Use of standard mapping of service provision to drive mental health and alcohol and drug care systems: International experiences



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Integration of mental health (MH) and alcohol and drug (AOD) care

DRIVERS

- Overlap of service provision
- Comorbidity across these target groups
- Need to increase the efficiency of care provision in the context of a healthcare crisis impacting specifically MH and AOD
- Deskilling and professional shortage impacting in both population groups

CHALLENGES & NEEDS

- Organisational and funding barriers that should be overcome before putting an integration plan in place.
- Increase the cross-collaboration, knowledge transfer and capacity so staff in AOD can take activities related to MH, particularly in moderate and severe cases, and vice versa.
- Different framework and models of care that are related to different terminology and understanding of service provision.
- Lack of comprehensive assessment of the availability, characteristics and tentative overlap and gaps in the service provision in the two systems.

2 main problems when describing and classifying services:

Commensurability

-many different types and levels of services, but we need to be able to group and compare like with like



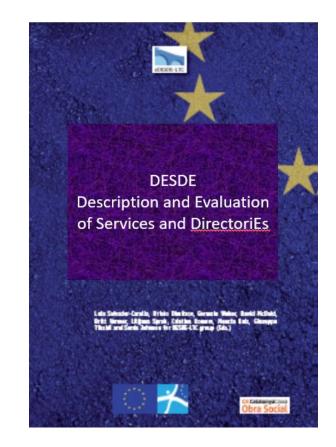
Unclear and variable terminology

-names of services don't always reflect actual care provision

-names of services and of types of care vary across and even within jurisdictions

Magnitude of terminological bias in international health services research: a disambiguation analysis in mental health

M. R. Gutierrez-Colosia^{1,2}, P. Hinck³, J. Simon^{4,5}, A. Konnopka^{3,6}, C. Fischer⁴, S. Mayer⁴, V. Brodszky⁷, L. Hakkart-van Roijen⁸, S. Evers^{9,10}, A. Park¹¹, H. H König³, W. Hollingworth¹², J. A Salinas-Perez^{13,14}, the PECUNIA Group⁴ and L. Salvador-Carulla^{14,15}





21 Atlases of MH Care in Australia since 2015

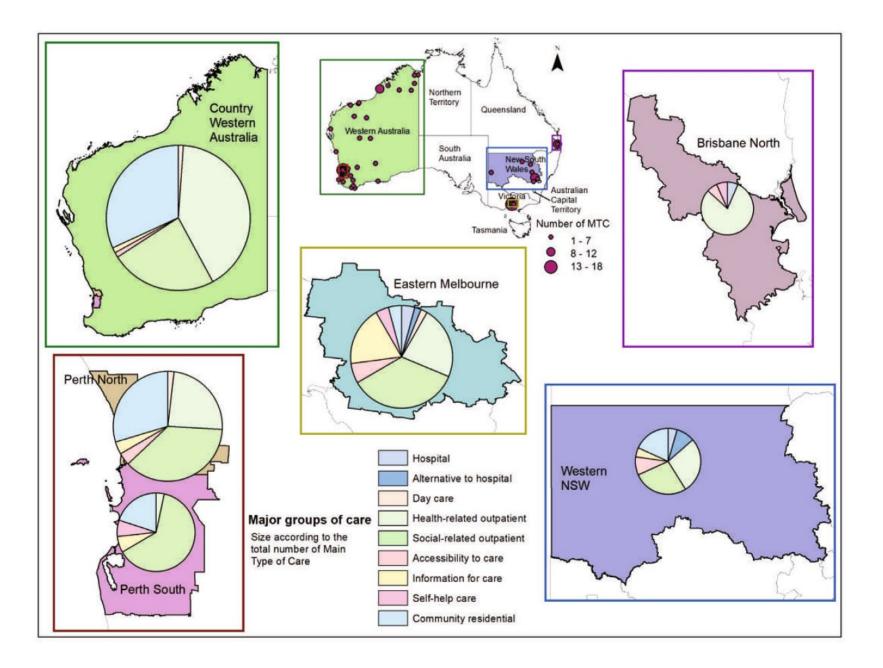
Standardised description of services, permitting comparisons in 13 PHNs

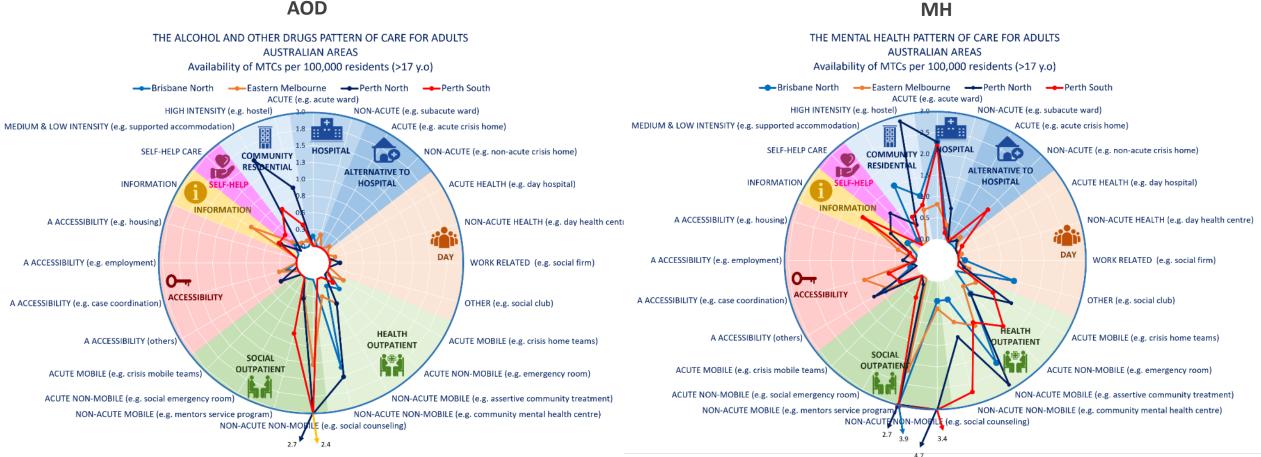




Alcohol and Other Drug Service Availability, Capacity, and Diversity in Urban and Rural Australia: An Integrated Atlas

BIANCA CALABRIA, PH.D.,^{*a*} JOSE A. SALINAS-PEREZ, PH.D.,^{*b,c*} HOSSEIN TABATABAEI-JAFARI, M.D., PH.D.,^{*c*,*} JOHN MENDOZA, B.ED.,^{*d*} TANYA BELL, PH.D.,^{*e*} JANET HOPKINS, GRADCERT ENTREPRENEURSHIP AND INNOVATION,^{*f*} MARYANNE FURST, M.HSC.(DD),^{*c*} MAREE TEESSON, PH.D.,^{*g*} JAMES GILLESPIE, PH.D.,^{*h*} NASSER BAGHERI, PH.D.,^{*c*} & LUIS SALVADOR-CARULLA. JOURNAL OF STUDIES ON ALCOHOL AND DRUGS / MAY 2021 —

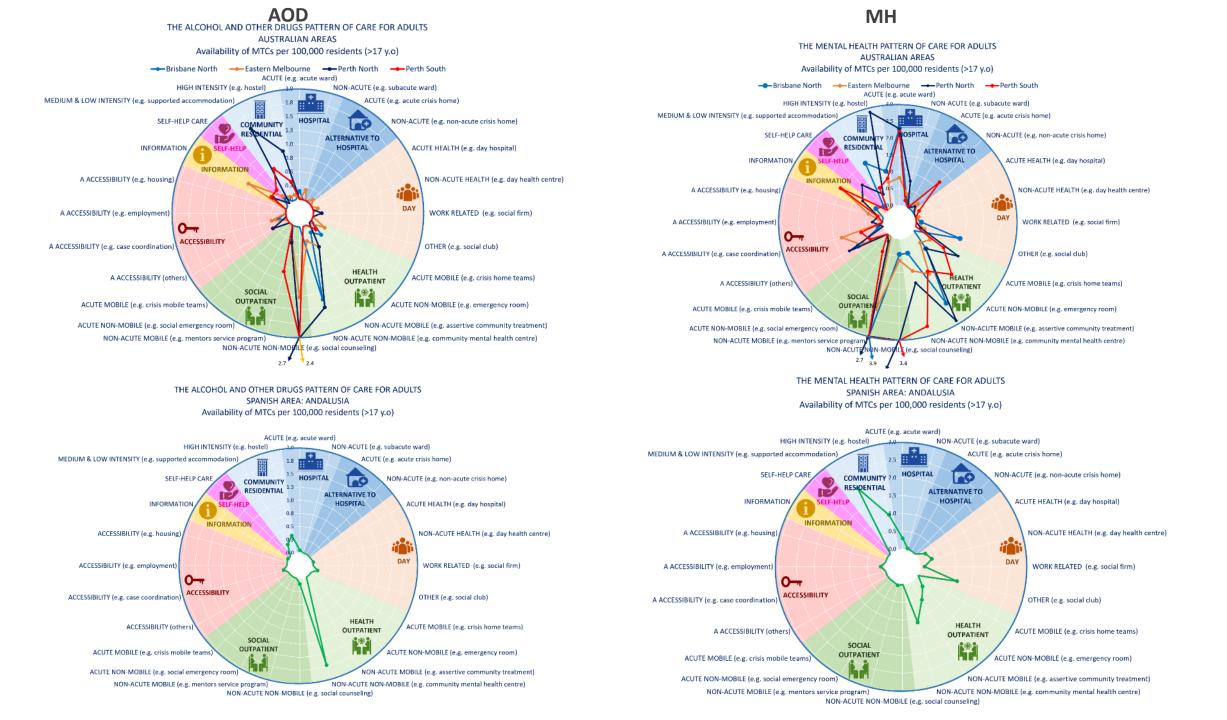




AOD



Alcohol and Drug Services in Andalucia (Spain)



CONCLUSIONS

Evidence on the ineffectiveness of partial treatment models (sequential and parallel), as they are unable to meet the complex and diverse socio-health needs of these patients.

Integrated treatment models are considered the most appropriate approach for these individuals, as they have greater evidence of effectiveness and efficiency.

Each country or region should adopt the one that best fits the characteristics of the healthcare system in which it is to be implemented.

Distinction between political-administrative integration of systems or agencies (focused on mental health and addiction services) and integrated treatment programs (focused on patients).

Avoid duplications and complementarities identifying specific resources or those that address needs not covered by either network (for example, therapeutic communities for patients with dual pathology, resources for patients with cohabitation issues, etc.).

Training for health professionals (especially Primary Care) and Mental Health on addictive behaviors and intervention in addictive behaviors.