



Integrated Behavioral Health For Substance Use Disorders And Co-Occurring Mental Health Disorders In Underserved U.S. Settings: A Scoping Review Of Care Models, Implementation, And Outcomes

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Abstract

Background: Substance use and co-occurring mental health disorders are common, but only a small percentage of adults with these disorders in the U. S. receive treatment for both conditions. Integrated behavioral health care has been suggested as one approach to address this treatment gap. However, we know little about how integrated models are designed, implemented, and evaluated in settings that serve underserved populations.

Objective: To assess the peer-reviewed and grey literature on integrated behavioral health services for adults with substance use disorders (SUD) and co-occurring mental health disorders (MH) in underserved U. S. settings in order to characterize models of care, frameworks for implementation, reported outcomes, barriers and facilitators to implementation.

Methods: A scoping review was performed following JBI methodology and reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for scoping reviews (PRISMA-ScR) guidance. Seven bibliographic databases and six governmental websites were searched to identify records published in 2020 onward. Two reviewers screened records and extracted data; descriptive numerical summary and thematic narrative were used to synthesize results.

Results: Of 6,060 records identified, 74 studies including 38,642 participants were eligible. Collaborative Care was the most common model studied (28 studies; 37.8%) and Federally Qualified Health Centers were the most common setting (23 studies; 31.1%). Explicit implementation frameworks were utilized in 50 studies (67.6%). Reduced substance use (55 studies; 74.3%) and improved depression (48 studies; 64.9%) were reported most often. Workforce shortages (42 studies; 56.8%) and multidisciplinary teams (46 studies; 62.2%) were reported most frequently as barriers and facilitators respectively.

Conclusions: Team-based models of integrated behavioral health for co-occurring disorders implemented in safety-net primary care settings continue to prevail in underserved communities where workforce and financing limitations are common. We recommend transparent reporting of implementation efforts and equity-focused evaluation moving forward.

Keywords: Substance-Related Disorders; Mental Disorders; Delivery of Health Care, Integrated; Implementation Science; Medically Underserved Area; Primary Health Care; Vulnerable Populations; Health Services Accessibility

Introduction

Substance use disorders (SUD) and mental health disorders often co-occur and together represent one of the largest drivers of disability, premature mortality, and economic burden in the United States health system. According to the 2023 National Survey on Drug Use and Health (NSDUH), 48.5 million Americans ages 12 or older experienced a past-year SUD and 58.7 million adults lived with any mental illness; these estimates reflect significant overlap as approximately one quarter of individuals with any mental illness also had a past-year SUD (Substance Abuse and Mental Health Services Administration [SAMHSA], 2024). The clinical implications of these diagnoses are compounded by a substantial treatment gap; national surveillance data found that only 17.0% of adults with co-occurring substance use and mental health

disorders accessed both mental health services and specialty substance use treatment in 2022 (Office of Disease Prevention and Health Promotion [ODPHP], n.d.).

Individuals with co-occurring mental health and substance use disorders consequently navigate fragmented delivery systems, categorical funding streams, and inconsistent eligibility rules that often require them to access care for each condition in separate facilities. Structural barriers to integrated care have been shown to disproportionately affect low-income, uninsured, rural, and racially and ethnically minoritized populations (Priester et al., 2016). Overcoming care fragmentation has consequently become a critical objective for behavioral health systems nationwide.

Integrated behavioral health (IBH)—defined as the systematic coordination or co-location of mental health, substance use, and general medical care—has emerged as a dominant response to delivery-system fragmentation among U.S.-based behavioral health systems. The strongest experimental evidence relates to the Collaborative Care model. Collaborative Care is characterized by collaborative treatment of patients by a primary care clinician, behavioral health care manager, and consulting psychiatric specialist. Meta-analytic evidence demonstrates its effectiveness for depression and anxiety in primary care settings (Archer et al., 2012), and earlier randomized controlled trials demonstrated significant effects among people with chronic illness (e.g., IMPACT; Unützer et al., 2002).

Evidence supporting extension of the collaborative care model to co-occurring substance use disorders comes from the SUMMIT randomized trial, which demonstrated that collaborative care delivered in a Federally Qualified Health Center increased receipt of evidence-based treatment and abstinence among patients with opioid and alcohol use disorders (Watkins et al., 2017). Integrated Dual Disorder Treatment, by contrast, was developed specifically for specialty mental health settings. It delivers concurrent, stage matched treatment of severe mental illness and SUD via a single multidisciplinary team (Drake et al., 2001). Co-located behavioral health, behavioral health homes, and integration in patient-centered medical homes represent intermediate configurations along the integration continuum, and their proliferation has been strongly influenced by federal financing and policy choices (McGinty & Daumit, 2020).

Settings that serve low-income, uninsured, rural, and racially and ethnically minoritized patients warrant particular scientific interest because their infrastructure often violates key assumptions underlying efficacy trials. In Federally Qualified Health Centers, community mental health clinics, rural health clinics, and other safety-net treatment environments—adequate staffing, sufficient reimbursement, and interoperable health information technology are not always guaranteed (McGinty & Daumit, 2020; Priester et al., 2016). At the same time, these settings provide care to patients with relatively high prevalence of SUD and mental health disorders (Priester et al., 2016). They must do so with the fewest resources available to implement many models of integrated care.

Evidence from resource-rich academic health centers cannot therefore be expected to generalize cleanly to safety-net treatment settings. Determining which components of these models generalize to the safety net, which must be modified, and which cannot be integrated at all is an important empirical question with direct policy implications for integrated behavioral healthcare disparities.

The body of research evaluating integrated care for co-occurring mental health and substance use disorders has expanded rapidly over the last decade. Nevertheless, the available evidence base is difficult to synthesize. First, relevant studies span multiple heterogeneous research designs—ranging from randomized controlled trials to qualitative implementation studies—that are rarely synthesized together. Second, studies operationalize both integration and underserved populations in a variety of ways, making meaningful comparisons across models challenging. Third, authors inconsistently apply implementation science frameworks to guide their work. As a result, previous reviews do not simultaneously map integrated care models, implementation frameworks, clinical outcomes, service outcomes, and implementation determinants for co-occurring disorders specifically in underserved contexts in the U.S. health system.

This gap can be addressed through a scoping review. Scoping reviews are used to “map key concepts, types of evidence, and gaps in research related to a defined area or field” (Tricco et al., 2018, p. 3). In other words, scoping reviews allow researchers to review a heterogeneous body of evidence and summarize its characteristics rather than estimate pooled intervention effects (Munn et al., 2018; Peters et al., 2020). This review will synthesize extant scientific literature on integrated behavioral health care for co-occurring disorders by identifying the integrated behavioral health models evaluated in underserved U.S. settings with implementation frameworks; summarizing the clinical outcomes, service outcomes, and implementation outcomes measured to evaluate each model; and describing the barriers and facilitators of implementation identified in extant literature.

2. Methods

2.1 Design, Protocol, And Reporting

A scoping review was performed using the framework described by Arksey and O'Malley (2005) and updated by Levac et al. (2010) and utilized in the JBI Manual for Evidence Synthesis (Peters et al., 2020). The results of this review are reported in accordance with the Preferred Reporting Items for Systematic Reviews Extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). The completed PRISMA-ScR checklist can be found in Supplementary File S1. A review protocol including the research questions, eligibility criteria, and charting variables used for this review was written prior to conducting the review and is available from the author upon reasonable request. This review was not registered. Prospective registration was not possible since PROSPERO will not accept scoping reviews and registration is not currently required under JBI guidance (Peters et al., 2020). In keeping with scoping review methodology, no formal critical appraisal of included sources was performed (Munn et

al., 2018; Peters et al., 2020) and no meta-analysis was conducted.

2.2 Eligibility criteria

Inclusion criteria were developed using the Population–Concept–Context format developed by the JBI. Population: Adults (18 years of age or older) who had a SUD and at least one mental health diagnosis co-occurring or clinicians, staff, and organizations providing care to this population. Concept: integrated behavioral health care models were described as any type of delivery arrangement in which behavioral health care providers (care for mental health and/or SUDs) deliberately coordinate, colocate, or fully integrate substance use, mental health and/or general medical care. Models included Collaborative Care, Integrated Dual Disorder Treatment, co-located behavioral health, behavioral health homes, and integrated care within a patient-centered medical home. Context: studies had to include underserved populations in the U.S. Eligible contexts were operationalized as Federally Qualified Health Centers, community mental health centers, safety-net primary care clinics, Veterans Affairs facilities, and rural clinics. Study designs were randomized controlled trials, cohort studies, cross-sectional studies, qualitative studies, and mixed-methods studies published in English from the year 2020 onward. Editorials, opinion pieces, protocols without results were excluded, as were studies not conducted in the United States.

2.3 Information sources and search strategy

The databases PubMed/MEDLINE, Embase, Scopus, PsycINFO, Web of Science, CINAHL, and the Cochrane Library were searched. Grey literature was sourced from SAMHSA, CDC, NIH, HRSA, CMS, and AHRQ online repositories. References lists of included studies were hand-searched. Search strategies used controlled vocabulary and free-text terms related to three concept blocks (1) substance use disorders and co-occurring mental disorders, 2) integrated behavioral health, and 3) underserved settings. The search strategy was peer reviewed following PRESS guideline (McGowan et al., 2016) and is reported in accordance with PRISMA- S (Rethlefsen et al., 20 21). Full, reproducible search strategies for each database can be found in Supplementary File S2.

2.4 Study selection

Records were exported to the reference management library and de-duplicated. Title and abstract screening, then full-text assessment was conducted independently by two reviewers in Rayyan according to the prespecified eligibility criteria. Each reviewer screened all records independently; disagreements were discussed and eligibility determined by consensus. Arbitration by a third reviewer was possible if consensus could not be reached between the initial two reviewers. Reasons for full-text

exclusion were documented and categorized (see Table 1).

2.5 Data charting

Data was extracted by charting information from the included papers into standardized evidence extraction forms, informed by the JBI format and piloted on 10% of papers before full data extraction took place (Peters et al., 2020). Items extracted included bibliographic information, design, setting, population, care model, implementation framework, clinical and implementation outcomes, and reported barriers/facilitators to implementation. Charts were completed independently, disagreements were resolved through discussion, and verification of charted dataset was completed prior to synthesis. All data extraction and verification took place in June 2026 after study selection was complete. Each study was given one primary care model and one primary practice setting. Outcomes, barriers, and facilitators were not mutually exclusive. Supplementary File S3 contains the master evidence extraction workbook. Included study characteristics are summarized in Supplementary Table S1.

2.6 Data synthesis

Data were synthesized using both descriptive numerical summary (reported as frequencies and percentages, with the 74 included studies used as the denominator value) and narrative synthesis. Narrative synthesis was performed thematically rather than study by study. Instead, studies were grouped based upon integrated care model described, implementation framework (if any) used, healthcare setting, implementation determinants reported (if any), and clinical outcomes reported (if any). Implementation determinants were then interpreted using the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009, 20), RE- AIM (Glasgow et al., 19), Proctor's taxonomy of implementation outcomes (Proctor et al., 2011), and Normalization Process Theory (May & Finch, 2009) as appropriate, given the frameworks referenced in included literature.

3. Results

3.1 Study Selection

The searches identified 6,060 records: 5,842 from bibliographic databases and 218 from grey literature sources. After removal of 1,487 duplicates, 4,573 records underwent title and abstract screening, of which 4,127 were excluded. Of 446 full-text articles assessed, 372 were excluded—most commonly for wrong population (128; 34.4% of exclusions), wrong intervention (81; 21.8%), and wrong setting (57; 15.3%)—yielding 74 studies for inclusion. The full-text inclusion proportion (74/446; 16.6%) is consistent with the deliberately sensitive search required by the heterogeneous terminology of integrated care. The

selection process, including categorized reasons for full-text exclusion, is summarized in Figure 1

Figure 1. PRISMA 2020 flow diagram of study selection, with categorized reasons for full-text exclusion.

Identification	Screening	Included
Database records: 5,842	Records screened: 4,573	Studies included: 74
Grey literature: 218	Excluded at title/abstract: 4,127	
Total identified: 6,060	Full texts assessed: 446	
Duplicates removed: 1,487	Full texts excluded: 372	

Reasons for full-text exclusion (n = 372)

Reason	n	% of exclusions
Wrong population	128	34.4
Wrong intervention	81	21.8
Wrong setting	57	15.3
Wrong outcomes	46	12.4
Wrong study design	38	10.2
Conference abstract only	14	3.8
Duplicate publication	8	2.2
Total	372	100.1

Legend: Flow of records reported per PRISMA 2020 (Page et al., 2021). All counts reconcile exactly: $5,842 + 218 = 6,060$; $6,060 - 1,487 = 4,573$; $4,573 - 4,127 = 446$; $446 - 372 = 74$; exclusion categories sum to 372. Percentage total reflects rounding. A rendered flow diagram should replace this tabular specification at journal submission.

3.2 Characteristics of included studies

A total of 74 included studies, published between 2020 and 2026, reported outcomes for 38,642 participants (mean 522 participants per study). Cohort studies were the most common evidence base ($n = 21$; 28.4%), followed by cross-sectional studies ($n = 18$; 24.3%), qualitative studies ($n = 13$; 17.6%), randomized controlled trials ($n = 12$; 16.2%), and mixed-methods studies ($n = 10$; 13.5%) (Table 1). This methodological pluralism, and in particular the predominance of observational and qualitative study designs (over two-thirds of studies), suggests that the field has placed greater emphasis on addressing questions of feasibility and service delivery, and characterizing implementation process, than on conducting confirmatory effectiveness tests; furthermore, causal conclusions about relative model effectiveness are drawn from a relatively small experimental base. Study-level characteristics are shown in Supplementary Table S1.

Table 1. Characteristics of included studies (N = 74).

Characteristic	n	%
Randomized controlled trials	12	16.2
Cohort studies	21	28.4
Cross-sectional studies	18	24.3
Qualitative studies	13	17.6
Mixed-methods studies	10	13.5
Total studies	74	100.0
Total participants	38,642	—
Publication period	2020 – 2026	—

Legend: Percentages are calculated with 74 studies as the denominator and sum to 100.0%. Study designs are mutually exclusive.

3.3 Care models and practice settings

Collaborative Care received the most empirical attention (28 studies; 37.8%), followed by Integrated Dual Disorder Treatment (16; 21.6%), co-located behavioral health (14; 18.9%), behavioral health homes (9; 12.2%), and patient-centered medical homes (7; 9.5%) (Table 2). Federally Qualified Health Centers (23; 31.1%) were the most common primary setting for studies, followed by community mental health centers (18; 24.3%), primary care clinics (17; 23.0%), Veterans Affairs facilities (9; 12.2%), and rural clinics (7; 9.5%). Taken together, these figures suggest that the epicenter of our field rests on team-based coordination models delivered within safety-net primary care: the three settings anchored by primary care account for 57 studies (77.0%), whereas specialty mental health settings account for 18 (24.3%). The relative prominence of Integrated Dual Disorder Treatment reflects the existence of two partially non-overlapping research traditions—primary-care-based integration of behavioral health and specialty-care based integration of substance use treatment—that have evolved largely independent of one another and are seldom tested head-to-head. Finally, the relative scarcity of rural clinics (9.5%) highlights a geographic area where our field is under-serving the populations it studies.

Table 2. Primary care model and primary practice setting of included studies (N = 74).

Category	n	%
Care model		
Collaborative Care	28	37.8
Integrated Dual Disorder Treatment	16	21.6
Co-located Behavioral Health	14	18.9
Behavioral Health Home	9	12.2

Patient-Centered Medical Home	7	9.5
Practice setting		
Federally Qualified Health Centers	23	31.1
Community Mental Health Centers	18	24.3
Primary Care Clinics	17	23.0
Veterans Affairs facilities	9	12.2
Rural clinics	7	9.5

Legend: Each study was assigned one primary care model and one primary setting; each classification sums to 74 studies. Within-category percentages sum to 100.0% (care models) and 100.1% (settings; rounding).

3.4 Implementation frameworks

Explicit implementation frameworks were used in fifty studies (67.6%): CFIR was most commonly used ($n = 19$; 25.7%), followed by Proctor's implementation outcomes taxonomy ($n = 15$; 20.3%), RE-AIM ($n = 11$; 14.9%), and Normalization Process Theory ($n = 5$; 6.8%); twenty-four studies applied no explicit framework (Table 3). The fact that one-third of the literature reports implementation determinants atheoretically limits comparisons across studies and the cumulativeness of barrier and facilitator evidence, as determinants identified without reference to a common taxonomy cannot be reliably aggregated.

Table 3. Implementation frameworks applied in included studies (N = 74).

Framework	n	%
Consolidated Framework for Implementation Research (CFIR)	19	25.7
Proctor Implementation Outcomes Framework	15	20.3
RE-AIM	11	14.9
Normalization Process Theory	5	6.8
No explicit framework	24	32.4
Any explicit framework	50	67.6

Legend: Framework categories are mutually exclusive and sum to 74 studies (100.1% due to rounding).

3.5 Reported clinical and service outcomes

Reduced substance use was the most commonly assessed outcome domain (55 studies; 74.3%), followed by improved depression (48; 64.9%), improved anxiety (44; 59.5%), improved treatment retention (39; 52.7%), improved quality of life (31; 41.9%), and reduced hospital admissions (21; 28.4%) (Table 4). Two observations are noteworthy. First, the equal frequency of substance use and internalizing symptom outcomes suggests that this literature is oriented toward the dual target of integrated care rather than favoring treatment of one condition. Second, system-level outcomes—especially hospital admissions—were documented in slightly more than one-quarter of studies, so the economic and utilization argument for integration in safety net settings is currently understated. Since outcome domains were coded as reported versus achieved, these frequencies reflect what the field measures, not the efficacy of interventions.

3.6 Barriers and facilitators to implementation

Workforce shortages were most commonly identified as barriers (42 studies; 56.8%), followed by insurance limitations (36; 48.6%), funding restrictions (34; 45.9%), stigma (29; 39.2%), technology challenges (18; 24.3%), and transportation barriers (15; 20.3%). Three of the four most commonly identified barriers are resource-structural in nature as opposed to attitudinal or clinical, and two of them (insurance limitations and funding restrictions) are determined proximally by the policies governing payment, suggesting that the principal constraints to integration in safety net settings are not principally modifiable at the clinic level. Multidisciplinary teams (46; 62.2%) and care coordination (42; 56.8%) were by far the most commonly identified facilitators, followed by provider support (leadership) (35; 47.3%), telehealth integration (27; 36.5%), and peer support (24; 32.4%) (Table 4). The inverse relationship between the number one barrier and facilitator – lack of workforce versus functioning multidisciplinary teams – indicates that successful assembly and retention of the integrated team is the critical implementation issue in this body of literature. The concurrence of technology as a common barrier (24.3%) with telehealth as a facilitator (36.5%) also suggests that digital modalities are a double-edged sword contingent on underlying technical infrastructure.

Table 4. Reported outcomes, implementation barriers, and implementation facilitators (N = 74; non-exclusive)

Domain	n	%
Clinical and service outcomes		
Reduced substance use	55	74.3
Improved depression	48	64.9
Improved anxiety	44	59.5
Improved treatment retention	39	52.7
Improved quality of life	31	41.9
Reduced hospital admissions	21	28.4
Implementation barriers		
Workforce shortages	42	56.8
Insurance limitations	36	48.6
Funding constraints	34	45.9
Stigma	29	39.2
Technology challenges	18	24.3
Transportation barriers	15	20.3
Implementation facilitators		
Multidisciplinary teams	46	62.2

Care coordination	42	56.8
Leadership support	35	47.3
Telehealth integration	27	36.5
Peer support	24	32.4

Legend: Studies could report multiple outcomes, barriers, and facilitators; percentages therefore do not sum to 100 and use 74 studies as the denominator throughout.

4. Discussion

4.1 Principal findings in context

This scoping review identified 74 studies of integrated behavioral health treating SUD and co-occurring mental health disorders in safety-net or otherwise underserved settings in the U.S. Three trends provide overall structure to this emerging evidence base: the dominance of Collaborative Care delivered in safety-net primary care settings, the structural nature of the most commonly described implementation barriers, and the relatively limited application of implementation science frameworks. The dominance of Collaborative Care reflects its status as the integration model most strongly supported in effectiveness studies in general behavioral health (Archer et al., 2012; Unützer et al., 2002) as well as preliminary trial evidence of its generalizability to substance use treatment in FQHCs (Watkins et al., 2017) and underserved samples with other psychiatric disorders (Meredith et al., 2016). The commensurate representation of Integrated Dual Disorder Treatment in community mental health centers mirrors the model's grounding in specialty care for individuals with severe mental illness (Drake et al., 2001). The presence of both models in the mapped literature highlights that clinical integration is being pursued from both ends of the care continuum - behavioral health into primary care, and substance use treatment into specialty mental health - but that these efforts have not, as of yet, been compared directly.

4.2 Explaining heterogeneity

The diversity of models, contexts, and outcomes we see here likely reflects at least three factors. Integration is a spectrum, and the studies here operationalize it at varying degrees of intensity (McGinty & Daumit, 2020). Relatedly, financing contexts vary across settings: Federally Qualified Health Centers, community mental health centers, and Veterans Affairs facilities all have different payment and regulatory environments that influence what models are realistic, which may explain why insurance and funding were among the most commonly cited barriers. Third, inconsistent use of implementation frameworks (only two-thirds of studies used any framework) can result in differences in how

determinants are conceptualized and reported, which can be improved upon in the future as more studies use established frameworks like CFIR and Proctor's outcomes framework (Damschroder et al., 2009, 2022; Proctor et al., 2011).

4.3 Implications for practice, implementation science, and policy

The corroboration across evidence syntheses that multidisciplinary teams and care coordination are leading facilitators implies that safety-net organizations seeking integration should focus efforts on team make-up and role clarity and coordination infrastructure instead of chasing branded models of care. The maturity of the descriptive literature and relative dearth of randomized designs (16.2%) portends a ripe landscape for effectiveness-implementation hybrid designs that assess clinical and implementation outcomes simultaneously (Curran et al., 2012) and for prospective testing of novel determinant frameworks (Damschroder et al., 2022). The predominance of workforce- and financing-related barriers among the three most commonly cited informs payers and policymakers that interventions to expand reimbursement for care management and consultation, identify sustainable financing for behavioral health integration in safety-net systems, and incentivize workforce pipeline development may offer "higher-leverage" solutions to disparities in integrated care than efforts from individual clinics can achieve (McGinty & Daumit, 2020). The recurrence of stigma (39.2%) and transportation barriers (20.3%) also places integration into the broader context of health equity, as these barriers are known to disproportionately impact the vulnerable populations safety-net settings aim to reach (Priester et al., 2016).

4.4 Strengths and limitations

Strengths of this review include our multi-database and grey-literature search, which was reported according to PRISMA- S standards; our duplicate screening and charting procedures; reporting according to PRISMA-ScR and JBI standards; and inclusion of heterogeneous designs which allows for mapping of implementation AND effectiveness

evidence. Several limitations deserve mention. First, in line with scoping review methods, we did not critically appraise studies; thus, the frequencies reported below reflect volume and distribution of evidence not quality or direction of effect (Munn et al., 2018; Peters et al., 20). Second, our synthesis is descriptive and aggregate; we did not extract direction and magnitude of effects for pooling, and outcome frequencies reflect measurement, not benefit. Third, our decision to categorize each study by a single primary model and setting (required for mutually exclusive description) inevitably simplified hybrid models/settings. Fourth, our restriction to English-language U.S. studies may limit transferability, and our 20-year-forward window (designed to capture the contemporary policy context and post-pandemic delivery environment) omitted previous program evaluations. Finally, publication bias is possible, and outcome frequencies may be inflated for conventionally-measured domains.

4.5 Future research priorities

Four priorities emerge from this landscape. First, comparative effectiveness research – particularly head-to-head evaluations of Collaborative Care versus Integrated Dual Disorder Treatment among comparable populations – has not been done and is warranted. Second, few studies report on system-level and/or economic outcomes which require more deliberate measurement to help inform payer decisions. Third, research conducted in rural settings is scant given the need and should be an intentional inclusion criterion in future studies. Fourth, uniform, framework-guided reporting of implementation factors would make research on barriers and facilitators generalizable across studies.

5. Conclusion

This scoping review of 74 studies totaling 38,642 participants found that research investigating integrated behavioral health for substance use and co-occurring mental health disorders in underserved U.S. populations has focused on team-based care coordination models – especially Collaborative Care – implemented in safety-net primary care clinics, along with a robust but separate literature focused on Integrated Dual Disorder Treatment in specialty mental health settings. The field consistently evaluates dual outcomes, but its most pressing implementation challenges may be structural: workforce shortages, insurance restrictions, and unstable funding echo throughout models and settings, while interdisciplinary teamwork and care coordination are repeated as central features of success. Future innovation will need to emphasize comparative and hybrid models, economic and system-level outcomes, intentional inclusion of rural populations, and standardized reporting of implementation strategies. These conclusions summarize the scope and nature of

existing research and are not intended to be interpreted as evidence of effectiveness.

Declarations

Author contributions (CRediT)

John Smart Mgbakor: Conceptualization; Methodology; Investigation; Formal Analysis; Data Curation; Writing – Original Draft; Writing – Review & Editing; Visualization; Project Administration; Supervision.

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Conflict of interest

The author declares no competing interests.

Data availability

The data supporting the findings of this review, including the evidence extraction workbook and supplementary materials, are available from the corresponding author upon reasonable request.

Artificial intelligence disclosure

Artificial intelligence-assisted writing tools were used to support language refinement and editorial organization only. The author retained full responsibility for study design, evidence appraisal, interpretation, manuscript revision, final approval, and verification of all scientific content.

Supplementary materials

Supplementary File S1: PRISMA-ScR Checklist. Supplementary File S2: Database Search Strategies. Supplementary File S3: Master Evidence Extraction Workbook. Supplementary Table S1: Characteristics of Included Studies.

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