

Networking Psychiatry and Addiction Services: Real-World Data and Perspectives on the Integration between Community Mental Health and Addiction Services in Settimo Torinese

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Abstract: This observational study describes the collaborative model between a Community Mental Health Center (CMHC) and an Addiction Service (Servizio per le Dipendenze, SerD) within a local healthcare setting in the Piedmont Region of Italy. The study aimed to explore the clinical characteristics of patients jointly managed by the two services and to identify the factors underlying different levels of psychiatric intervention. Clinical records were retrospectively reviewed, collecting demographic data, psychiatric diagnoses, primary substance of abuse, and type of intervention provided by the CMHC. The findings highlight a clinically heterogeneous population with distinct profiles according to the primary substance of abuse. Patients with crack cocaine use disorder were younger, more frequently affected by psychotic disorders and personality disorders, and were more often managed through intensive multidisciplinary care. Patients with heroin use disorder showed more chronic clinical trajectories and were predominantly managed through psychiatric consultation. Patients with alcohol use disorder were generally older and commonly presented with depressive disorders. However, multivariate analysis suggested that the intensity of psychiatric intervention was more strongly associated with psychiatric diagnosis than with the primary substance of abuse itself. These findings suggest that close collaboration between Community Mental Health Centers and Addiction Services may promote a more appropriate allocation of healthcare resources, reduce overlap between services, and tailor interventions according to patients' psychiatric and care needs. The proposed model may provide a useful framework for future research and for the development of more structured and transferable models of integrated care.

Keywords: dual diagnosis; substance use disorder; integrated care; community psychiatry

1. Introduction

Patients with co-occurring psychiatric disorders and substance use disorders (SUDs), commonly referred to as individuals with dual diagnosis, represent one of the most clinically challenging populations treated by community mental health services. They frequently present with severe and persistent psychopathology, high rates of physical comorbidity, poor treatment adherence, and worse outcomes than individuals affected by either psychiatric disorders or SUDs alone [1]. In addition, they often experience substantial psychosocial impairment, including unemployment, financial hardship, family disruption, social marginalization, and increased involvement with the criminal justice system [2,3].



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The management of dual diagnosis requires an integrated, multidisciplinary approach that addresses psychiatric, biological, psychological, and social needs. Effective care therefore relies on close collaboration among Community Mental Health Centers (CMHCs), Addiction Services (SerD), general hospitals, social services, and, in some cases, the criminal justice system. Nevertheless, fragmented care pathways and the absence of shared clinical frameworks may compromise continuity of care and reduce treatment effectiveness.

Over the past decade, several Italian regions have promoted initiatives aimed at strengthening collaboration between CMHCs and SerD through organizational integration, multidisciplinary assessment, joint professional training, and individualized rehabilitation planning [4,5]. Despite these efforts, no standardized national model has been established, and collaborative practices continue to vary considerably across healthcare settings.

Within the Local Health Authority TO4 (Azienda Sanitaria Locale TO4, ASL TO4, Piedmont, Italy), CMHCs and SerD remain administratively independent while operating within a structured collaborative framework based on regular multidisciplinary case discussions, psychiatric consultation within the Addiction Service, and joint management of patients with complex clinical needs.

However, real-world evidence describing how these collaborative models operate in routine clinical practice remains limited. The present study aimed to describe the collaborative model between the CMHCs of Settimo Torinese and San Mauro Torinese and the SerD of Settimo Torinese. Specifically, we sought to characterize the socio-demographic and clinical profile of jointly managed patients, explore differences in patterns of psychiatric care according to demographic and clinical characteristics, with particular attention to the primary substance of abuse, and provide a real-world description of this integrated care model. Rather than evaluating its effectiveness, this descriptive observational study was designed to generate hypotheses for future analytical research and service development.

2. Materials and Methods

2.1. Study Design and Participants

This retrospective observational study included all patients jointly managed by the Addiction Service (Servizio per le Dipendenze, SerD) of Settimo Torinese and the Community Mental Health Centers (CMHCs) of Settimo Torinese and San Mauro Torinese between 1 January 2020 and 31 December 2025. Both services operate within the same geographical catchment area. No predefined exclusion criteria were applied. One patient had incomplete Addiction Service data and could therefore not be classified according to the primary substance of abuse. This patient was retained in analyses for which the relevant clinical information was available and excluded only from analyses requiring substance-use data.

The two services maintained independent responsibility for patient referral, diagnostic assessment, treatment planning, and duration of care. Data were retrospectively extracted from electronic medical records, including demographic characteristics (sex and age), duration of treatment (defined as the interval between the first and last recorded clinical contact), and number of psychiatric consultations.

2.2. Clinical Variables

Psychiatric diagnoses were established through routine specialist clinical assessment according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) criteria [6]. No standardized diagnostic instruments were used. For statistical purposes, diagnoses were grouped into broad DSM-5-TR diagnostic categories. The study was not designed to distinguish primary psychiatric disorders from substance-induced syndromes; accordingly, psychiatric diagnoses were analyzed according to the categories documented in the clinical records, without attempting to establish the etiological relationship between substance use and psychiatric symptoms.

Substance-related disorders were classified according to the primary substance of abuse documented by the Addiction Service. The dataset did not include a systematic record of all substances used by each patient; therefore, the prevalence of polysubstance use could not be reliably determined. Secondary substance use that was not considered clinically problematic or diagnostically relevant by the treating service may not have been recorded. In addition to substance-related disorders, gambling disorder was included among the primary diagnoses recorded by the Addiction Service, although it does not involve the use of a psychoactive substance.

2.3. Classification of Psychiatric Care

According to the organizational model adopted by the Italian National Action Plan for Mental Health and implemented within the Piedmont Regional Health Service [7], psychiatric interventions provided by the CMHC were classified into three hierarchical levels:

- Consultation, defined as psychiatric assessment delivered within the Addiction Service and involving up to ten clinical consultations.
- Specialist psychiatric care, defined as follow-up exceeding ten psychiatric consultations without involvement of other CMHC professionals.
- Comprehensive multidisciplinary care, defined as cases requiring multidisciplinary CMHC involvement and/or complex interventions (including psychiatric hospitalization, residential rehabilitation, or community-based psychosocial interventions), regardless of the number of psychiatric consultations.

These three categories were considered indicators of increasing intensity of CMHC involvement. Although greater intensity of care may be associated with greater clinical and psychosocial needs, it should not be interpreted as a direct or standardized measure of overall clinical complexity.

2.4. Statistical Analysis

Statistical analyses were performed using IBM SPSS Statistics version 24 (IBM Corp., Armonk, NY, USA). Categorical variables were summarized as frequencies and percentages, whereas continuous variables were expressed as mean $\pm$ standard deviation.

Associations between the level of psychiatric intervention and categorical clinical variables were assessed using Pearson's chi-square test or Fisher's exact test, as appropriate. Comparisons of continuous variables between two groups were performed using the independent-samples *t*-test, applying Welch's correction when homogeneity of variances was violated. Differences in age across the three levels of psychiatric intervention were evaluated using one-way analysis of variance (ANOVA).

To identify independent predictors of psychiatric intervention intensity, an ordinal logistic regression model was fitted using psychiatric intervention level (consultation < specialist psychiatric care < comprehensive multidisciplinary care) as the dependent variable. Age was entered as a continuous predictor, whereas psychiatric diagnoses and primary substances of abuse were included as dichotomous variables. Model fit was evaluated using Nagelkerke's pseudo- R^2 , and the proportional odds assumption was assessed using the test of parallel lines. Results are reported as odds ratios (ORs) with 95% confidence intervals (95% CIs). Statistical significance was set at $p < 0.05$. The ordinal logistic regression analysis was conducted on complete cases with available data for all predictors included in the model ($n = 139$).

2.5. Ethics and Data Governance

This study was based on a retrospective analysis of clinical data collected as part of routine healthcare practice by professionals authorized to access and process such information. No additional procedures or patient contacts were performed for research purposes. Data used for the analysis were handled in anonymized and aggregated form, with no information allowing individual patients to be identified. In accordance with the institutional procedures applicable to this retrospective analysis of routinely collected clinical data, formal review by an Ethics Committee was not required. Authorization for publication was requested from and granted by the Health Directorate of ASL TO4 (protocol no. 00 77957, 7 July 2026).

3. Results

3.1. Sample Characteristics

The general clinical and demographic characteristics of the sample are reported in Table 1.

The limited number of patients within some diagnostic and substance use categories limited the possibility of drawing robust conclusions for less prevalent substances of abuse and psychiatric diagnoses. Therefore, subsequent analyses focused on the three most frequently represented primary substances of abuse (crack cocaine, heroin, and alcohol) and the three most common psychiatric diagnostic categories (personality disorders, schizophrenia spectrum and other psychotic disorders, and depressive disorders).

3.2. Sex Differences

A significant association was found between sex and personality disorders, which were more frequent among women than men (37.2% vs. 11.3%; $p < 0.001$). In contrast, no significant association was observed between sex and schizophrenia spectrum and other psychotic disorders, although these diagnoses were numerically more frequent among men ($p = 0.077$).

No statistically significant associations were found between sex and depressive disorders or the primary substance of abuse (alcohol, crack cocaine, or heroin). The distribution of psychiatric diagnoses and primary substances of abuse according to sex is presented in Figure 1.

Table 1. Demographic, clinical, substance-use, and CMHC intervention characteristics of the study sample.

Characteristic	n (%) or Mean $\pm$ SD
Total sample	140
Sex	
Male	97 (69.3)
Female	43 (30.7)
Age, years	46.0 $\pm$ 12.3
Primary substance of abuse *	
Alcohol	43 (30.9)
Heroin	38 (27.3)
Crack cocaine	25 (18.0)
Cocaine hydrochloride	14 (10.1)
Tetrahydrocannabinol (THC)	10 (7.2)
Gambling disorder	8 (5.8)
Amphetamines	1 (0.7)
Psychiatric diagnosis	
Depressive disorders	37 (26.4)
Schizophrenia spectrum and other psychotic disorders	29 (20.7)
Personality disorders	27 (19.3)
Bipolar and related disorders	19 (13.6)
Anxiety disorders	9 (6.4)
Neurocognitive disorders	7 (5.0)
Impulse-control disorders	4 (2.9)
No psychiatric diagnosis	3 (2.1)
Post-traumatic stress disorder	2 (1.4)
Attention-deficit/hyperactivity disorder	2 (1.4)
Obsessive-compulsive disorder	1 (0.7)
Level of CMHC intervention	
Psychiatric consultation	83 (59.3)
Specialist psychiatric care	18 (12.9)
Comprehensive multidisciplinary care	39 (27.9)

Note. Values are presented as n (%) unless otherwise indicated. * Primary substance-of-abuse data were available for 139 patients; percentages for this variable are therefore calculated on n = 139. CMHC = Community Mental Health Center; SD = standard deviation.

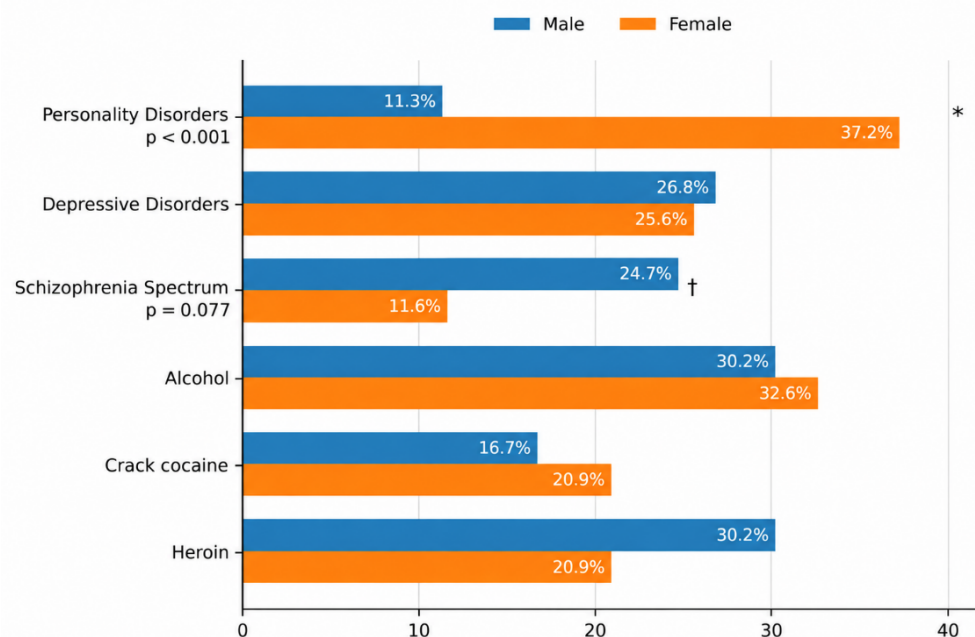


Figure 1. Percentage distribution of psychiatric diagnoses and primary substances of abuse according to sex.

* indicates statistically significant differences ($p < 0.05$), whereas † indicates a trend toward statistical significance ($p < 0.10$).

3.3. Age

Significant age differences were observed according to both primary substance of abuse and psychiatric diagnosis (Figure 2). Patients with alcohol use disorder and those diagnosed with depressive disorders were significantly older than their respective comparison groups (both $p < 0.001$). Likewise, patients with heroin use disorder were older than those without heroin use disorder ($p = 0.032$).

Conversely, patients with crack cocaine use disorder were significantly younger than those without crack cocaine use disorder ($p < 0.001$). A similar pattern was observed for schizophrenia spectrum and other psychotic disorders, which were associated with a younger mean age ($p = 0.043$).

Although patients with personality disorders also tended to be younger, this difference did not reach statistical significance ($p = 0.060$).

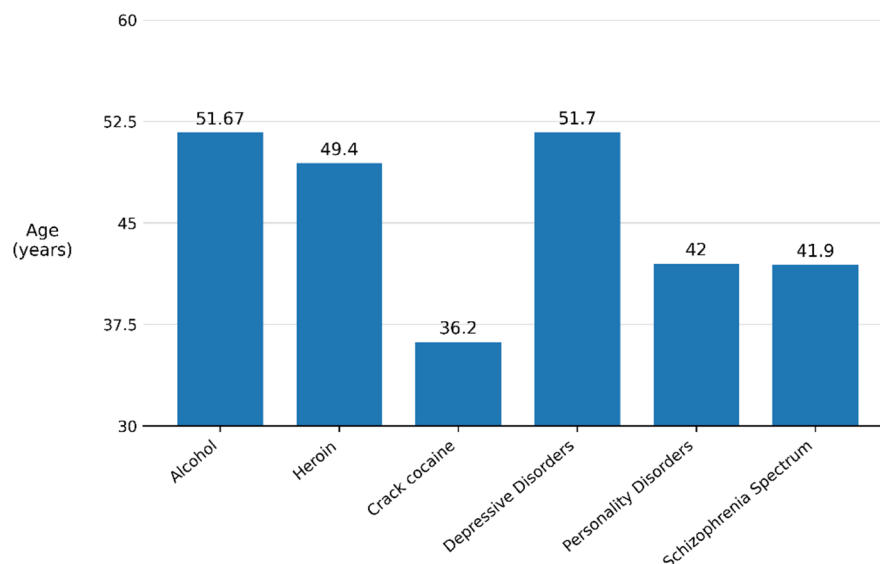


Figure 2. Mean age according to the primary substance of abuse and the main psychiatric diagnostic categories.

3.4. Primary Substance of Abuse and Psychiatric Diagnosis

Significant associations were observed between the primary substance of abuse and psychiatric diagnostic categories (Figure 3).

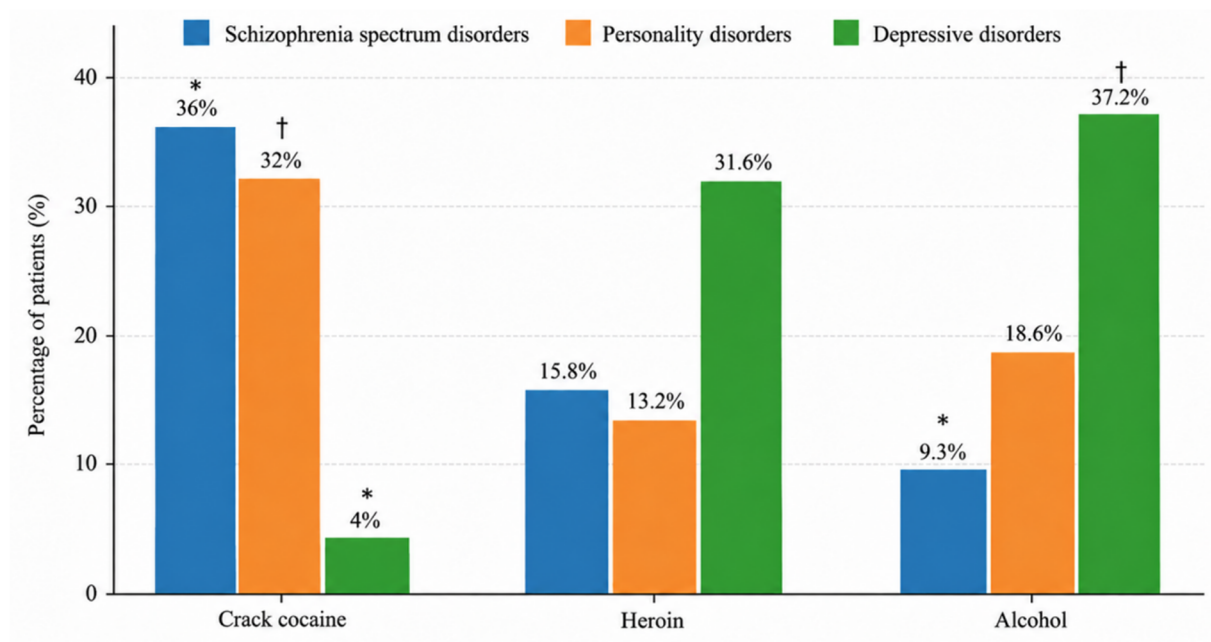


Figure 3. Percentage distribution of the main psychiatric diagnostic categories according to the primary substance of abuse. Bars represent the proportion of patients with schizophrenia spectrum and other psychotic disorders,

personality disorders, and depressive disorders within each primary substance of abuse category (crack cocaine, heroin, and alcohol). * indicates statistically significant associations ($p < 0.05$), whereas † indicates a trend toward statistical significance ($0.05 < p < 0.10$).

Alcohol use disorder was inversely associated with schizophrenia spectrum and other psychotic disorders, which were less frequent among patients with alcohol use disorder than among those with other primary substances of abuse ($p = 0.033$). Conversely, a higher prevalence of depressive disorders was observed among patients with alcohol use disorder, although the association did not reach statistical significance ($p = 0.059$).

Crack cocaine use disorder showed the opposite pattern. Patients with crack cocaine use disorder were significantly more likely to receive a diagnosis of schizophrenia spectrum and other psychotic disorders ($p = 0.029$) and significantly less likely to have a diagnosis of depressive disorders ($p = 0.005$). A higher prevalence of personality disorders was also observed among patients with crack cocaine use disorder, although the association was not statistically significant ($p = 0.079$).

3.5. Patterns of Psychiatric Care

The distribution of the three levels of psychiatric intervention provided by the Community Mental Health Centers is shown in Figure 4.

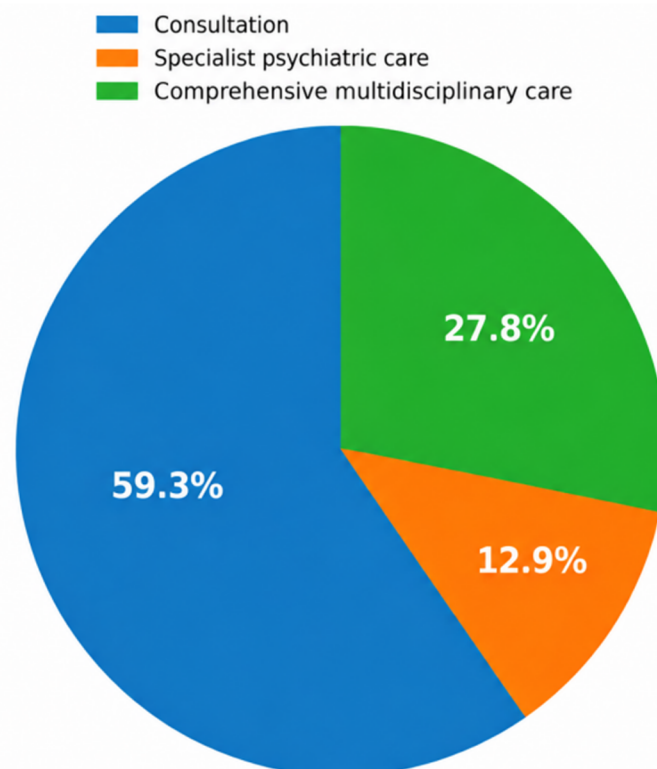


Figure 4. Distribution of the levels of psychiatric intervention provided by the Community Mental Health Centers.

Overall, patients jointly managed by the Community Mental Health Centers and the Addiction Service had been known to the CMHCs for a mean of 4.0 years. Among patients receiving psychiatric consultation only, the mean duration of follow-up was approximately 2.3 years. Within this subgroup, patients received an average of 3.2 psychiatric consultations, corresponding to approximately 1.4 consultations per year.

A moderate positive correlation was observed between the duration of follow-up and the number of psychiatric consultations among patients receiving consultation only (Pearson's $r = 0.368$, $p = 0.001$), indicating that longer follow-up was associated with a greater number of consultations.

No significant association was found between sex and the level of psychiatric intervention ($p = 0.690$) (Figure 5).

3.6. Age and Level of Psychiatric Intervention

A one-way analysis of variance (ANOVA) revealed significant differences in mean age across the three levels of psychiatric intervention (Figure 6) ($F(2,137) = 3.39$, $p = 0.037$). Patients receiving psychiatric consultation

were the oldest, whereas those receiving comprehensive multidisciplinary care were the youngest. Patients receiving specialist psychiatric care showed intermediate mean age values.

A significant linear trend ($p = 0.010$) indicated a progressive decrease in mean age from psychiatric consultation to comprehensive multidisciplinary care, suggesting that younger patients were more likely to require more intensive psychiatric intervention.

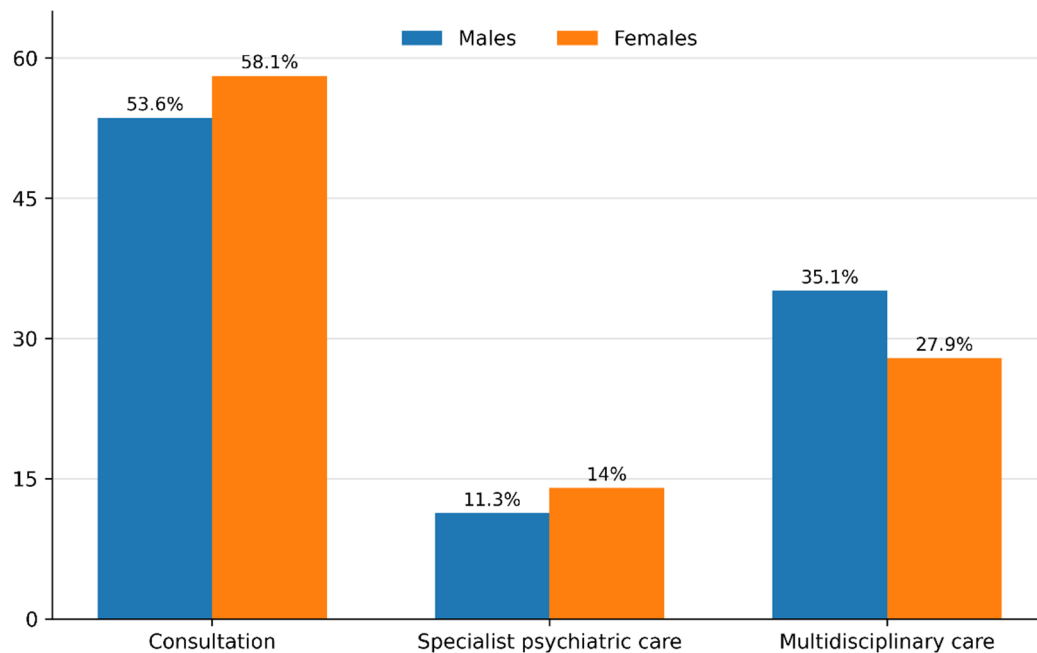


Figure 5. Distribution of psychiatric intervention levels according to sex.

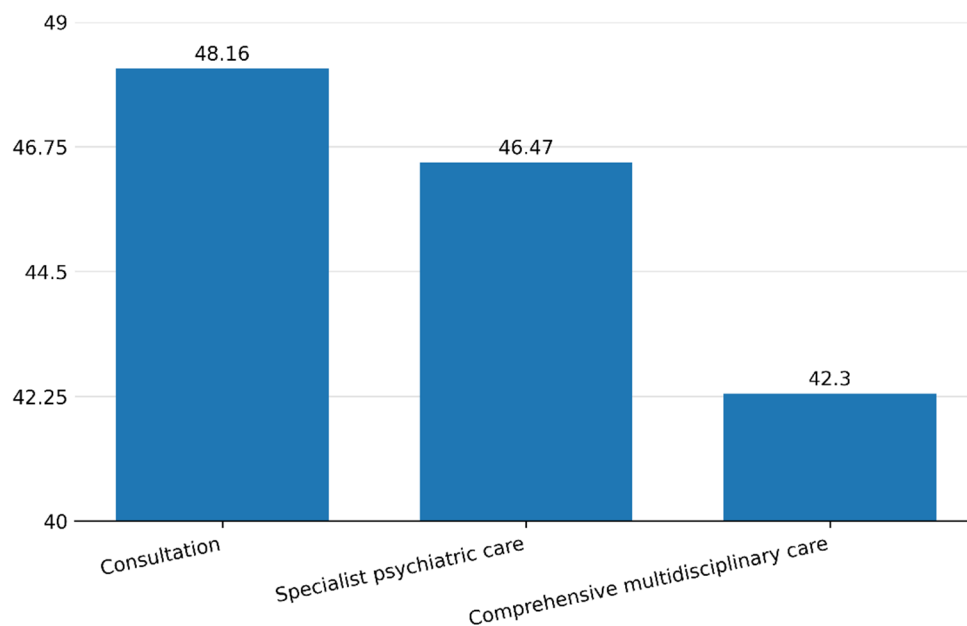


Figure 6. Mean age according to the level of psychiatric intervention.

3.7. Psychiatric Diagnoses, Primary Substance of Abuse, and Level of Psychiatric Intervention

The level of psychiatric intervention was significantly associated with several psychiatric diagnostic categories (Figure 7). Patients with schizophrenia spectrum and other psychotic disorders were more likely to receive comprehensive multidisciplinary care, whereas patients with depressive disorders were predominantly managed through psychiatric consultation. Similarly, patients with personality disorders were more frequently allocated to comprehensive multidisciplinary care than patients without personality disorders (all $p < 0.01$).

Among primary substances of abuse, no significant association was found between alcohol use disorder and the level of psychiatric intervention ($p = 0.405$). In contrast, patients with crack cocaine use disorder were significantly more likely to receive comprehensive multidisciplinary care ($p = 0.001$), whereas patients with heroin use disorder were predominantly managed through psychiatric consultation ($p = 0.003$).

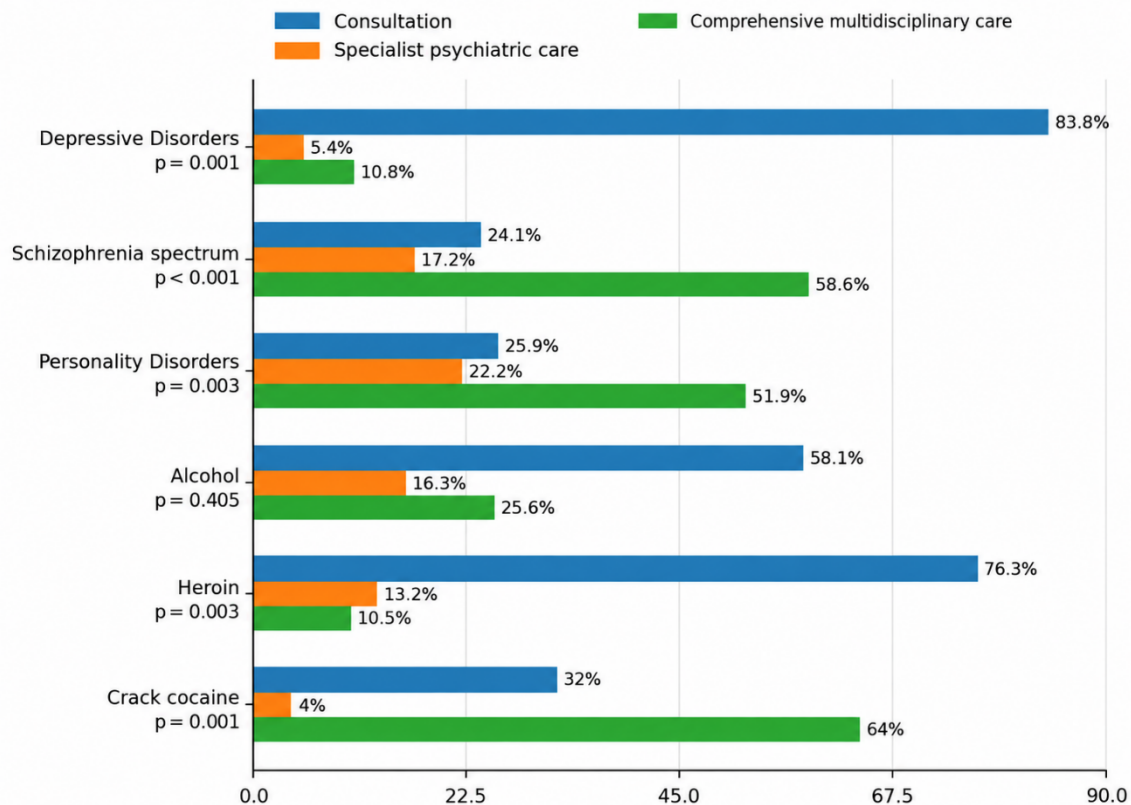


Figure 7. Percentage distribution of the levels of psychiatric intervention within each psychiatric diagnostic category and primary substance of abuse.

3.8. Logistic Regression

The ordinal logistic regression model showed a satisfactory fit to the data (Nagelkerke's pseudo- $R^2 = 0.337$) and met the proportional odds assumption (test of parallel lines, $p = 0.482$).

After adjustment for age, psychiatric diagnoses, and primary substance of abuse, schizophrenia spectrum and other psychotic disorders were independently associated with higher levels of psychiatric intervention (OR = 4.92, 95% CI 1.81–13.51, $p = 0.002$), as were personality disorders (OR = 4.29, 95% CI 1.59–11.63, $p = 0.004$). In contrast, heroin use disorder was independently associated with lower levels of psychiatric intervention (OR = 0.24, 95% CI 0.08–0.76, $p = 0.012$). Crack cocaine use disorder, alcohol use disorder, age, and depressive disorders were not independently associated with the level of psychiatric intervention. Overall, these findings suggest that the intensity of CMHC involvement was more strongly associated with psychiatric diagnosis than with the primary substance of abuse, with the exception of heroin use disorder (Table 2 and Figure 8).

Table 2. Ordinal logistic regression predicting higher levels of CMHC intervention.

Predictor	OR	95% CI	p Value
Schizophrenia spectrum and other psychotic disorders	4.92	1.81–13.51	0.002
Personality disorders	4.29	1.59–11.63	0.004
Crack cocaine use disorder	1.49	0.49–4.52	0.481
Age	1.00	0.96–1.04	0.933
Alcohol use disorder	0.76	0.39–1.50	0.595
Depressive disorders	0.42	0.14–1.23	0.114
Heroin use disorder	0.24	0.08–0.76	0.012

Note. The dependent variable was the level of CMHC intervention, ordered as consultation < specialist psychiatric care < comprehensive multidisciplinary care. ORs > 1 indicate higher odds of receiving a more intensive level of CMHC intervention,

whereas ORs < 1 indicate lower odds. The model showed a Nagelkerke pseudo- R^2 of 0.337 and met the proportional odds assumption (test of parallel lines, $p = 0.482$).

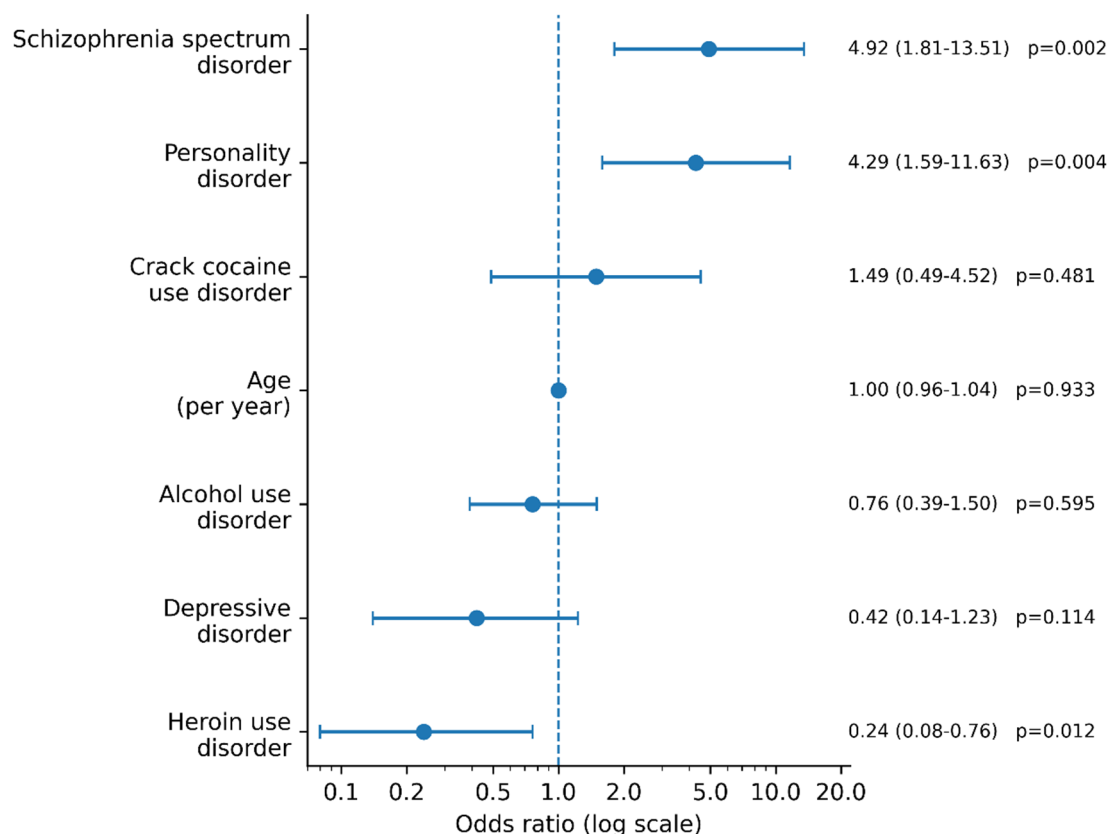


Figure 8. Forest plot showing odds ratios (ORs) and 95% confidence intervals derived from the ordinal logistic regression model predicting the level of psychiatric intervention provided by the Community Mental Health Centers (psychiatric consultation → specialist psychiatric care → comprehensive multidisciplinary care). The vertical reference line indicates an OR of 1. Odds ratios < 1 indicate a lower likelihood of more intensive psychiatric intervention, whereas odds ratios > 1 indicate a higher likelihood of more intensive psychiatric intervention.

4. Discussion

The predominance of male patients observed in the present sample is consistent with previous studies reporting a higher prevalence of substance use disorders among men and a greater likelihood of accessing specialized addiction services. However, women with substance use disorders may face greater barriers to treatment, suggesting that their lower representation may reflect both differences in prevalence and disparities in access to care [8].

The mean age of the study population should not be interpreted as reflecting the onset of either substance use or psychiatric disorders, both of which commonly begin during adolescence or early adulthood [9]. Patients jointly managed by the Community Mental Health Centers and the Addiction Service had a mean age of 46.0 years. Previous studies have shown substantial delays between disorder onset and treatment seeking [10], making the age distribution observed in the present study broadly consistent with previous findings. No significant age differences were observed between men and women, in agreement with evidence suggesting that sex differences in substance use disorders may become less consistent across the lifespan [11].

The classification of patients according to a single primary substance of abuse did not capture the full complexity of individual patterns of substance use. The observed distribution of substances may also have been influenced by referral patterns and service utilization. Novel psychoactive substances may be difficult to detect through conventional monitoring systems [12], whereas hallucinogens and dissociative substances may less frequently lead to treatment seeking and can be perceived as non-problematic or even beneficial in some contexts [13–15]. Bhalla et al. reported prevalences of alcohol, cannabis, opioid, and cocaine use broadly comparable with the present sample [16]. The lower representation of cannabis may partly reflect its role as a secondary substance not systematically recorded as the primary diagnosis.

Psychiatric comorbidity was highly prevalent, particularly bipolar disorders, personality disorders, schizophrenia spectrum disorders, and depressive disorders, in agreement with previous reports [16]. Patients with crack cocaine, heroin, and alcohol use disorders nevertheless showed distinct demographic and clinical profiles and were managed through different levels of psychiatric intervention.

Patients with crack cocaine use disorder showed distinct demographic and clinical characteristics. Previous studies have reported sex differences in patterns of crack use and associated behaviors [17,18]. In the present sample, however, gender differences were less pronounced and were more consistent with Italian epidemiological data indicating a nearly equal distribution between men and women [19]. Personality disorders were more frequent among women, whereas schizophrenia spectrum disorders showed a trend toward greater prevalence among men, in line with previous literature [20,21].

Patients with crack cocaine use disorder were significantly younger than those using other substances. This finding is consistent with previous reports associating crack cocaine use with earlier onset, greater clinical severity, illegal activities, and social marginalization [22,23]. Crack cocaine use was also associated with a higher prevalence of schizophrenia spectrum disorders, consistent with clinical evidence linking crack cocaine use to psychotic symptoms [24]. Preclinical findings further support the biological plausibility of this association, with crack cocaine inhalation inducing schizophrenia-like behavioral and neurobiological alterations in animal models [25]. Personality disorders were likewise more frequent, in agreement with studies reporting high rates of antisocial and borderline personality disorders among cocaine and crack cocaine users [26,27]. Depressive disorders were relatively uncommon; one possible explanation is that depressive symptoms may become more evident later in the course of stimulant use, although this hypothesis cannot be tested in the present retrospective dataset [28,29].

Patients with crack cocaine use disorder were more frequently managed through comprehensive multidisciplinary care. However, ordinal logistic regression showed that neither crack cocaine use nor younger age independently predicted the level of psychiatric intervention. Rather, higher levels of CMHC involvement were more strongly associated with schizophrenia spectrum and personality disorders, which may reflect greater psychiatric and psychosocial care needs. This pattern is consistent with a complementary model of care between Community Mental Health Centers and Addiction Services [30].

Patients with heroin use disorder displayed a different clinical profile. Epidemiological studies suggest that sex differences are more evident in the early stages of heroin use, whereas the risk of developing heroin use disorder becomes more comparable between sexes once exposure has occurred [31]. A more rapid progression of heroin use among women has also been reported [32], although no significant sex difference was observed in the present sample.

Patients with heroin use disorder were significantly older than those using other substances. Previous studies have documented both late-onset cases and the chronic course of opioid use disorder [33]. The interval between first heroin use and access to specialized treatment is highly variable [34], whereas opioid agonist therapy is associated with greater treatment retention and continuity of care [35–37].

Psychiatric comorbidity among patients with heroin use disorder has been consistently reported [38–40]. In the present sample, heroin use tended to be associated with depressive disorders, although this relationship did not reach statistical significance. The limited sample size may have contributed to this finding, while any role of opioid agonist treatment in attenuating affective symptoms remains hypothetical [41].

Patients with heroin use disorder were more frequently managed through psychiatric consultation rather than comprehensive multidisciplinary care. Ordinal logistic regression confirmed heroin use disorder as an independent predictor of lower-intensity psychiatric intervention. This finding may reflect the well-established role of the Addiction Service in providing structured treatment pathways for opioid use disorder. Depressive disorders were not independently associated with intervention level, whereas schizophrenia spectrum and personality disorders were more strongly associated with higher levels of CMHC involvement.

Patients with alcohol use disorder also showed a distinct clinical profile. Although alcohol use disorder remains more prevalent among men, recent studies suggest a narrowing of the gender gap [42]. Among treatment-seeking patients, women may show greater psychological distress and personality dysfunction [43], with biological, psychological, and behavioral factors contributing to these differences [44]. No significant sex differences were observed in the present sample.

Patients with alcohol use disorder were significantly older than those using other substances. This may reflect the long interval between the onset of problematic alcohol use and referral to specialized services rather than a later onset of the disorder itself [45–48]. Patients with depressive disorders were also older. Previous studies have described a frequent temporal association between long-standing alcohol misuse and depressive disorders, although the present study was not designed to determine whether depressive symptoms were primary or substance-induced [49–51].

An inverse association was observed between alcohol use disorder and schizophrenia spectrum disorders. This finding should be interpreted in light of the composition of the present sample, since patients without alcohol use disorder were more likely to use substances strongly associated with psychosis. The lower prevalence of schizophrenia spectrum disorders among patients with alcohol use disorder may therefore reflect differences in the distribution of primary substances rather than any protective effect of alcohol itself [52–54]. By contrast, the association between alcohol use disorder and depressive disorders is consistent with previous literature [55].

Although patients with alcohol use disorder were more frequently managed through psychiatric consultation, this association did not reach statistical significance. Ordinal logistic regression showed that neither alcohol use disorder, age, nor depressive disorders independently predicted the level of psychiatric intervention. Overall, higher levels of CMHC involvement were more strongly associated with schizophrenia spectrum and personality disorders than with alcohol use, age, or depressive disorders alone.

5. Conclusions

Despite the limited number of variables included in the present study (age, sex, psychiatric diagnosis, primary substance of abuse, and level of psychiatric intervention), the analysis of patients jointly managed by the Community Mental Health Centers and the Addiction Service provided a clear representation of the heterogeneity and clinical complexity of this population.

Three distinct clinical profiles emerged. Patients with crack cocaine use disorder were younger, more frequently affected by schizophrenia spectrum and personality disorders, and more often required comprehensive multidisciplinary care. Patients with heroin use disorder were older, showed more chronic treatment trajectories, and were predominantly managed through psychiatric consultation. Patients with alcohol use disorder were also generally older and more frequently presented with depressive disorders, although they were likewise mainly managed through consultation.

The distinction between psychiatric consultation, specialist psychiatric care, and comprehensive multidisciplinary care allowed the Community Mental Health Centers to allocate resources according to patients' clinical needs while maintaining a complementary role alongside the Addiction Service. Although the univariate analyses suggested that younger age, crack cocaine use, heroin use, alcohol use, and depressive disorders were associated with different levels of psychiatric intervention, the multivariable analysis provided a more nuanced interpretation. After adjustment for the other clinical variables, the intensity of psychiatric intervention was primarily associated with psychiatric diagnosis—particularly schizophrenia spectrum and personality disorders—rather than with age or the primary substance of abuse. Heroin use disorder represented the only substance independently associated with a lower level of psychiatric intervention, possibly reflecting the well-established role of the Addiction Service in the long-term management of opioid use disorder.

Overall, these findings suggest that, within an integrated model of care, higher levels of Community Mental Health Center involvement are more strongly associated with psychiatric diagnosis and related care needs than with the primary substance of abuse itself. Such an approach may promote a more appropriate allocation of resources, avoid unnecessary overlap between services, and strengthen the complementary collaboration between mental health and addiction services.

The present study has several limitations. First, psychiatric diagnoses were retrospectively extracted from routine clinical records and were not established using standardized diagnostic interviews. Moreover, the study was not designed to distinguish primary psychiatric disorders from substance-induced syndromes, and some degree of diagnostic misclassification cannot therefore be excluded. Second, the study included only patients jointly managed by the Community Mental Health Centers and the Addiction Service, and selection or referral bias may have influenced the clinical characteristics of the sample. Third, patients were classified according to a single primary substance of abuse, as documented by the Addiction Service. Because the dataset did not systematically capture all substances used by each patient, the prevalence and clinical impact of polysubstance use could not be reliably assessed. Fourth, no standardized measures of symptom severity, functional impairment, or overall illness burden were available, and several relevant social variables, including employment, housing conditions, and educational level, were not systematically recorded. Finally, the relatively small sample size and the single-service, single-catchment-area design limit the generalizability of the findings to other healthcare settings and organizational models.

Future studies including larger samples, longitudinal follow-up, standardized clinical and functional assessments, and more comprehensive information on patterns of substance use and social functioning will be necessary to confirm these findings and evaluate the effectiveness and transferability of integrated models of care.

Funding

This research received no external funding.

Institutional Review Board Statement

Formal Ethics Committee review was not required for this retrospective study, in accordance with institutional procedures, as the study involved the analysis of routinely collected clinical data in anonymized and aggregated form, with no additional procedures or patient contact. Authorization for publication was granted by the Health Directorate of ASL TO4 (protocol No. 00 77957, 7 July 2026).

Informed Consent Statement

Informed consent for the processing of personal data, including their use for scientific research purposes, was obtained from all patients at the time of admission to the service.

Data Availability Statement

The data supporting the findings of this study are not publicly available due to privacy and confidentiality restrictions related to sensitive clinical information. Aggregated data may be made available from the author upon reasonable request, subject to applicable institutional and data-protection requirements.

Conflicts of Interest

The author declares no conflict of interest.

Use of AI and AI-Assisted Technologies

During the preparation of this work, the author used ChatGPT (OpenAI) to assist with checking statistical analyses and English-language editing. The author reviewed and verified the resulting content and takes full responsibility for the content of the published article.

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