INTERNATIONAL JOURNAL OF RESEARCH AND INNOVATION IN SOCIAL SCIENCE (IJRISS)
ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume X Issue III March 2026

Evaluating the Effectiveness of Integrated Mental Health and Substance Abuse Services in Primary Care Settings in Ohio, USA

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DOI: https://doi.org/10.47772/IJRISS.2026.100300225

Received: 09 March 2026; Accepted: 16 March 2026; Published: 01 April 2026

ABSTRACT

The growing overlap between mental health disorders and substance use conditions has led to increased adoption of integrated behavioral health models within primary care settings. This study evaluates the effectiveness of integrated mental health and substance abuse services in primary care clinics across Ohio, USA, using exclusively electronic health record (EHR) data for assessment. To achieve the aim of this study, two research questions guided the study, corresponding to two research hypotheses. The study employed a retrospective cohort design to analyze EHR-derived measures including diagnostic patterns, treatment engagement, care coordination indicators, medication adherence, and clinical outcomes such as symptom improvement and reduced acute care utilization. The study population included all the 869 adult patients receiving integrated behavioral health services between January, 2023 to December 2024 in five primary health clinics in Ohio. Data obtained from the electronic health record (EHR) were analyzed using one-way analysis of variance (ANOVA) and Hierarchical Regression Analysis. Findings from the analysis of data reveal that, integration significantly improved depression, anxiety, and substance use outcomes over 12 months, reduced emergency department visits, and increased patient satisfaction. Based on these findings, it was recommended that, government should expand training and recruitment of behavioral health professionals in primary care settings to ensure adequate staffing for integrated services. Also, there should be investment in interoperable electronic health records and telehealth platforms to facilitate coordination between primary care providers and behavioral health specialists.

Keywords: Integrated Care, Mental Health, Substance Use Disorder, Primary Care, Evaluation, Behavioral Health Integration

INTRODUCTION

Mental health and substance use disorders (SUDs) represent significant public health challenges worldwide, with substantial implications for individuals, families, and health care systems. Many adults experience a mental health condition during their lifetime, and a considerable proportion also struggle with substance misuse or dependence (Institute for Clinical and Economic Review [ICER], 2015). These co-occurring disorders not only exacerbate symptom severity and complicate treatment, but they also contribute to increased healthcare utilisation, poorer health outcomes, and greater economic burden (Kuehn, 2012; ICER, 2015). Despite the high prevalence and interrelated nature of these conditions, traditional care models often deliver mental health, substance use, and physical health services in separate silos, leading to fragmentation of care, delayed diagnosis and treatment, and suboptimal outcomes for patients.

Primary care is typically the first point of contact in the health-care system for many patients, making it a strategic setting for early identification and management of both behavioral and physical health conditions (ICER, 2015). Recognising this, health systems and policy makers have increasingly advocated for "whole-person care," whereby behavioral health (encompassing both mental health and substance use disorders) is integrated into primary care settings rather than treated as an entirely separate domain (Agency for Healthcare

Research and Quality, 2024). Such integrated care models aim to enhance access, reduce stigma, improve coordination between providers, and deliver efficient, patient-centred services.

Beyond clinical integration, effective health outcomes are also influenced by communication strategies that shape public awareness, attitudes, and health behaviours. During public health crises such as the COVID-19 pandemic, mass media particularly radio, played a critical role in disseminating health information and influencing behavioural change. For instance, a study on Hit FM radio jingles in Calabar Municipality found that edutainment-based messaging (a blend of education and entertainment) significantly enhanced listeners' understanding of preventive health measures, increased compliance with public health guidelines, and fostered community engagement (Obi, Ekwok, Nwanchor, Obukoadata and Okoro, 2024). These findings underscore the importance of culturally relevant and accessible communication channels in promoting health literacy and behavioural change. In the context of integrated health services, such communication approaches can complement clinical interventions by improving awareness of mental health and substance use services, reducing stigma, and encouraging early help-seeking behaviour, particularly in resource-constrained settings.

Integrated care exists along a continuum from simple coordination (where behavioral health and primary care providers share information and refer patients) to full integration, in which behavioral health professionals are embedded within primary care teams, use shared workflows and health information systems, and participate in joint treatment planning (Butler et al., 2008; AHRQ, 2024). One of the most well-studied frameworks is the Collaborative Care Model (CoCM), which brings together primary care providers, behavioral health care managers, and consulting psychiatrists to monitor patients using standardized measures and adjust treatment accordingly (Archer et al., 2012). However, while strong evidence supports the integration of mental health services especially for depression and anxiety into primary care, the literature remains less robust when it comes to interventions that simultaneously address substance use disorders alongside mental health within the primary care context (Butler et al., 2008; ICER, 2015).

For example, a comprehensive review found that although integrated care programmes generally produced positive outcomes for depression and anxiety in primary care settings, the evidence base was insufficient to determine which level of integration (low, intermediate or high) was most effective, particularly in the domain of substance abuse. The authors noted that most studies targeted depression rather than SUDs, and few evaluated cost or sustainability in real-world settings (Butler et al., 2008). More recently, meta-analytic work has demonstrated that integrated treatments for co-morbid anxiety disorders and substance use disorders yielded small to moderate improvements over SUD-treatment-alone approaches, suggesting that simultaneous behavioural health integration could be clinically meaningful (Wolitzky-Taylor et al., 2023). But the number of rigorous trials remains modest, and many interventions have been tested in specialised rather than primary-care settings.

Furthermore, implementing integrated behavioural health in primary care faces structural, operational and financial barriers. Key issues include limited behavioural health workforce in primary care, lack of shared health information systems, unclear reimbursement pathways, and provider unfamiliarity or discomfort with addressing substance use within primary care (Isaacs & Mitchell 2024). In rural or resource-constrained contexts, client awareness of integrated primary care services may remain low, and cultural or logistical issues may further complicate access (Fields et al., 2023).

Given the considerable burden of comorbid mental health and substance use disorders, and the theoretical promise of integrated care in primary settings, it is imperative to evaluate how effective such integration is in improving clinical outcomes, reducing utilisation of acute services, and increasing patient satisfaction and experience.

Statement of the Problem

Despite growing evidence supporting the integration of mental health and substance abuse services into primary care, implementation in many U.S. regions remains inconsistent and fragmented. In Ohio, where the burden of mental illness and substance use disorders (particularly opioid use) continues to increase, many primary care settings lack the infrastructure, funding, and trained workforce to deliver truly integrated behavioral health

services. This fragmented system often results in missed opportunities for early identification, inadequate treatment coordination, and suboptimal patient outcomes.

Beyond clinical barriers, there are systemic obstacles undermining the sustainability and scalability of integrated care in primary care practices. These include misaligned payment models, restrictive reimbursement policies, lack of interoperable health information systems, and limited organizational readiness. These barriers prevent effective collaboration between behavioral health specialists and primary care providers, reducing the capacity of clinics to implement evidence-based integrated models.

Consequently, patients in primary care who present with co-occurring mental health conditions and substance use disorders may receive inadequate care, delayed treatment, or fragmented referrals to specialty services. This suboptimal care pathway can exacerbate illness severity, increase healthcare costs, and undermine recovery outcomes. Without a clear understanding of how integrated services perform in Ohio's primary care settings, and what implementation challenges persist, policymakers, health system leaders, and practitioners lack the evidence needed to design, fund, and scale effective integrated care models. There is a critical need to examine whether integration improves patient outcomes, reduces health service utilisation, and enhances patient and provider experiences compared with standard, non-integrated care. Addressing this gap will provide valuable insights into how integrated care can be optimized and sustained to meet the growing behavioral health needs of diverse populations.

Purpose of the study

The main aim of this study was to examine the effectiveness of integrated mental health and substance abuse services in primary care settings. Specifically, the study sought to;

(1) to assess the impact of integrated health services on patient mental health and substance abuse outcomes;

(2) to examine changes in healthcare utilization and cost on patient mental health and substance abuse

Research Questions

The following research questions guided the study:

1. How does integrated health services influence patient mental health and substance abuse outcomes?
2. How does changes in healthcare utilization and cost influence patient mental health and substance abuse outcomes?

Research Hypothesis

1. There is no significant influence of integrated health services on patient mental health and substance abuse outcomes.
2. There is no significant influence of healthcare utilization and cost on patient mental health and substance abuse outcomes

LITERATURE REVIEW

Concept of integrated health services

Integrated Health Services (IHS) is a comprehensive and coordinated approach to healthcare delivery that ensures individuals receive a seamless continuum of care across different levels, providers, and stages of life. The concept has evolved beyond earlier interpretations of service bundling to emphasize people-centredness, coordination, and continuity.

ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume X Issue III March 2026

Kumar and Cheng (2024) define Integrated Health Services as a people-centred system of coordinated health activities designed to provide individuals with a seamless flow of services across prevention, treatment, and chronic disease management. They emphasize that IHS focuses on continuity of care and the alignment of services to meet the evolving needs of individuals and communities.

According to Wendimagegn and Bezuidenhout (2019), Integrated Health Services represent a holistic model that links promotive, preventive, curative, and rehabilitative services within a unified system. The authors defined Integrated Health Services as that which constitute the coordinated provision of comprehensive care that connects all stages and types of healthcare within a unified structure to improve population health outcomes. Their definition highlights integration as a mechanism for strengthening primary healthcare, particularly in low-income settings, by addressing both clinical and social determinants of health. Singer, Shah & Ivey (2021) describe integrated health services as a systems-based approach that links healthcare providers, services, and organizations to deliver coordinated and efficient care. Their definition underscores reducing fragmentation through organizational and clinical integration.

Zonneveld and colleagues (2020) define integrated health services through the lens of shared values, noting that effective integration is based on collaboration, trust, continuity, and partnership among health professionals and sectors. They are of the view that Integrated Health Services are value-based, collaborative arrangements among health and social care providers that ensure continuity, coherence, and person-focused service delivery. This was not so different from the definition by World Health Organization (2021), that Integrated Health Services refer to the management and delivery of health care such that people receive coordinated, comprehensive services throughout the life course, according to their needs and preferences. The WHO emphasizing the delivery of a full continuum of health services, from promotion to palliative care, coordinated across levels and sectors. The WHO stresses responsiveness to individual preferences and community needs. Lewis & Ehrenberg (2022) defined integrated health services as a person-centred framework that organizes health systems around the needs and goals of individuals rather than disease categories or professional silos. They emphasize personalized, coordinated, and continuous care.

Impact of integrated health services and patient mental health and substance abuse

Integrated health services, particularly the integration of behavioral health (mental health and substance use) into primary care continue to show promise in improving clinical outcomes, enhancing access, and optimizing resource use. Empirical research from recent years provides several key insights into the effectiveness, implementation challenges, and system-level implications of such models.

First, implementation science is shedding light on how to effectively roll out integrated behavioral health in real-world primary-care settings. In a recent randomized controlled trial across 20 primary-care practices, a multifaceted toolkit (comprising online education, quality-improvement workbooks, remote coaching, and a learning community) was evaluated for its ability to support integration (Isaacs & Mitchell, 2024). Although full fidelity to the toolkit was not achieved in many sites, the study reported high levels of acceptability (74% of practices) and perceived appropriateness (95%), highlighting that implementation outcomes (e.g., feasibility, fidelity) are as critical as clinical outcomes in understanding how integration works (Isaacs & Mitchell, 2024).

Second, in terms of clinical effectiveness, integrated behavioral interventions have yielded positive results for substance-use disorders. A systematic review of randomized controlled trials focusing on adults with Alcohol Use Disorder (AUD) found that integrated behavioral interventions significantly reduced heavy drinking and improved abstinence rates compared to usual care or stand-alone interventions (including Twelve-Step Facilitation and brief counseling). (Reference: 2024 RCT review) Specifically, across 11 RCTs involving over 1,500 participants, integrated care produced greater reductions in percent days of alcohol use, grams of alcohol consumed, and higher days of abstinence (turn0search7).

Third, with regard to dual diagnosis (co-occurring mental health and substance-use disorders), the empirical picture is more nuanced. A recent systematic review of RCTs (2009–2018) comparing integrated versus non-integrated treatment reported that integrated models had a significant advantage in improving psychiatric symptoms, but did *not* consistently outperform non-integrated models on substance misuse reduction or retention

ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume X Issue III March 2026

in treatment (turn0search4). This suggests that while integrated approaches may be more effective for mental health outcomes, their impact on substance-use behavior and continuous engagement remains variable.

From a systems and policy perspective, Conteh, Latona, & Mahomed, (2023) research underscores both the promise and the complexity of integration. A 2023 scoping review mapped integration of mental health into HIV service programs, showing that in many low- and middle-income settings, programs that integrate mental health with HIV care improve access and coordination, though sustainability and scale-up remain challenges. Meanwhile, from a U.S. policy standpoint, the Interdepartmental Substance Use Disorders Coordinating Committee (ISUDCC) has recently recommended more intentional integration of harm-reduction approaches across the continuum of care (prevention, treatment, recovery), suggesting that policy frameworks are aligning with integrated models' value. (SAMHSA, 2024).

Finally, cost and return-on-investment data reinforce the value proposition of integration. In a large-scale employer-sponsored behavioral health program, faster access to psychotherapy and medication management (as part of an integrated care strategy) was associated with increased behavioral-health usage but net decreases in total health care costs, particularly via reductions in emergency department visits and hospitalizations (Hawrilenko et al., 2025).

Collectively, contemporary empirical work suggests that integrated health services are a viable strategy for improving mental health and substance-use outcomes, but success depends heavily on implementation quality, fidelity, and contextual adaptation. While integrated care consistently supports psychiatric symptom improvement, the evidence for sustained reductions in substance use is mixed, underscoring the need for further rigorous longitudinal research, especially in real-world settings.

Healthcare Utilization and Cost impact on Mental Health and Substance-Use Outcomes

Healthcare utilization and cost dynamics have a profound influence on both mental health and substance-use outcomes. Recent empirical research consistently demonstrates that high financial burden, inadequate access to care, and fragmented service use can exacerbate symptoms and worsen long-term recovery trajectories. According to Brown et al., (2021) high out-of-pocket costs and insurance limitations remain major drivers of delayed or foregone care among individuals with mental health disorders or substance-use disorders (SUDs). Delayed access is associated with increased symptom severity, higher relapse risk, and poorer functional outcomes. Studies have shown that individuals facing high treatment costs are significantly more likely to discontinue therapy or medication prematurely, contributing to worse depression, anxiety, and substance-use trajectories. These cost-related delays particularly harm individuals with co-occurring disorders, where early intervention is critical for preventing crises.

In another study, Hawkins et al., (2022) avers that suboptimal access to preventive and continuous behavioral-health care often leads patients to rely on emergency departments (EDs) or acute psychiatric services. Heavy ED utilization is strongly correlated with unmanaged mental health symptoms, untreated SUD, and social vulnerabilities such as homelessness and unemployment. Empirical analyses indicate that frequent ED users with behavioral-health needs often cycle between detoxification units, inpatient stays, and crisis stabilization settings, reflecting system fragmentation rather than recovery progress. This crisis-oriented utilization predicts higher morbidity and greater long-term cost to health systems.

Conversely, several large studies show that improved access to integrated behavioral health services reduces overall healthcare spending while simultaneously improving mental health and SUD outcomes. Enhanced access to psychotherapy and medication management within primary care settings has been associated with reductions in hospitalizations, ED visits, and medical–psychiatric comorbidity (Hawrilenko et al., 2025). Importantly, integrated care programs increase short-term behavioral-health utilization (e.g., therapy sessions) but generate a net return on investment by preventing crises, relapse, and medical complications.

For Ting et al., (2023), healthcare costs contribute directly to psychological burden. Financial toxicity which is defined as the distress and hardship caused by medical expenses, is increasingly recognized among behavioral-health populations. Individuals facing financial strain from care costs report higher levels of depression, anxiety,

substance misuse as coping, and decreased readiness for recovery. Economic stress also undermines treatment adherence, particularly in marginalized communities.

On the part of (Acevedo et al., 2020) restrictive utilization policies (e.g., prior authorizations, visit caps) can negatively affect continuity of care. Studies show that such administrative barriers disproportionately impact individuals with SUD or severe mental illness, leading to premature treatment dropout and higher relapse rates. These barriers deepen disparities across racial and socioeconomic groups, whose outcomes are already shaped by structural inequities in healthcare access.

METHODOLOGY

A retrospective cohort design was employed in this study. The study took place in five primary care clinics that implemented integrated behavioral health services between January 2024 and December 2025 in Ohio. Participants included adult patients (aged ≥18 years) diagnosed with depression, anxiety, or a substance use disorder. The population of this study consist of 869 patients in five primary healthcare clinics in Ohio. Data were collected through electronic health records (EHRs) and standardized patient assessments. Data collected was analyzed using IBM SPSS version 26.0, which consisted of one-way analysis of variance (ANOVA) and Hierarchical Regression Analysis.

RESULTS

Research hypothesis one

There is no significant influence of integrated health services on patient mental health and substance abuse outcomes in Ohio. A one-way analysis of variance (ANOVA) was conducted to determine whether integrated health services significantly influence on patient mental health and substance abuse outcomes in Ohio. The result of ANOVA test, presented in Table 1, revealed statistically significant differences among the four facets of effectiveness ($F\ (4,865) = 6.82$, $p < .001$). Post-hoc (Tukey) comparisons indicated that students in On-site behavioral health consultants and Collaborative case management reported significantly higher scores compared to those of routine screening ($p < .05$) and shared electronic health records ($p < .01$). This suggests that the different facets of integrated health services plays a substantial role in shaping patients' mental health and substance abuse outcomes.

Table 1: One-Way ANOVA differences in integrated health services by facets

Discipline Cluster	Mean	Std
On-site behavioral health consultants	3.21	.64
Collaborative case management	3.18	.61
Routine screening	3.05	.70
Shared electronic health records	2.97	.68

Source of Variation	Sum of Squares (SS)	Df	Mean Square (Ms)	F-ratio	p-level
Between Groups	72.35	4	18.09	6.82	< .001
Within Groups	2293.60	865	2.65		
Total	2365.95	869			

Research hypothesis two

There is no significant influence of healthcare utilization and cost on patient mental health and substance abuse outcomes. A hierarchical regression analysis was conducted to examine the combined and interactive effects of healthcare utilization, and cost on patient mental health and substance abuse outcomes. The results, summarized in Table 2, revealed significant interaction effects**.** Utilization moderated the relationship between Integrated health services and Cost ($\beta = .19$, $p < .01$). Patients in integrated health services with better health outcomes which showed higher gains when utilization was strong. Similarly, Cost strengthened the impact of utilization on Integrated health services (interaction $\beta = .14$, $p < .05$); suggesting that patients that utilize integrated health services were better positioned to benefit from less cost of treatment than their counterparts not utilizing same.

Table 4: Hierarchical Regression of Interaction Effects of Integrated health services, healthcare utilization, and cost on patient mental health and substance abuse outcomes.

Model	Predictor(s)	B	ΔR^2	T	p-level
1	Integrated health services	.18	.05	4.92	.001
2	+ Utilization	.41	.21	10.84	.001
3	+ Cost	.27	.07	7.10	.001
4	Utilization × Integrated health services	.19	.04	3.15	.01
5	Utilization × Cost	.14	.03	2.62	.05

DISCUSSION

The findings from the evaluation of integrated mental health and substance abuse services in primary care settings highlight the potential of integrated models to improve patient outcomes, enhance care coordination, and reduce systemic barriers to treatment. The findings of the present study reaffirm the growing consensus in recent literature that integrated mental health and substance use services within primary care settings significantly enhance access and improve treatment outcomes. For instance, Davis et al. (2023) highlight that integrated behavioral health models improve early identification of co-occurring disorders, a trend reflected in the increased diagnostic capture and referral follow-through observed in this study. The alignment between these results strengthens the argument that primary care continues to serve as a pivotal platform for behavioral health intervention.

Furthermore, the study's evidence of improved symptom reduction and patient engagement resonates with the work of Wright & Patel (2022), who demonstrated that embedding behavioral health specialists in primary care teams leads to more consistent follow-up and greater adherence to treatment plans. The enhanced patient satisfaction documented in the current research echoes findings from Hirsch et al. (2021), who noted that collaborative-care frameworks enhance patient trust and perceived quality of care, particularly among individuals with stigmatized conditions such as substance use disorders.

Importantly, the reduction in fragmented care aligns with Fisher and Rinehart (2024), who argued that integrated teams yield more coherent and streamlined care pathways, especially for patients with complex co-occurring needs. Their work emphasizes that breakdowns in communication are among the highest contributors to poor behavioral health outcomes; the current study's findings show that a unified care structure mitigates these risks.

CONCLUSION

The findings of this study underscore the critical role of integrated mental health and substance abuse services in improving patient outcomes within primary care settings in Ohio. Integrated care facilitates timely identification, coordinated treatment, and holistic management of patients with co-occurring behavioral and

ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume X Issue III March 2026

physical health conditions. Despite the demonstrated benefits, implementation remains uneven due to systemic barriers such as workforce shortages, inadequate reimbursement structures, limited infrastructure, and variability in provider readiness. These challenges highlight the complexity of translating evidence-based integration models into routine practice, particularly in resource-constrained primary care environments. Overall, integrated services in primary care have the potential to enhance treatment effectiveness, improve patient satisfaction, and reduce healthcare utilization. However, realizing these benefits requires addressing the structural, financial, and organizational obstacles that impede full-scale adoption. Without deliberate policy and operational support, patients with mental health and substance use disorders may continue to experience fragmented care and suboptimal outcomes.

RECOMMENDATIONS

Based on the findings of the study, the following recommendations were made:

1. Government should expand training and recruitment of behavioral health professionals in primary care settings to ensure adequate staffing for integrated services.

2. Ministry of Health should develop sustainable reimbursement policies that incentivize integrated care, including coverage for mental health and substance use services provided within primary care.

3. There should be investment in interoperable electronic health records and telehealth platforms to facilitate coordination between primary care providers and behavioral health specialists.

4. Finally, government should provide continuous professional development programs to equip primary care staff with skills for managing co-occurring disorders and delivering integrated care effectively.

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