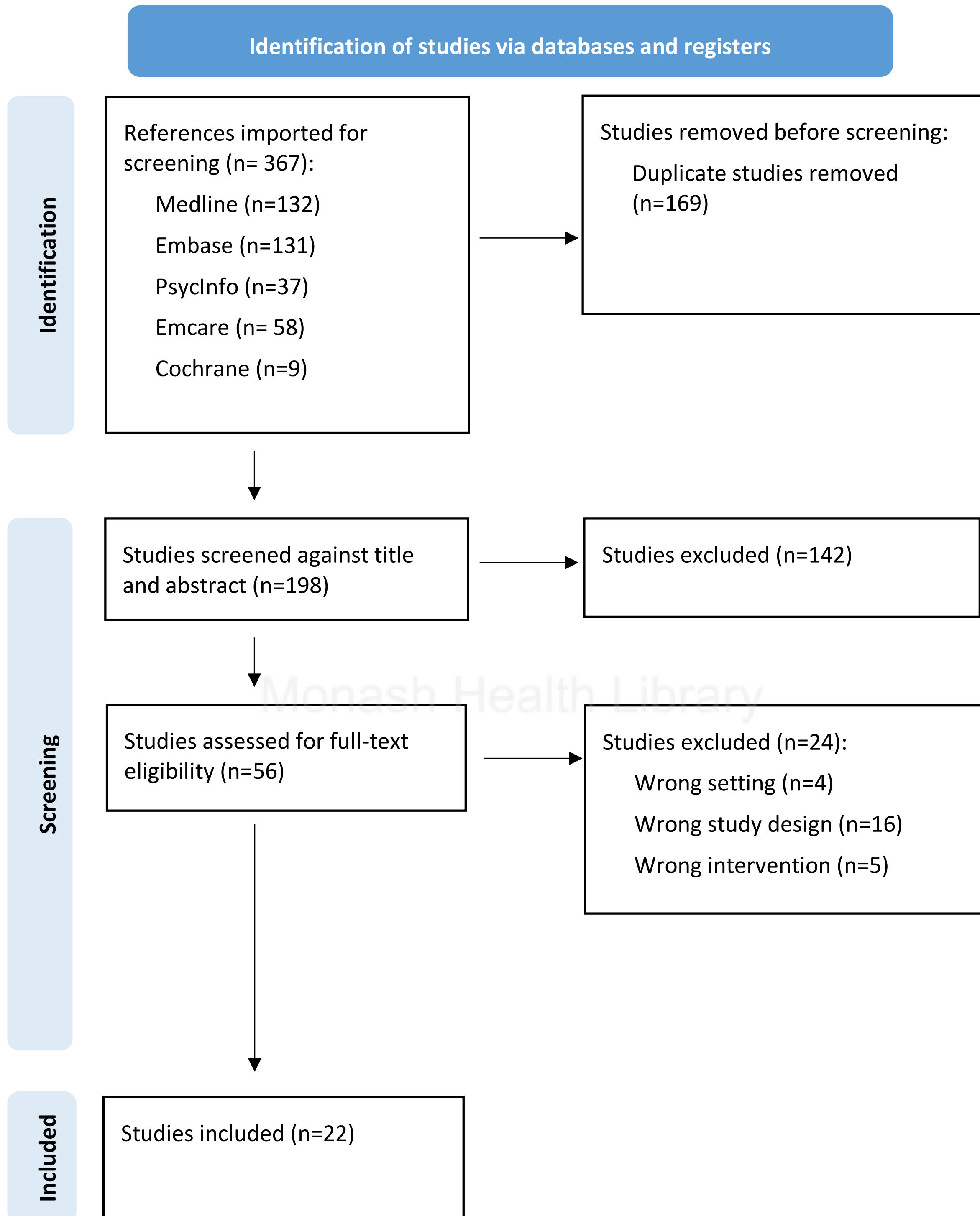
PRISMA CHART



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This report contains curated literature results against a unique set of criteria at a particular point in time. Users of this service are responsible for independently appraising the quality, reliability, and applicability of the evidence cited. We strongly recommend consulting the original sources and seeking further expert advice.

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