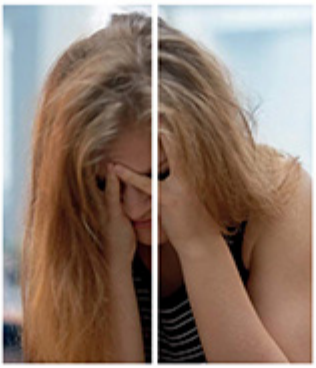

2016

Bedre tilgang til tverrfaglig spesialisert rusbehandling for barn og unge voksne

Systematisk litteratursøk med sortering

folkehelseinstituttet

Utgitt av Folkehelseinstituttet
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Innhold

Hovedbudskap

Kunnskapssenteret har på forespørsel fra Oslo universitetssykehus søkt etter oppsummert forskning for arbeidet med rusbehandling av barn, unge og unge voksne. I et avklaringsmøte ble vi enige om å søke etter eksisterende systematiske oversikter som har undersøkt effekten av lavterskeltilbud, selvhenvisning, tidlig intervensjon og enkel tilgang til spesialist. Målet med tiltakene er bedre tilgang til tverrfaglig spesialisert rusbehandling.

Metode

Vi utførte et systematisk litteratursøk i flere databaser. Søket ble utført i november 2015 og potensielt relevante referanser ble sortert etter tema.

Resultat

Vi fant åtte referanser til mulige relevante oversikter. Tema i oversiktene var:

- Henvisning
- Kriseteam
- Samhandling primærhelse- og spesialisthelsetjeneste
- Tidlig intervensjon etterfulgt av spesialisert rusbehandling
- Organisert opptrapping av behandling.

De åtte referansene var publisert mellom 2010 og 2015. En av oversiktene var en systematisk oversikt publisert i Cochrane-biblioteket.

Vi har ikke vurdert oversiktenes metodiske kvaltiet eller lest rapportene i fulltekst. Vi kan derfor ikke trekke noen konklusjoner om oversiktenens resulater eller være sikker på at de oppfyller alle kriteriene for systematiske oversikter. Vi presenterer sammendragene fra oversiktene.

Tittel:
Bedre tilgang til tverrfaglig spesialisert rusbehandling for barn og unge voksne

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Publikasjonstype:
Systematisk litteraturlisøk med sortering

Svarer ikke på alt:
Ingen kvalitetsvurdering

Hvem står bak denne publikasjonen?
Folkehelseinstituttet har gjennomført oppdraget etter forespørsel Oslo universitetssykehus

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Når ble litteratursøket utført?
Søk etter studier ble avsluttet i november 2015.

Key messages

The Knowledge Centre was commissioned by the Oslo University Hospital to conduct a systematic litereture search of systematic reviews about the effects of improved access to specialist mental health care for children, youths and young adults.

Methods
We conducted a systematic literature search in several databases. The search was completed in November 2015. Potentially relevant references were thematically listed.

Results
We found eight references to potentially relevant systematic reviews. The themes in the reviews were:

- Referral
- Crisis team
- Integrating primary and specialist care
- Early intervention
- Stepped care

All eight references were publications from 2010 to 2015. One of the reviews was a Cochrane review.

We have not read the full text nor critically appraised the quality ov the reviews. Therefore we cannot draw any conclusions regarding the reviews results. Some of the references may not be truly systematically perfomed. The available abstracts are presented.

Title:
Improved access to specialized addiction treatment for children and young adults

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Type of publication:
Systematic reference list

Doesn't answer everything:
No quality assessment

Publisher:
Norwegian Knowledge Centre for the Health Services

Updated:
Last search for studies:
November 2015.

Forord

Nasjonalt kunnskapssenter for helsetjenesten (Kunnskapssenteret) har på forespørsel fra Oslo universitetssykehus søkt etter oppsummert forskning som kan være relevant å vite om i arbeidet med rusbehandling av barn, unge og unge voksne.

Når forskningsfunn benyttes som beslutningsgrunnlag, bør det tas utgangspunkt i tilgjengelig forskning med best mulig kvalitet. Vår tillit påvirkes blant annet av studiedesign og metodisk kvaltiet. I dette prosjektet har vi ikke lest rapportene i fulltekst eller vurdert den metodiske kvaliteten. I Kunnskapssenterets håndbok «Slik oppsummerer vi forskning» http://www.kunnskapssenteret.no/verktoy/slik-oppsummerer-vi-forskning er det sjekklister som kan brukes til å vurdere kvaliteten av systematiske oversikter. Sjekklisten kan være et godt hjelpemiddel i det videre arbeidet med å ta stilling til forskningens kvalitet, herunder hvilken tillit vi kan ha til resultatene.

Prosjektgruppen har bestått av:

- Therese Kristine Dalsbø, Kunnskapssenteret
- Ingvild Kirkehei, Kunnskapssenteret
- Berge Andreas Steinsvåg, Oslo Universitetssykehus
- Liv Merete Reinar, Kunnskapssenteret

Alle forfattere og fagfeller har fylt ut et skjema som kartlegger mulige interessekonflikter. Ingen oppgir interessekonflikter.

Oslo, mars 2016

Signe Flottorp	Liv Merete Reinar	Therese Kristine Dalsbø
Avdelingsleder	*Seksjonsleder*	*Prosjektleder*

Innledning

Kunnskapssenteret fikk en henvendelse fra Oslo universitetssykehus som vurderer å starte en ungdomspoliklinikk som er ment å være et lavterskeltilbud. Formålet er at barn og unge kan komme uten formell henvisning og dermed få enkel tilgang til spesialist og tidlig intervensjon. Oslo universitetssykehus ønsket en oversikt over eksisterende kunnskapsoppsummeringer som vil kunne inngå som en del av kunnskapsgrunnlaget for tiltaket.

Bakgrunnen er at bestiller mener at klinisk erfaring viser at psykiske lidelser og avhengighetslidelser oppstår tidlig i ungdomsårene, og at prognosen bedres ved tidlig intervensjon.

Formålet med en ungdomspoliklinikk er å tilby tidlig og enkel intervensjon for barn, ungdom og unge voksne som har ulike psykiske helseproblemer, rusproblemer, psykososiale problemer, familieproblemer og utfordringer i forbindelse med skole, utdanning eller jobb.

Avgrensning og problemstilling

Formålet med dette prosjektet har vært å lage et systematisk søk etter systematiske oversikter som vurderer effekt av lavterskeltilbud, selvhenvisning, tidlig intervensjon og enkel tilgang til spesialist for å oppnå bedre tilgang til tverrfaglig spesialisert rusbehandling for barn, ungdom og unge voksne (opp til 25 år).

Metode

Vi utførte et systematisk litteratursøk med påfølgende sortering av referansene. Søket ble gjennomgått ut fra forhåndsdefinerte inklusjonskriterier.

Inklusjonskriterier

Studiedesign:
Systematiske oversikter publisert fra 2010 til november 2015 ble inkludert

Populasjon:	Barn, ungdom, unge voksne (anslagsvis 12 til 25 år) med utfordringer i forhold til rusmiddelbruk
Tiltak:	Organisering av tjenestetilbudet for å oppnå bedre/enklere/tidligere tilgang til rusbehandling
Sammenlikning:	Vanlig praksis
Utfall:	Helse, bruk av rusmidler, sosioøkonomiske forhold inklusiv utdanning, arbeid og økonomi og livskvalitet

Litteratursøking

Vi søkte i relevante medisinske databaser med relevante søketermer og filter for systematiske oversikter. Vi avgrenset ikke litteratursøket på referansens publikasjonsspråk eller publikasjonssted.

Vi søkte i følgende databaser:

- MEDLINE (Ovid),
- Embase (Ovid),
- PsycINFO (Ovid),
- Cochrane Database of Systematic Reviews,
- Health Technology Assessment Database (HTA),
- Database of Abstracts of Reviews of Effects (DARE),
- Epistemonikos,
- PubMed og
- ISI Web of Science.

Søkeord var blant annet:

- mental disease
- addiction

- alcoholism
- drug dependence
- drug abuse
- drug misuse
- multiple drug abuse
- referral
- gatekeeper
- early intervention

Søkestrategien er presentert i vedlegg.

Utvelging og sortering av mulige relevante referanser

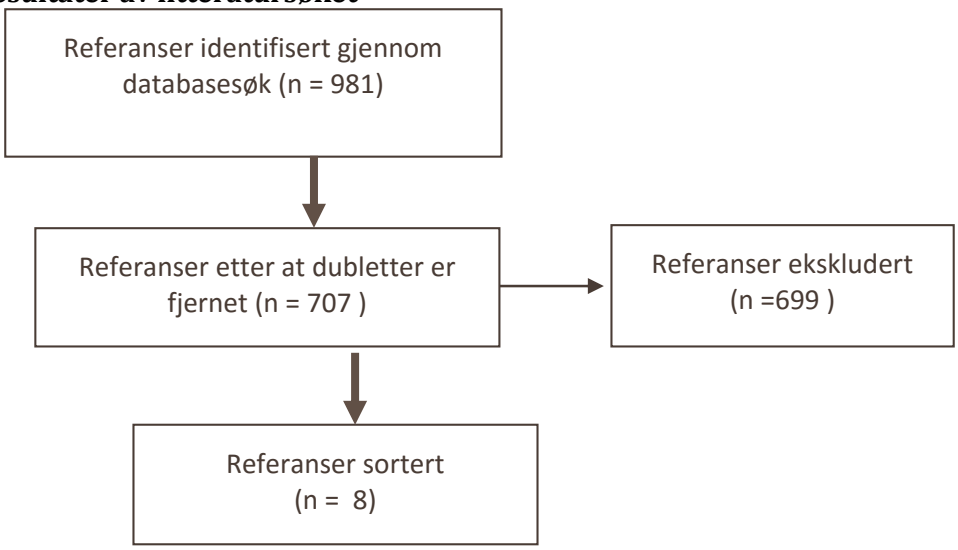
To personer leste gjennom alle referansene fra litteratursøket. Prosjektleder sorterte de mulige relevante referansene inn i ulike tematiske kategorier. Sammendraget fra referansene ble kopiert fra kilden de kom fra.

Utvelging av referanse ble gjort ut fra tittel og sammendrag, der det var tilgjengelig. Vi leste ikke rapportene i fulltekst og har ikke vurderte oversiktenes metodiske kvalitet. Resultater er ikke sammenstilt eller oppsummert.

Vi kan ha inkludert oversikter som ikke tilfredsstiller kravene til å være en systematisk oversikt. Derfor beskriver vi de sorterte referansene som mulige relevante systematisk oversikter. Siden sorteringen er basert på tittel og sammendrag kan noen av de inkluderte referansene være feilsortert. Det er også mulig at enkelte referanser ikke er relevante for vår problemstilling.

Resultater

Resultater av litteratursøket



Flytskjema

Inkluderte referanser (N=8)

Vi inkluderte åtte referanser til mulige relevante oversikter (1-8) sortert i fem temaer. Tre av referansene omhandlet alkoholmisbruk (5-7). En av referansene handlet om både alkohol- og nikotinavhengighet (6). En av referansene var publisert i Cochrane-biblioteket (4). Tema i oversiktene var henvisning, kriseteam, samhandling, tidlig intervensjon og opptrapping av behandling (se tabell nedenfor og tematisk sortert liste over referansene med sammendrag).

Tabell 1: Inkluderte referanser, sortert etter tema

Referanse	Tema
Blank 2014, Jonas 2012 og Velasco 2011 (1, 7, 8)	Henvisning
Carpenter 2013 (2)	Kriseteam
Cerimele 2010 og Gillies 2015 (3, 4)	Samhandling primærhelse- og spesialisthelsetjeneste
Glass 2015 (5)	Tidlig intervensjon etterfulgt av spesialisert rusbehandling
Jaehne 2012 (6)	Organisert opptrapping av behandling

Tabell 2: Inkluderte referanser med sammendrag, sortert etter tema
Henvisning (3 referanser)

Referanse	Sammendrag
Blank L, Baxter S, Woods HB, Goyder E, Lee A, Payne N, et al. Referral interventions from primary to specialist care: a systematic review of international evidence. Br J Gen Pract 2014;64(629):E765-E774.	Abstract: Background Demand management defines any method used to monitor, direct, or regulate patient referrals. Strategies have been developed to manage the referral of patients to secondary care, with interventions that target primary care, specialist services, or infrastructure. Aim To review the international evidence on interventions to manage referral from primary to specialist care. Design and setting Systematic review. Method Iterative, systematic searches of published and unpublished sources public health, health management, management, and grey literature databases from health care and other industries were undertaken to identify recent, relevant studies. A narrative synthesis of the data was completed to structure the evidence into groups of similar interventions. Results The searches generated 8327 unique results, of which 140 studies were included. Interventions were grouped into four intervention categories: GP education (n = 50); process change (n = 49); system change (n = 38); and patient-focused (n = 3). It is clear that there is no 'magic bullet' to managing demand for secondary care services: although some groups of interventions may have greater potential for development, given the existing evidence that they can be effective in specific contexts. Conclusions To tackle demand management of primary care services, the focus cannot be on primary care alone; a whole-systems approach is needed because the introduction of interventions in primary care is often just the starting point of the referral process. In addition, more research is needed to develop and evaluate interventions that acknowledge the role of the patient in the referral decision.
Jonas DE, Garbutt JC, Brown JM, Amick HR, Brownley KA, Viera AJ, et al. Screening, behavioral counseling, and referral in primary care to reduce alcohol misuse. Rockville (MD): Agency for Healthcare Research and Quality;	OBJECTIVES: To assess the effectiveness of screening followed by behavioral counseling for adolescents and adults with alcohol misuse in primary care settings. DATA SOURCES: MEDLINE®, Embase®, the Cochrane Library, CINAHL®, PsycINFO®. Additional studies were identified from reference lists and technical experts. REVIEW METHODS: Two people independently selected, extracted data from, and rated the quality of relevant trials

2012. (Report No 12-EHC055-EF).	and systematic reviews. Quantitative analyses were conducted for outcomes when feasible and used subgroup analyses to explore whether results differed by intensity, sex, country, person delivering the counseling, or setting. Two reviewers graded the strength of evidence (SOE). RESULTS: A total of 23 trials and six systematic reviews were included. The trials generally enrolled subjects with risky/hazardous drinking, usually excluding those with alcohol dependence. Among adults receiving interventions, consumption decreased by 3.6 drinks per week (weighted mean difference [WMD], 3.6, 95% confidence interval [CI], 2.4 to 4.8), 12 percent fewer subjects reported heavy drinking episodes (risk difference 0.12, 95% CI, 0.07 to 0.16), and 11 percent more subjects reported drinking beneath recommended limits (risk difference, 0.11, 95% CI, 0.08 to 0.13) over 12 months compared with controls (moderate SOE). Interventions improved some utilization outcomes (e.g., hospital days and costs: low SOE). For most health outcomes, available evidence either demonstrated no difference between interventions and controls (e.g., mortality: low SOE) or was insufficient to draw conclusions (e.g., accidents, injuries, alcohol-related liver problems: insufficient SOE). The best evidence of effectiveness is for brief (generally, 10 to 15 minutes) multicontact interventions. For older adults, trials provided evidence of effectiveness, but effect sizes were smaller than for all adults. Trials enrolling college students provided evidence of effectiveness for reducing consumption and heavy drinking episodes (moderate SOE) and some accident, utilization, and academic outcomes (low, low, and moderate SOE, respectively). Studies in adults found benefits lasting several years; for college students, some benefits found at 6 months were no longer significantly different for intervention versus control groups at 12 months. The one study enrolling pregnant women did not find a significant difference for reduction in consumption. Evidence was insufficient for adolescent populations. No studies randomized subjects, practices, or providers to screening and a comparator, and none of the included studies reported followup with referrals as an outcome. CONCLUSIONS: Behavioral counseling interventions improve behavioral outcomes for adults with risky/hazardous drinking. For most health outcomes, available evidence either found no

	difference between interventions and controls or was insufficient to draw conclusions. The best evidence of effectiveness is for brief multicontact interventions.
Velasco Garrido M, Zentner A, Busse R. The effects of gatekeeping: A systematic review of the literature. Scand J Prim Health Care 2011;29(1):28-38.	Abstract: Objective. To assess the effects of physician-centred gatekeeping on health, health care utilization, and costs by conducting a systematic review of the literature. Methods. Systematic search in PubMed (MEDLINE and Pre-MEDLINE), EMBASE, and the Cochrane Library, from the databases' respective inception dates up to January 2010, using the search words ''gatekeeping'', ''gatekeeper**'', ''first contact'', and ''self-referral''. We included RCTs, CCTs, cohort studies, CBAs, and interrupted time-series. We included only studies in which the gatekeeper function was exercised by a physician and that reported health and patient-related outcomes including quality of life and satisfaction, quality of care, health care utilization, and/or economic outcomes (e.g. expenditures or efficiency). Selection was made independently by two reviewers and discrepancies were solved by consensus after discussion. Data on target population, intervention, additional interventions, study results, and methodological quality were extracted. Methodological quality was assessed independently by two reviewers following the previously defined criteria. Discrepancies were solved by consensus after discussion. Results. This review includes 26 studies in 32 publications. The majority of studies (62%) reported data from the United States and in most gatekeeping was associated with lower utilization of health services (up to −−78%) and lower expenditures (up to −−80%). However, there was great variability in the magnitude and direction of the differences. Conclusion. Overall, the evidence regarding the effects of gatekeeping is of limited quality. Many studies are available regarding the effects on health care utilisation and expenditures, whereas effects on health and patient-related outcomes have been studied only exceptionally and are inconclusive.
Kriseteam (1 referanse)	
Carpenter RA, Falkenburg J, White TP, Tracy DK. Crisis teams: Systematic review of their effectiveness in practice.	Abstract: Aims and method Crisis resolution and home treatment teams (variously abbreviated to CRTs, CRHTTs, HTTs) were introduced to reduce the number and duration of in-patient admissions and better manage individuals in crisis. Despite their ubiquity, their evidence base is challengeable. This systematic review explored whether

Psychiatrist 2013;37(7):232-237.	CRTs: (a) affected voluntary and compulsory admissions; (b) treat particular patient groups; (c) are cost-effective; and (d) provide care patients value. Results Crisis resolution teams appear effective in reducing admissions, although data are mixed and other factors have also influenced this. Compulsory admissions may have increased, but evidence that CRTs are causally related is inconclusive. There are few clinical differences between 'gate-kept' patients admitted and those not. Crisis resolution teams are cheaper than in-patient care and, overall, patients are satisfied with CRT care. Clinical implications High-quality evidence for CRTs is scarce, although they appear to contribute to reducing admissions. Patient-relevant psychosocial and longitudinal outcomes are under-explored.

Samhandling primærhelse- og spesialisthelsetjeneste (2 referanser)	
Cerimele JM, Strain JJ. Integrating primary care services into psychiatric care settings: A review of the literature. Prim Care Companion J Clin Psychiatry 2010;12(6).	Abstract: Objective: This review assesses the outcomes of integrating primary care medical services into psychiatric care settings. Data Sources: PubMed, the Cochrane database, and PsycINFO were searched using the key words integrated care, family medicine, primary care, and internal medicine in combination with psychiatry or psychiatric clinic and ward to identify reports published between 1980 and December 2009 in English. Study Selection: Four studies evaluating medical care services on a psychiatry ward or in a psychiatry clinic were found. Trials involving psychiatric services in primary care clinics (the medical-psychiatric model) were excluded. Data Extraction: Data describing setting, patient population, intervention, measured outcomes, and discussion points were collected. Data Synthesis: It was learned that several models of integrated care exist, and patients in these integrated groups received more preventive health measures and showed improved scores on the Medical Outcomes Study 36-item Short-Form Health Survey and Behavior and Symptom Identification Scale and reduced rates of specialist referral. Conclusions: These data indicate that placing primary care physicians in psychiatric care settings improves health maintenance, care coordination, and satisfaction with nonpsychiatric medical care. Future studies should further address costs, the training of primary care physicians to deliver care in these settings, and whether this integrated model is more effective in specific populations such as those with schizophrenia. © 2010 Physicians Postgraduate Press, Inc.

Gillies D, Buykx P, Parker Alexandra G, Hetrick Sarah E. Consultation liaison in primary care for people with mental disorders. Cochrane Database of Systematic Reviews 2015 (9):CD007193.	Abstract: Background: Approximately 25% of people will be affected by a mental disorder at some stage in their life. Despite the prevalence and negative impacts of mental disorders, many people are not diagnosed or do not receive adequate treatment. Therefore primary health care has been identified as essential to improving the delivery of mental health care. Consultation liaison is a model of mental health care where the primary care provider maintains the central role in the delivery of mental health care with a mental health specialist providing consultative support. Consultation liaison has the potential to enhance the delivery of mental health care in the primary care setting and in turn improve outcomes for people with a mental disorder.Objectives: To identify whether consultation liaison can have beneficial effects for people with a mental disorder by improving the ability of primary care providers to provide mental health care.Search methods: We searched the EPOC Specialised Register, Cochrane Central Register of Controlled Trials (CENTRAL), and bibliographic databases: MEDLINE, EMBASE, CINAHL and PsycINFO, in March 2014. We also searched reference lists of relevant studies and reviews to identify any potentially relevant studies.Selection criteria: We included randomised controlled trials (RCTs) which compared consultation liaison to standard care or other service models of mental health care in the primary setting. Included participants were people attending primary care practices who required mental health care or had a mental disorder, and primary care providers who had direct contact with people in need of mental health care.Data collection and analysis: Two review authors independently screened the titles and abstracts of identified studies against the inclusion criteria and extracted details including the study design, participants and setting, intervention, outcomes and any risk of bias. We resolved any disagreements by discussion or referral to a third author. We contacted trial authors to obtain any missing information.We collected and analysed data for all follow-up periods: up to and including three months following the start of treatment; between three and 12 months; and more than 12 months following the start of therapy.We used a random-effects model to calculate the risk difference (RD) for binary data and number needed to treat for an additional beneficial outcome (NNTB), if differences between groups were significant.

The mean difference (MD) or standardised mean difference (SMD) was calculated for continuous data.Main results: There were 8203 citations identified from database searches and reference lists. We included 12 trials with 2605 consumer participants and more than 905 primary care practitioner participants. Eleven trials compared consultation liaison to standard care and one compared consultation liaison to collaborative care, with a case manager co-ordinating mental health care. People with depression were included in eight trials; and one trial each included people with a variety of disorders: depression, anxiety and somatoform disorders; medically unexplained symptoms; and drinking problems. None of the included trials reported separate data for children or older people.There was some evidence that consultation liaison improved mental health up to three months following the start of treatment (two trials, n = 445, NNTB 8, 95% CI 5 to 25) but there was no evidence of its effectiveness between three and 12 months. Consultation liaison also appeared to improve consumer satisfaction (up to three months: one trial, n = 228, NNTB 3, 95% CI 3 to 5; 3 to 12 months: two trials, n = 445, NNTB 8, 95% CI 5 to 17) and adherence (3 to 12 months: seven trials, n = 1251, NNTB 6, 95% CI 4 to 13) up to 12 months. There was also an improvement in the primary care provider outcomes of providing adequate treatment between three to 12 months (three trials, n = 797, NNTB 7, 95% CI 4 to 17) and prescribing pharmacological treatment up to 12 months (four trials, n = 796, NNTB 13, 95% CI 7 to 50). There was also so e evidence that consultation liaison may not be as effective as collaborative care in regards to symptoms of mental disorder, disability, general health status, and provision of treatment.The quality of these findings were low for all outcomes however, apart from consumer adherence from three to 12 months, which was of moderate quality. Eight trials were rated a high risk of performance bias because consumer participants were likely to have known whether or not they were allocated to the intervention group and most outcomes were self reported. Bias due to attrition was rated high in eight trials and reporting bias was rated high in six.Authors' conclusions: There is evidence that consultation liaison improves mental health for up to three months; and satisfaction and adherence for up to 12 months in people with mental disorders, particularly those who are depressed. Primary care providers were also more likely to provide adequate treatment and prescribe pharmacological therapy for up to 12

	months. There was also some evidence that consultation liaison may not be as effective as collaborative care in terms of mental disorder symptoms, disability, general health status, and provision of treatment. However, the overall quality of trials was low particularly in regards to performance and attrition bias and may have resulted in an overestimation of effectiveness. More evidence is needed to determine the effectiveness of consultation liaison for people with mental disorders particularly for those with mental disorders other than depression.
Tidlig intervensjon etterfulgt av spesialisert rusbehandling (1 referanse)	
Glass JE, Hamilton AM, Powell BJ, Perron BE, Brown RT, Ilgen MA. Specialty substance use disorder services following brief alcohol intervention: a meta-analysis of randomized controlled trials. Addiction 2015;110(9):1404-1415.	Abstract: BACKGROUND AND AIMS: Brief alcohol interventions in medical settings are efficacious in improving self-reported alcohol consumption among those with low-severity alcohol problems. Screening, Brief Intervention and Referral to Treatment initiatives presume that brief interventions are efficacious in linking patients to higher levels of care, but pertinent evidence has not been evaluated. We estimated main and subgroup effects of brief alcohol interventions, regardless of their inclusion of a referral-specific component, in increasing the utilization of alcohol-related care. METHODS: A systematic review of English language papers published in electronic databases to 2013. We included randomized controlled trials (RCTs) of brief alcohol interventions in general health-care settings with adult and adolescent samples. We excluded studies that lacked alcohol services utilization data. Extractions of study characteristics and outcomes were standardized and conducted independently. The primary outcome was post-treatment alcohol services utilization assessed by self-report or administrative data, which we compared across intervention and control groups. RESULTS: Thirteen RCTs met inclusion criteria and nine were meta-analyzed (n=993 and n=937 intervention and control group participants, respectively). In our main analyses the pooled risk ratio (RR) was=1.08, 95% confidence interval (CI)=0.92-1.28. Five studies compared referral-specific interventions with a control condition without such interventions (pooled RR=1.08, 95% CI=0.81-1.43). Other subgroup analyses of studies with common characteristics (e.g. age, setting, severity, risk of bias) yielded non-statistically significant results.

	CONCLUSIONS: There is a lack of evidence that brief alcohol interventions have any efficacy for increasing the receipt of alcohol-related services.Copyright © 2015 Society for the Study of Addiction.
Organisert opptrapping av behandling (1 referanse)	
Jaehne A, Loessl B, Frick K, Berner M, Hulse G, Balmford J. The efficacy of stepped care models involving psychosocial treatment of alcohol use disorders and nicotine dependence: a systematic review of the literature. Current Drug Abuse Reviews 2012;5(1):41-51.	Abstract: Of particular interest in the psychosocial treatment of addictions is determining how much therapy is required to bring about behaviour change. Stepped care approaches, where non-responders to a less intensive therapy receive a more intensive intervention, aim to only provide intensive assistance to those who need it, thereby allocating therapeutic resources more efficiently. This paper provides a systematic review of stepped care models involving different levels of psychosocial intervention for the treatment of alcohol use disorders and smoking cessation. Five publications on alcohol and three on smoking were included in the review. Due to the heterogeneity of outcome measures, participant characteristics and interventions, a narrative review format was employed. Overall, little evidence was found to suggest that stepping up non-responders to more intensive therapy improved outcomes, a finding that could partially be attributed to a lack of power to find significant effects. In one study, the application of a stepped care approach was found to reduce treatment costs compared with usual care. There was some evidence that the greater differentiation between the intensity of the interventions offered at each step, the better the outcome. Further research is needed to evaluate the efficacy of stepped care approaches to providing psychosocial treatment, employing larger samples and/or consistent definitions of the nature of the interventions offered at each step, and assessing treatment response in a timely manner.

Diskusjon

Hovedfunn

Vi fant åtte referanser til mulige relevante oversikter (1-8). Tema i oversiktene var:

- Henvisning
- Kriseteam
- Samhandling primærhelse- og spesialisthelsetjeneste
- Tidlig intervensjon etterfulgt av spesialisert rusbehandling
- Organisert opptrapping av behandling

De åtte referansene var publisert mellom 2010 og 2015. En av oversiktene var en systematisk oversikt publisert i Cochrane-biblioteket.

Kvaliteten på forskningsresultatene

Vi har ikke vurdert tilliten til forskningsresultatene.

Styrker og svakheter

Mulige begrensninger ved systematiske oversikter

Når vi søker etter systematiske oversikter vil vi ikke fange opp all relevant forskning som finnes innenfor et fagfelt. Når vi ikke vurderer kvaliteten til de systematiske oversiktene kan det være mulig at noen er av så dårlig kvalitet at funnene ikke er troverdige. Siden oversiktene ikke alltid er oppdaterte kan det finnes nye, relevante enkeltstudier som ikke er fanget opp.

Mulige skjevheter i oppsummeringsprosessen

Det er vanskelig å finne gode søkeord for å fange opp relevante tiltak innenfor fagfeltet rusbehandling fordi det organiseres ulikt på tvers av landegrenser. Vi forsøkte å ha brede inklusjonskriterier for å fange opp oversikter om effekt av ulike tiltak innen psykisk helsevern. Dermed øker risikoen for at vi har tatt med oversikter som ikke bare omhandler rusbehandling. Det var vanskelig å vurdere om oversikten tok for seg barn, ungdom eller unge voksne og der vi var i tvil valgte vi å inkludere referansen. Dette kan bety at noen av de inkluderte referansene ikke er relevant eller at de er relevant, men av dårlig kvalitet.

Referanser

1. Blank L, Baxter S, Woods HB, Goyder E, Lee A, Payne N, et al. Referral interventions from primary to specialist care: a systematic review of international evidence. Br J Gen Pract 2014;64(629):E765-E774.

2. Carpenter RA, Falkenburg J, White TP, Tracy DK. Crisis teams: Systematic review of their effectiveness in practice. Psychiatrist 2013;37(7):232-237.

3. Cerimele JM, Strain JJ. Integrating primary care services into psychiatric care settings: A review of the literature. Prim Care Companion J Clin Psychiatry 2010;12(6).

4. Gillies D, Buykx P, Parker Alexandra G, Hetrick Sarah E. Consultation liaison in primary care for people with mental disorders. Cochrane Database of Systematic Reviews 2015(9):CD007193.

5. Glass JE, Hamilton AM, Powell BJ, Perron BE, Brown RT, Ilgen MA. Specialty substance use disorder services following brief alcohol intervention: a meta-analysis of randomized controlled trials. Addiction 2015;110(9):1404-1415.

6. Jaehne A, Loessl B, Frick K, Berner M, Hulse G, Balmford J. The efficacy of stepped care models involving psychosocial treatment of alcohol use disorders and nicotine dependence: a systematic review of the literature. Current Drug Abuse Reviews 2012;5(1):41-51.

7. Jonas DE, Garbutt JC, Brown JM, Amick HR, Brownley KA, Viera AJ, et al. Screening, behavioral counseling, and referral in primary care to reduce alcohol misuse. Rockville (MD): Agency for Healthcare Research and Quality; 2012. (Report No 12-EHC055-EF).

8. Velasco Garrido M, Zentner A, Busse R. The effects of gatekeeping: A systematic review of the literature. Scand J Prim Health Care 2011;29(1):28-38.

Vedlegg

Søkestrategi

Søkestrategi

Alle søk ble utført 25.11. 2015

Søketreff totalt: 981
Søketreff etter dublettkontroll: 707

Søket ble utført i følgende databaser: MEDLINE (Ovid), Embase (Ovid), PsycINFO (Ovid), Cochrane Database of Systematic Reviews, Health Technology Assessment Database (HTA), Database of Abstracts of Reviews of Effects (DARE), Epistemonikos, PubMed og ISI Web of Science.

Søket bestod av emneord og tekstord for tiltaket kombinert med emneord og tekstord for populasjonen. Søket ble videre avgrenset med et presist filter for systematiske oversikter. Alle søk, med unntak søket i Cochrane Database of Systematic Reviews ble avgrenset til publikasjonsår 2010-2015.

Ovid MEDLINE, Embase, PsycINFO (samsøk)

Søketreff:
Embase 1980 to 2015 Week 47: 197
Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE(R) and Ovid OLDMEDLINE(R) 1946 to Present: 245
PsycINFO 1806 to November Week 3 2015: 186

507 treff totalt etter Ovid dublettkontroll

1. Gatekeeping/
2. "Referral and Consultation"/
3. (gatekeep* or gate keep* or (early adj3 intervention*) or referral* or stepped care or (specialist* adj3 access*) or seamless healthcare or seamless health care or seamless care or head space or headspace or head strong or headstrong).tw.
4. or/1-3

5. mental disorders/ or adjustment disorders/ or exp anxiety disorders/ or exp dissociative disorders/ or exp eating disorders/ or exp factitious disorders/ or exp impulse control disorders/ or exp mental disorders diagnosed in childhood/ or exp mood disorders/ or exp neurotic disorders/ or exp personality disorders/ or exp "schizophrenia and disorders with psychotic features"/ or exp somatoform disorders/ or substance-related disorders/ or exp alcohol-related disorders/ or amphetamine-related disorders/ or cocaine-related disorders/ or inhalant abuse/ or marijuana abuse/ or exp opioid-related disorders/ or phencyclidine abuse/ or psychoses, substance-induced/ or substance abuse, intravenous/ or exp substance withdrawal syndrome/
6. (((mental* or psychosocial*) adj2 (disorder* or disease* or ill*)) or anxiet* or obsessive compulsive disorder* or panic disorder* or panic attack* or phobic disorder* or phobia* or phobic neuroses or stress disorder* or personality disorder* or dissociative disorder* or eating disorder* or anorexia or bulimia or attention deficit disorder* or hyperactivity disorder* or ADHD or conduct disorder* or Asperger* or autism or autistic or Tourette* or mood disorder* or affective disorder* or depressive or depression or neurotic disorder* or neurosis or schizophren* or psychosis or psychotic or Schizoid or Schizotyp* or substance-related disorder* or ((substance* or drug* or alcohol or amphetamine or cocaine or marijuana or opioid*) adj2 ("use" or misuse or abuse or disorder* or dependen*)) or alcoholi* or narcotic*).tw.
7. or/5-6
8. 4 and 7
9. ((systematic* adj2 review*) or meta-anal*).pt,tw.
10. 8 and 9
11. 10 use pmoz [MEDLINE]
12. early intervention/
13. patient referral/
14. 12 or 13 or 3
15. mental disease/ or exp addiction/ or adjustment disorder/ or alexithymia/ or exp anxiety disorder/ or exp autism/ or exp behavior disorder/ or exp dissociative disorder/ or emotional disorder/ or exp memory disorder/ or exp mental deficiency/ or mental instability/ or exp mood disorder/ or exp neurosis/ or exp personality disorder/ or exp psychosis/ or exp psychosomatic disorder/ or psychotrauma/ or exp thought disorder/ or addiction/ or alcoholism/ or exp drug dependence/ or drug abuse/ or drug misuse/ or multiple drug abuse/
16. 15 or 6
17. "systematic review"/
18. meta analysis/
19. ((systematic* adj2 review*) or meta-anal*).tw.
20. or/17-19
21. 14 and 16 and 20
22. 21 use emez
23. limit 22 to exclude medline journals
24. (abstract or conference or conference paper or conference proceeding or conference proceeding article or conference proceeding conference paper or conference proceeding editorial or conference proceeding note or "conference proceeding review" or

journal conference abstract or journal conference paper or "journal conference review").pt.
25. 24 use emez
26. 25 and 22
27. 23 or 26 [Embase]
28. early intervention/
29. professional referral/ or client transfer/
30. 28 or 29 or 3
31. mental disorders/ or adjustment disorders/ or exp affective disorders/ or alexithymia/ or exp anxiety disorders/ or autism/ or exp chronic mental illness/ or exp dissociative disorders/ or exp eating disorders/ or elective mutism/ or exp factitious disorders/ or exp hysteria/ or exp impulse control disorders/ or koro/ or exp mental disorders due to general medical conditions/ or exp neurosis/ or exp paraphilias/ or exp personality disorders/ or exp pervasive developmental disorders/ or pseudodementia/ or exp psychosis/ or schizoaffective disorder/ or exp attention deficit disorder/ or exp behavior disorders/ or conduct disorder/ or exp memory disorders/
32. drug abuse/ or exp alcohol abuse/ or exp drug dependency/ or exp inhalant abuse/ or exp addiction/ or exp drug addiction/
33. 31 or 32 or 6
34. exp Meta Analysis/
35. ((systematic* adj2 review*) or meta-anal*).tw.
36. (meta analysis or "systematic review").md.
37. or/34-35
38. 30 and 33 and 37
39. 38 use psyh [PsycINFO]
40. 11 or 27 or 39
41. limit 40 to yr="2010 -Current"
42. remove duplicates from 41

Cochrane Library
Søketreff: Cochrane Reviews 44, DARE 22, HTA 13,

#1 MeSH descriptor: [Gatekeeping] explode all trees
#2 MeSH descriptor: [Referral and Consultation] this term only
#3 (gatekeep* or (gate next keep*) or (early near/3 intervention*) or referral* or "stepped care" or (specialist* near/3 access*) or "seamless healthcare" or "seamless health care" or "seamless care" or "head space" or headspace or "head strong" or headstrong):ti,ab,kw
#4 #1 or #2 or #3
#5 MeSH descriptor: [Mental Disorders] explode all trees
#6 (((mental* or psychosocial*) near/2 (disorder* or disease* or ill*)) or anxiet* or (obsessive next compulsive next disorder*) or (panic next disorder*) or (panic next attack*) or (phobic next disorder*) or phobia* or "phobic neuroses" or (stress next disorder*) or (personality next disorder*) or (dissociative next disorder*) or (eating next disorder*) or anorexia or bulimia or (attention next deficit next disorder*) or (hyperactivity next disorder*) or ADHD or (conduct next disorder*) or Asperger* or autism or

autistic or Tourette* or (mood next disorder*) or (affective next disorder*) or depressive or depression or (neurotic next disorder*) or neurosis or schizophren* or psychosis or psychotic or Schizoid or Schizotyp* or (substance next related next disorder*) or ((substance* or drug* or alcohol or amphetamine or cocaine or marijuana or opioid*) near/2 (use or misuse or abuse or disorder* or dependenc*)) or alcoholi* or narcotic*):ti,ab,kw
#7 #5 or #6
#8 #4 and #7
Limits HTA, DARE: Publication Year from 2010 to 2015

Epistemonikos
Søketreff systematic reviews: 99
Søketreff structured summaries: 11
Advanced search
Title or abstract: (gatekeep* OR "gate keeper" OR “gate keeping” OR "stepped care" OR "stepped health care" OR "stepped healthcare" OR "early intervention" OR "seamless care" OR "seamless healthcare" OR "seamless health care" OR referral* OR “specialist access” OR “access to specialist”) AND (mental OR psychosocial* OR anxiet* OR "obsessive compulsive disorder" OR panic OR phobic OR phobia* OR neuroses OR stress OR "personality disorder" OR dissociative OR "eating disorder" OR "eating disorders" OR anorexia OR bulimia OR "attention deficit" OR hyperactivity OR ADHD OR conduct OR Asperger* OR autism OR autistic OR Tourette* OR mood OR affective OR depressive OR depression OR neurotic OR neurosis OR schizophren* OR psychosis OR psychotic OR Schizoid OR Schizotyp* OR substance OR alcohol* OR amphetamine OR cocaine OR marijuana OR opioid* OR "drug dependency" OR “drug dependence” OR narcotic*)
Limits: Cochrane Library: NO
Publication date: 2010-2015

ISI web of Science
Søketreff: 269
TOPIC: ("gatekeeper*" OR "gate keeper*" OR “gate keeping” OR “gatekeeping” OR "stepped care" OR "stepped health care" OR "stepped healthcare" OR "early intervention" OR "seamless care" OR "seamless healthcare" OR "seamless health care" OR referral* OR “specialist access” OR “access to specialist”) AND TOPIC: ("mental" OR "psychosocial*" OR "anxiet*" OR "obsessive compulsive disorder" OR "panic" OR "phobic" OR "phobia*" OR "neuroses" OR "stress" OR "personality disorder" OR "dissociative" OR "eating disorder" OR "eating disorders" OR "anorexia" OR "bulimia" OR "attention deficit" OR "hyperactivity disorder" OR "ADHD" OR "conduct disorder" OR "Asperger*" OR "autism" OR "autistic" OR "Tourette*" OR "mood disorder" OR "mood disorders" OR "affective disorder" OR "affevctive disorders" OR "depressive" OR "depression" OR "neurotic" OR "neurosis" OR "schizophren*" OR "psychosis" OR "psychotic" OR "Schizoid" OR "Schizotyp*" OR "substance use" OR "substance abuse" OR "alcohol*" OR "amphetamine" OR "cocaine" OR "marijuana" OR "opioid*") AND TOPIC: (("systematic*" NEAR/2 "review*") or "meta-analysis")
Indexes=SCI-EXPANDED, SSCI, A&HCI, ESCI Timespan=2010-2015

PubMed

Søketreff: 16

(gatekeep* OR "gate keeper" OR “gate keeping” OR "stepped care" OR "stepped health care" OR "stepped healthcare" OR "early intervention" OR "seamless care" OR "seamless healthcare" OR "seamless health care" OR referral* OR “specialist access” OR “access to specialist”) AND (mental OR psychosocial* OR anxiet* OR "obsessive compulsive disorder" OR panic OR phobic OR phobia* OR neuroses OR stress OR "personality disorder" OR dissociative OR "eating disorder" OR "eating disorders" OR anorexia OR bulimia OR "attention deficit" OR hyperactivity OR ADHD OR conduct OR Asperger* OR autism OR autistic OR Tourette* OR mood OR affective OR depressive OR depression OR neurotic OR neurosis OR schizophren* OR psychosis OR psychotic OR Schizoid OR Schizotyp* OR substance OR alcohol* OR amphetamine OR cocaine OR marijuana OR opioid* OR "drug dependency" OR “drug dependence” OR narcotic*) AND ("systematic review" or meta-analysis) AND pubstatusaheadofprint

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