Addressing Treatment Capacity of Uninsured Adults with Co-Occurring Disorders

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Abstract

Purpose: To report on the success of an initiative involving the transformation of a group of small substance use treatment only or mental health treatment only provider agencies serving uninsured adults into providers of co-occurring disorder treatment.

Design: The report uses a case study narrative to describe the initiative and the transformation of the participant agencies from being providers of mental health or substance use treatment to providers of co-occurring disorders.

Findings: Six agencies serving uninsured adults expanded their scope of patient treatment services to include the capacity to treat adults with co-occurring disorders. This was achieved with modest support funding from a local foundation. The initiative has been ongoing for 5 years.

Practical Implications: The outcome of this initiative demonstrates the financial and practical feasibility of improving and expanding treatment services to low resourced patient populations. The participating agencies were able to improve their capacity to treat patients with substance use or mental health issues that previously they were not prepared to treat and thus increased their ability to provide integrated care.

Originality/value: The initiative described here shows that the treatment of concomitant substance use and mental health disorders is within the range of many small-scale treatment providers if provided the leadership and support. Delivery of effective treatments to populations experiencing co-occurring disorders that are underserved and undertreated are achievable in community-based clinical practices. This has implications for developing treatment capacity outside of hospital settings to enable treatment of co-occurring disorders to become more accessible.

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Background

According to the World Health Organization mental, neurological and substance use disorders make up 10% of the global burden of disease and 30% of non-fatal disease burden (World Health Organization, 2019). The growing recognition that these disorders are having significant impact on lives of millions of people worldwide is propelling the need to adopt more integrated models of care that can more effectively address conditions that require multiple types of treatment (Hodges, 2006; Jordans, Kohrt, Luitel, Lund, & Komproe, 2017; World Health Organization, 2013).

One of the most recent models of integrated care involves the treatment of people with dual diagnoses of mental health and substance use disorders also known as co-occurring disorders. Psychosocial interventions for people with co-occurring disorders encompass an expansive service array of a variety of treatment modalities including individual therapy, group therapy, and family interventions, residential treatment and ancillary services including care management, contingency management, and of more recent linkage, primary health care (Drake, 2007; Drake, O'Neal, & Wallach, 2008). Because treatment typically is not based on a pre-determined best treatment modality, it is difficult to characterize it as a specific set of treatments but is perhaps best to be thought as a response frame that utilizes different treatments depending on the functionality and responsiveness of the client.

The treatment of dually diagnosed or individuals with co-occurring disorders has advanced considerably since the concept of integration of treatment began to gain acceptance in the 1980's. However, the advancement of the treatment of mental health and substance use as co-occurring disorders has not proceeded smoothly in the United States or elsewhere in the world. In most countries there has been a slow acceptance that the treatment of both disorders can, and probably should be treated despite evidence that addressing substance use and behavioral health disorders simultaneously is an effective treatment (Dauber, Braun, Pfeiffer-Gerschel, Kraus, & Pogarell, 2018; Hodges, 2006; Roberts & Maybery, 2014).

While the development of effective treatment approaches has progressed, one of the major barriers to broader acceptance of treatment of co-occurring mental health and substance use disorders has been the capacity to provide this type of treatment outside of a hospital setting (Dauber, et al., 2018; Thornicroft et al., 2010). As a result, as the application of co-occurring disorders treatment models becomes more universal and being implemented in community-based setting there is a need to learn from examples of how these models can be successfully implemented in settings with limited resources and low levels of payment for the advanced levels of treatment these disorders require. The purpose of this paper is to share the results of a community health care initiative that was established to address co-occurring disorders among adults without health insurance by a group of community-based providers.

Introduction

Individuals with severe and persistent mental illness and substance use disorders present complex treatment needs that are often difficult to address in traditional

mental health and substance use treatment service systems. Research indicates that this population tends to overutilize higher cost crisis-oriented services, such as psychiatric hospitalization, emergency medical care, and the criminal justice system, and to underutilize more traditional and less costly treatment services, such as case management (Mangrum, Spence & Lopez, 2006). Along with their general prevalence, it is widely recognized that co-occurring disorders (CODs) are generally more severe, chronic, and less likely to result in positive treatment outcomes than single disorders (Mojtabai, Chen, Kaufman, & Crum, 2014; Sacks, et al., 2013; Sterling, Chi, & Hinman, 2011). It also is the case that people with CODs are less likely to seek and receive treatment for their needs (Matusow et al., 2013; Mojtabai, et al., 2014).

According to the Center for Behavioral Health Statistics and Quality (2015), among the estimated 7.9 million adults in the U.S. who reported having co-occurring behavioral health and substance use issues in 2014, more than half did not receive either type of service in the past year. Additionally, about a third (34.3%) of adults with co-occurring severe mental illness and a substance use disorder also did not receive any treatment for either type of disorder in the past year. Individuals who have mental illness are significantly more likely to have a substance use disorder than individuals who do not have mental illness. Conversely, clients with substance use disorders are much more likely to have a mental illness than people without substance use disorders (Center for Behavioral Health Statistics and Quality, 2015).

Parallel Treatment Systems for Substance Use and Mental Health Disorders

Because co-occurring disorders have the element of concurrence, it would make sense to screen for substance use disorders in behavioral health settings and for mental illness in substance use treatment settings. Yet, until relatively recently, most services for substance use disorders (SUD) and mental health disorders (MHD) were provided by clinicians trained in largely distinct treatment models and philosophies emphasizing one set of disorders as the primary and often exclusive target of treatment. As a consequence, the interactive nature of the COD client's comorbid disorders was often neglected, resulting in a "revolving door" of treatment between the mental health and substance use treatment service systems (Burnam & Watkins, 2006; Chan, Huang, Bradley, & Unützer, 2014; Ducharme, Knudsen, & Roman, 2006; Mangrum, et al., 2006).

When a co-occurring disorder is undetected, the untreated disorder can interfere with treatment and can impair recovery for the treated disorder. The debilitating effects of co-occurring illnesses and the stigma of having these illnesses can negatively impact motivation and ability to seek treatment (Matusow et al., 2013). The frequent separation of systems of treatment also has affected treatment service utilization. For individuals with co-occurring disorders, having to navigate two systems of care to obtain treatment can be a major barrier resulting in lower motivation to seek treatment, less capability of accessing adequate treatment, and an additional cost burden (Ducharme, et al., 2006; Havassy, Alvidrez, & Merickle., 2009).

Integration of Treatment of SUD and MHD – Co-Occurring Treatment

Recognition of the inadequacy of a treatment system that addressed substance use and mental health issues as separate and

not overlapping issues led to the decision to push for the integration of treatments for individuals with both substance use and mental health disorders (Kola & Kruszynski, 2010; Mojtabai, et al., 2014; Sterling, Chi, & Hinman, 2011). Increasing evidence of a large overlap of the disorders--that as many as half of individuals diagnosed with a substance use disorder also are likely to experience symptoms defining a mental health disorder (Ducharme, et al., 2006) pushed the field to embrace an approach that was likely to produce better treatment outcomes for individuals with co-occurring disorders. Leading this effort was the U.S. government's Substance Abuse and Mental Health Services Administration (SAMHSA). Individuals who suffer from these co-occurring disorders require an effective, integrated evidence-based practice model that recognizes the simultaneous occurrence of mental health and substance use disorders as presenting extensive problem (SAMHSA, 2005; SAMHSA, 2009). One of the most widely used models, the integrated dual-disorder treatment (IDDT) model, was developed for individuals with major mental health and substance use disorders (Kola & Kruszynski, 2010; Torrey, Tepper & Greenwold, 2011). IDDT is multidisciplinary approach that combines pharmacological (medication), psychological, educational, and social interventions to address the needs of clients and their family members.

Implementation of a Co-occurring Disorders Treatment Program

There is considerable evidence demonstrating the effectiveness of integrated treatment interventions that integrate mental health and substance use treatment for people with co-occurring conditions (Sacks et al., 2013). But, the effective delivery of COD treatment is not without its challenges. Service providers must be trained and be competent in treating both behavioral health and substance use disorders (Padwa, Guerrero, Braslow, & Fenwick, 2015). The practice of treatment of co-occurring disorders requires effective screening, diagnosing, treatment planning, and monitoring of case progress. The complexity of this effort can be challenging to practices with limited personnel resources and time frames to deliver effective treatment services (Boyle & Wieder, 2007). SAMHSA recommends an integrated screening and assessment approach that includes gathering information on mental status and substance use simultaneously (SAMHSA (n.d.) Additionally, screening and assessment for health-related concerns is recommended, which requires medically trained professionals to be involved in the process.

Evidence from the field indicates that early intervention with individuals with COD is essential to reducing substance use and improving psychological well-being; but engaging patients in substance use treatment is often challenging because many do not recognize their substance use as problematic, or they are not ready to change, or they are not ready to engage in treatment (Chan, et al., 2014). Other barriers to seeking and receiving COD treatment are cost, fear of hospitalization, and the stigma of being someone needing psychiatric or substance use treatment (Mojtabai, et al., 2014).

Implementation Challenges

The implementation of an integrated treatment model is likely to face a variety of barriers affecting the delivery of integrated care for co-occurring disorders. These barriers include administrative structures, financial resources, conflicting treatment

philosophies, too few sufficiently credentialed or experienced staff to delivery integrated treatment, staff stress and turnover, and operational pressures, e.g., having the time necessary to deliver treatment with fidelity, having the resources to support treatment delivery time, and having adequate staff with the clinical skills necessary to treat the complex of co-occurring disorders that a practice will encounter (Burnam & Watkins, 2006; Mojtabai et al., 2014; Priester, 2016; Sacks et al., 2013). Programs making a transition from a single treatment system to integrated care may have the additional barrier of overcoming the culture and history of a practice that previously provided only substance use or mental health services (Padwa et al., 2015; Sterling, et al., 2011). Studies show that former single treatment system providers tend to provide more services related to their prior area of specialization (Havassy, et al., 2009; Sterling, et al., 2011).

Cone Health Foundation's Co-Occurring Disorders Treatment Initiative for the Uninsured

In an era of declining resources and increasing health care needs, the problems of people with co-occurring behavioral health and substance use disorders assume special importance. In 2015, approximately 18,000 adults were estimated to have a co-occurring disorder in Greater Greensboro, North Carolina USA. Based on national estimates, it was projected that less than 10% percent of these individuals were likely to receive treatment for both conditions and 50% were not likely to receive any treatment. For the uninsured, based on their work with programs providing health care to the uninsured, Cone Health Foundation believed the rates of receipt of treatment were far less. To address this, the Foundation made a commitment to build capacity in the Greater Greensboro community to effectively address the needs of uninsured individuals with co-occurring mental health and substance use disorders. This commitment was transformed into an initiative designed to provide evidenced-based services to uninsured adult residents of Greater Greensboro suffering with COD diagnoses. Specifically, the initiative targeted an increase in the number of uninsured adults receiving evidence-based care for co-occurring disorders from 500 in 2015 to 6,000 by 2021. This represents about 33% of Greater Greensboro 's COD population.

To build this capacity, it was recognized that several actions had to be successfully achieved. One action was to ensure that providers *received comprehensive training on evidence-based practices to address co-occurring disorders.* It was not a forgone conclusion that providers would be open to receiving this training, especially given that it was directed at a service population with limited means of payment for services. A second action was to arrange for interested providers to receive *technical assistance to help them provide effective treatment services for individuals suffering from both behavioral health and substance use disorders.* Behavioral health and substance use treatment systems face challenges in obtaining funding that supports integrated treatment for co-occurring disorders. Committed leadership, joint planning, and the willingness to find creative solutions were key to overcoming challenges affecting the provision of these treatment services. For the first two actions, the Foundation contracted with an organization that provided technical assistance and training to help the provider agencies attain the standards of organizational and clinical practices established by SAMHSA. A third

action was determining how best to provide limited *financial support to increase organizational capacity to serve this group of clients utilizing evidence-based strategies.*

In October 2015, the Cone Health Foundation launched an initiative to build treatment capacity to serve adults with co-occurring behavioral health and substance use diagnoses. The partners for the initiative included six provider agencies – five were independent local nonprofits and one was affiliated with the local nonprofit hospital system. The initiative had three primary goals: 1. Increase community capacity to serve adults with co-occurring behavioral health and substance use issues (Capacity to Treat), 2. Provide integrated behavioral health/substance use treatment to adults with COD (Delivery of Treatment Services), and 3. Promote the adoption of integrated care as a model for treatment for behavioral health issues (Culture of Integrated Care). These goals are depicted in the following diagram.

[Insert Figure 1 about here]

The three goals are interrelated – the achievement of any one is dependent on the other two. **Capacity to Treat** requires the provider to have the necessary organizational structure, co-occurring disorders treatment trained and credentialed staff, and ability to screen, assess, and treat patients with fidelity to an evidence-based co-occurring disorders treatment model. **Delivery of Treatment Services** requires that a provider screen, assess, and treat patients with fidelity to an evidence-based co-occurring disorders treatment model. Additionally, a provider must implement a practice model that is responsive to a patient's needs in terms of reasonable frequency of appointments, treatment session of sufficient length to achieve treatment session goals, and availability to meet/consult regarding crisis events. **Culture of Integrated Care** requires a provider to implement a practice of integrated care that screens and assesses for both substance use and mental health disorders, that develops and executes a treatment plan that addresses both sets of disorders (recognizing the interrelatedness of the two), and focuses on progress on symptoms and issues relating to the symptoms and issues manifested by having a co-occurring SUD and MHD.

Results of the Initiative

Capacity to Treat

Prior to the implementation of the initiative, capacity to treat adults with COD was limited to a few community providers. This limited capacity was due to limited or no training in an evidence-based COD treatment model, ties to a treatment culture that focused on either behavioral health or substance use but not both together, lack of funding streams that would adequately pay for simultaneous or concurrent treatment of behavioral health and substance use issues, and limited recognition of the importance to the treatment success for the whole person with COD, which must include issues connecting behavioral health dysfunction and substance use. The six programs recruited to participate in the initiative represented small to moderate sized service providers serving Greater Greensboro. At the beginning of the initiative, two of the programs served exclusively drug and alcohol use patients, one primarily drug and alcohol use patients, and three primarily behavioral health patients. By mid-year (Year 1 of the initiative), five of the six programs had initiated or were in the process of implementing co-occurring treatment services for patients with substance use and mental health disorders. After the 2015-2016 program year (Year 1

of the initiative), one program chose not to continue participation with the initiative.

Delivery of Treatment

The impact of this change in capacity has resulted in over 9,200 uninsured adults being screened for COD and nearly 4,000 receiving treatment services. The numbers served are approximately 67% of the target of 6,000 adults to be served by 2021. The change in capacity to treat has produced a change in the delivery of treatment services by adding assessment tools for better screening and diagnosis, by helping providers establish feasible but effective treatment plans, and by increasing system recognition of both the challenges and prevalence of COD.

Culture of Integrated Care

This initiative has changed thinking about the parallel systems of behavioral health and substance use disorders and treatment and promoted a more holistic perspective on the identification, classification, and treatment of behavioral health issues. At the onset of this initiative, participating organizations had staff that were either certified addiction specialists or mental health therapists. Now these same organizations have dually licensed staff that can provide co-occurring disorders treatment services for all clients with a COD diagnosis. This initiative has helped participating organizations identify opportunities for improvement in how they screen for and diagnose substance use disorders through the implementation of new screening tools that better support a co-occurring population including the University of Rhode Island Change Assessment Scale (URICA) (McConnaughy, Prochaska, & Velicer, 1983) and a survey assessing the Social Determinants of Health. As a result of this initiative and its favorable outcomes, one participating agency changed its mission statement and to include Integrative Health Services to better reflect the services that are now offered to clients with co-occurring disorders. This initiative has also been instrumental in the successful implementation of the Stages of Change model to assess and treat based on stage of change for both mental health and substance use disorders. The culture that the initiative has built is reflected in the continuing participation by the partner programs in the initiative while receiving only modest support for client services and program capacity development trainings.

Service Impact

In addition to the service counts reported above, it is notable that the programs report over the last three years of the initiative maintaining an active caseload of about 870 uninsured patients. This represents about a fifth of the patient population served by the programs. This is rather remarkable, given the barriers to treatment that the uninsured face and the financial limitations the treatment agencies have in providing services in accordance with an evidence-based practice model. Other impact indicators of note include:

- Of more than 4,300 cases that received COD treatment, fewer than 10% had treatment issues for which the treatment agencies determined that a referral to an outside provider was warranted.
- Fewer than 10% of patients were identified as having been involved with the legal system (police or courts) due to their treatment issues.
- About 20% of patients visited the Emergency Department for issues relating to their COD treatment.
- Less than 10% of patients were hospitalized for health or behavioral issues connected with the mental health

and/or substance use disorders.

Limitations

This study presents a post assessment of an initiative and therefore there are several limitations to the findings. One is that the data reported are limited to cases served and no clinical outcomes are reported. The challenges of outcome reporting are numerous. The patients had multiple issues so identifying an issue to report on a single disorder would not be applicable to all patients. Another issue is when to report outcomes. There was no predetermined time point (i.e., at 6 months) when the participating providers collected "outcome" data. Each participating provider followed its own schedule of patient tracking which limited the ability to collect patient outcomes. For most patients their diagnoses remain applicable, but providers reported that for the most part their disorders were being effectively managed. Another issue is how to account for patient outcomes for those who do not return for treatment. These and other issues relating to outcomes require a more robust assessment than what was feasible. Another limitation is that no data on the cost of services is included. This includes both the set-up costs to be able to provide co-occurring treatment services and the operational costs of providing those services. Although most of the providers initially received some support costs, the funds provided by the Foundation were never intended to be sustaining or ongoing. As with outcome data, what the treatment agencies had the capacity to provide regarding cost data also was limited. Despite these limitations, we believe the "case study" of the initiative has value in demonstrating how a commitment to serving an underserved and vulnerable population group can be achieved.

Conclusions

The volume of assessments and intake for treatment services show that the COD initiative has been very successful in developing participating providers' capacity to serve adults with co-occurring behavioral health and substance use issues (Capacity to Treat). Prior to the implementation of the initiative, adults with co-occurring mental health and substance use disorders lacking the ability to pay for treatment were likely to receive treatment for either substance use or mental health concerns, but not both. The services they were likely to receive lacked the robustness of integrated treatment that is increasingly recognized as the ideal delivery model of treatment (Delivery of Treatment Services). As a result of the initiative, access to services has dramatically increased for uninsured adults with COD. Finally, and equally important as the other goals, there has been a transformation among the participating providers in their capacity to screen, assess, and treat patients that have a COD diagnosis within a practice framework that embraces integrated care as a model for treatment for behavioral health issues (Culture of Integrated Care).

The data on which this paper is based are from the fourth year of a six-year initiative. As with most new initiatives, there was a learning curve, set-backs, organizational resistance, and uncertainty about clinical practice implementation and expected outcomes. But along with these concerns has been the recognition of achievement in a relatively short period of time by a committed group of clinical services providers willing to receive training, change clinical practices, and adopt a model of patient care that required a change in thinking about mental health and substance use as co-occurring behavioral issues requiring a multisystem approach. The

resulting access and availability of COD services to the uninsured has meant that many of the more vulnerable citizens of Greater Greensboro have not only been able to access behavioral health care, but to access a system of care that can more effectively address behavioral, emotional, and physical dependency issues that have frequently been unaddressed or inadequately addressed through a single lens of mental health or substance use and not both and not simultaneously.

Perhaps one of the most important results of this initiative has been the formation of an intentional network of community providers that share goals focused on understanding and building integrated care approaches and working together to better serve the targeted population. Prior to the initiative, there was no effective network of treatment providers for these patients. Cone Health Foundation served as a facilitator for bringing providers together, inspiring the desire for more training and technical support. As a result of this effort to create a network, there was buy-in from providers who began to enhance services approaches, and with the help of consultants, began to deliver services that more efficiently and effectively met the needs of those served. Through regular face-to-face meetings, the provider stakeholders were able to dialogue, share ideas, strategize, and revise services to enhance quality and outcomes. Now, it is hard to imagine serving those who treat co-occurring disorders without this dynamic network of providers.

The results of the initiative described in this paper provide a concrete example of how a local health foundation can make significant impacts in addressing co-occurring disorders in partnership with community-based agencies. Philanthropy can help build the systems that can lower cost to the health system to maintain enabling them to provide essential care that is more affordable to individuals who need treatment and is sustainable by the providers of that treatment. Foundations have long been supporters of health initiatives, but the recent increase in "health legacy foundations" are moving some foundations into a realm of "strategic philanthropy" (Brest, 2015) with the goal of mapping out a strategic pathway through which the outcome being sought can be achieved (Easterling & McDuffee, 2018; Heinze, Banaszak-Holl, & Babiak, 2016). Through targeted programmatic funding, local health foundations are increasing their impact beyond simply grant making by identifying a specific issue, convening interagency groups to address issues, and building the capacity of those organizations to provide the services needed. In the case of the COD initiative, the issue was lack of access to treatment for co-occurring disorders among uninsured adults and the requisite response was the need to build service capacity to treat those individuals. Instead of relying on the existing provider agencies to develop individual response solutions, the Cone Health Foundation developed a community response in the form of a collaborative initiative that enabled the separate partners to work collectively towards building a new capacity to serve uninsured adults with COD and produce impact towards reducing the incidence of these community members going untreated.

Implications for National and International Dual Diagnosis Services

While this paper reports on an initiative that was initiated to provide treatment services for co-occurring disorders to uninsured adults in single medium size U.S. urban community, we believe the lessons gained are applicable to many places attempting to

introduce similar applications of integrated care. We believe this initiative can serve as example to communities anywhere especially those that may have limited resource providers that it is possible and perhaps even desirable to enter into a coalition that that can enable sharing of resources and expertise to enhance services and supports to for people who have co-occurring disorders. The effort to enhance community collaboration could be applied to any situation where there are fragments or divisions in service systems, regardless of how services are funded, e.g., through insurance, third party payers, or government supported systems of care.

Minkoff and Covell (2019) with The U.S. National Association of State Mental Health Program Directors addressed the need for enhancing services at the national and international level, particularly noting that community efforts that include case coordination and case management as well as integrated services are notable in broadening service systems' abilities to support people through a recovery model. Additionally, the World Health Organization supports guidelines that incorporate holistic health approaches when working with people who have co-occurring disorders (Marel, Mills, Kingston, Gournay, Deady, Kay-Lambkin, Baker, & Teesson, 2016). It is this movement toward a more holistic model that makes this initiative important as an example of what a community might do to tackle the challenges presented by those with co-occurring disorders. It is our fervent hope that the effort and success of this initiative will inspire others to create programs and services that will address the issues of mental health and substance use that affects so many lives and provide a path to recovery and a better quality of life.

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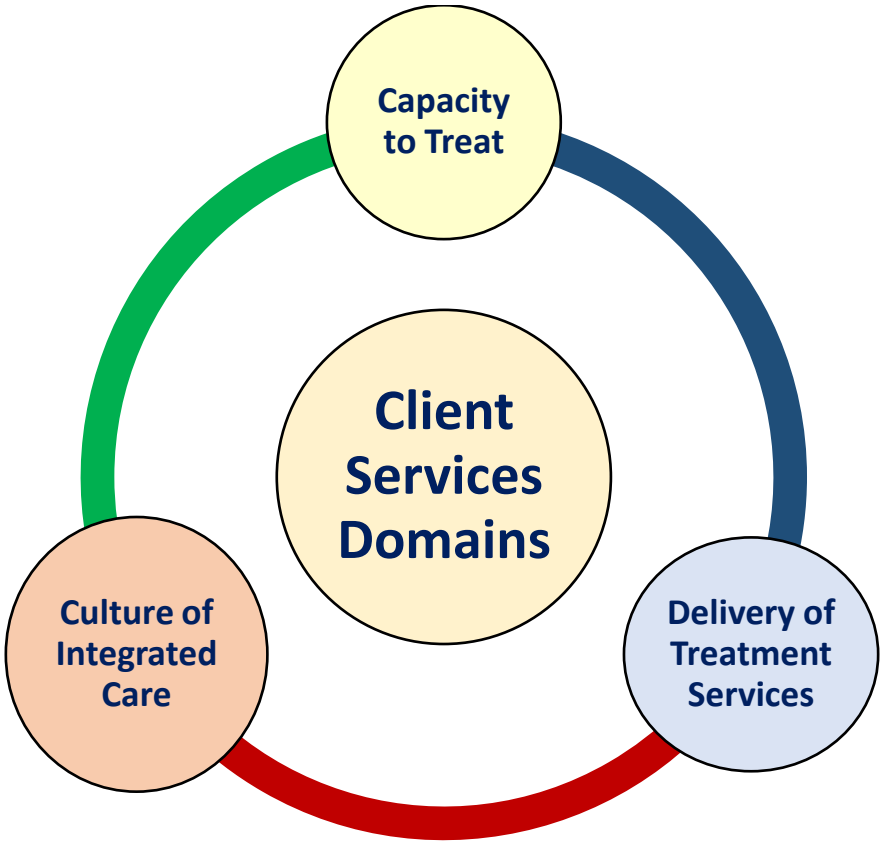

Figure 1.
Conceptual Framework of the Cone Health Foundation Co-Occurring Treatment Initiative

References

Boyle, P., & Wieder, B. (2007). Creating and sustaining integrated dual diagnosis treatment programs: some lessons learned in Ohio. *Journal of Dual Diagnosis*, *3*(2), 103-110. doi.org/10.1300/J374v03n02_12

Brest, P. (2015). Strategic philanthropy and its discontents. Stanford Social Innovation Review. Retrieved from https://ssir.org/up_for_debate/article/strategic_philanthropy_and_its_discontents#.

Burnam, M.A. & Watkins, K.E., 2006. Substance abuse with mental disorders: Specialized public systems and integrated care. *Health Affairs*, *25*(3), 648-658. doi.org/10.1377/hlthaff.25.3.648

Center for Behavioral Health Statistics and Quality, 2015. Behavioral health trends in the United States: results from the 2014 National Survey on Drug Use and Health. *HHS Publication No. SMA 15-4927, NSDUH Series H-50*. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.htm

Chan, Y.F., Huang, H., Bradley, K., & Unützer, J., 2014. Referral for substance abuse treatment and depression improvement among patients with co-occurring disorders seeking behavioral health services in primary care. *Journal of Substance Abuse Treatment*, *46*(2), 106-112. doi.org/10.1016/j.jsat.2013.08.016

Dauber, H., Braun, B., Pfeiffer-Gerschel, T., Kraus, L., & Pogarell, O. (2018). Co-occurring mental disorders in substance abuse treatment: The current health care situation in Germany. *International Journal of Mental Health and Addiction*, *16*(1), 66–80. doi.org/10.1007/s11469-017-9784-5

Drake, R. E. (2007). Psychosocial intervention research on co-occurring disorders. *Journal of Dual Diagnosis*, *3*(2), 85-93. https://doi.org/10.1300/J374v03n02_10

Drake, R. E., O'Neal, E. L., & Wallach, M. A. (2008). A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. *Journal of Substance Abuse Treatment*, *34*(1), 123-138. https://doi.org/10.1016/j.jsat.2007.01.011

Ducharme, L.J., Knudsen, H.K. and Roman, P.M., 2006. Availability of integrated care for co-occurring substance abuse and psychiatric conditions. *Community Mental Health Journal*, *42*(4), 363-375. doi.org/10.1007/s10597-005-9030-7

Easterling, D., & McDuffee, L., 2018. Becoming strategic: Finding leverage over the social and economic determinants of health. *The Foundation Review*, *10*(1), 90-112. doi.org/10.9707/1944-5660.1409

Havassy, B. E., Alvidrez, J., & Mericle, A. A. (2009). Disparities in use of mental health and substance abuse services by persons with co-occurring disorders. *Psychiatric Services*, *60*(2), 217-223. doi/full/10.1176/ps.2009.60.2.217

Heinze, K. L., Banaszak-Holl, J., & Babiak, K. (2016). Social entrepreneurship in communities: Examining the collaborative processes of health conversion foundations. *Nonprofit Management and Leadership*, *26*(3), 313-330. doi.org/10.1002/nml.21198

Hodges, C. L. (2006). Comorbidity: Toward a European evidence-base. In A. Baldacchino, & J. Corkery (Eds.). *Comorbidity: perspectives across*

Europe (pp. 331-349). London: European Collaborating Centres in Addiction Studies. Retrieved from https://www.academia.edu/19283800/Comorbidity_Perspectives_Across_Europe_Monograph_No_4

Jordans, M. J., Kohrt, B. A., Luitel, N. P., Lund, C., & Komproe, I. H. (2017). Proactive community case-finding to facilitate treatment seeking for mental disorders, Nepal. *Bulletin of the World Health Organization*, *95*(7), 531–536. doi.org/10.2471/BLT.16.189282

Kola, L. A., & Kruszynski, R. (2010). Adapting the integrated dual-disorder treatment model for addiction services. *Alcoholism Treatment Quarterly*, *28*(4), 437-450. https://doi.org/10.1080/07347324.2010.511067

McConnaughy, E. A., Prochaska, J. O., & Velicer, W. F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research & Practice*, *20*(3), 368-375. doi.org/10.1037/h0090198

Mangrum, L. F., Spence, R. T., & Lopez, M. (2006). Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders. *Journal of Substance Abuse Treatment*, *30*(1), 79-84. doi.org/10.1016/j.jsat.2005.10.004

Marel, C., Mills, K. L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., ... & Teesson, M. (2016). Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales. Retrieved from https://www.sydney.edu.au/matilda-centre/resources/for-clinicians.html#guidelines

Matusow, H., Guarino, H., Rosenblum, A., Vogel, H., Uttaro, T., Khabir, S., ... & Magura, S. (2013). Consumers' experiences in dual focus mutual aid for co-occurring substance use and mental health disorders. *Substance Abuse: Research and Treatment*, *7*, 39-47. doi.org/10.4137/SART.S11006

Minkoff, K. & Covell, N. (2019). Integrated systems and services for people with co-occurring mental health and substance use conditions: What's known, what's new, and what now? National Association of State Mental Health Program Directors Assessment #8. Retrieved from https://www.nasmhpd.org/sites/default/files/TAC_Paper_8_508C.pdf

Mojtabai, R., Chen, L. Y., Kaufmann, C. N., & Crum, R. M. (2014). Comparing barriers to mental health treatment and substance use disorder treatment among individuals with comorbid major depression and substance use disorders. *Journal of Substance Abuse Treatment*, *46*(2), 268-273. doi.org/10.1016/j.jsat.2013.07.012

Padwa, H., Guerrero, E. G., Braslow, J. T., & Fenwick, K. M. (2015). Barriers to serving clients with co-occurring disorders in a transformed mental health system. *Psychiatric Services*, *66*(5), 547-550. doi.org/10.1176/appi.ps.201400190

Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *Journal of Substance Abuse Treatment*, *61*(1), 47-59. doi.org/10.1016/j.jsat.2015.09.006

Roberts, B. M., & Maybery, D. (2014). Dual diagnosis discourse in Victoria Australia: The responsiveness of mental

health services. *Journal of Dual Diagnosis*, *10*(3), 139-144. doi:10.1080/15504263.2014.929332

Sacks, S., Chaple, M., Sirikantraporn, J., Sacks, J. Y., Knickman, J., & Martinez, J. (2013). Improving the capability to provide integrated mental health and substance abuse services in a state system of outpatient care. *Journal of Substance Abuse Treatment*, *44*(5), 488-493. doi.org/10.1016/j.jsat.2012.11.001

Sterling, S., Chi, F., & Hinman, A. (2011). Integrating care for people with co-occurring alcohol and other drug, medical, and mental health conditions. *Alcohol Research & Health*, *33*(4), 338-349. Retrieved from https://pubs.niaaa.nih.gov/publications/arh334/338-349.htm

Substance Abuse and Mental Health Services Administration (SAMHSA), (n.d.). Co-occurring disorders. Retrieved from https://www.samhsa.gov/disorders/co-occurring.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). Integrated treatment for co-occurring disorders: The evidence. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, U.S. Department of Health and Human Services. Retrieved from https://www.integration.samhsa.gov/integrated-care-models/Co_Occ_Disorders_04.pdf

Substance Abuse and Mental Health Service s Administration (SAMHSA) (2005). Substance abuse treatment for persons with co-occurring disorders. Treatment Improvement Protocol (TIP) Series, No. 42. HHS Publication No. (S MA) 133992. Rockville, MD. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK64197/

Thornicroft, G., Alem, A., Dos Santos, R. A., Barley, E., Drake, R. E., Gregorio, G., ... & Mari, J. (2010). WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care. *World Psychiatry*, *9*(2), 67-77. doi.org/10.1002/j.2051-5545.2010.tb00276.x

Torrey, W. C., Tepper, M., & Greenwold, J. (2011). Implementing integrated services for adults with co-occurring substance use disorders and psychiatric illnesses: A research review. *Journal of Dual Diagnosis*, *7*(3), 150-161. doi.org/10.1080/15504263.2011.592769

World Health Organization. (2019). Mental health. Retrieved from https://www.who.int/news-room/facts-in-pictures/detail/mental-health

World Health Organization. (2013). Mental health action plan 2013-2020. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf