Sarcouncil Journal of Internal Medicine and Public Health

ISSN(Online): 2945-3674

Volume- 05| Issue- 01| 2026

Review Article **Received:** 20-12-2025| **Accepted:** 15-01-2026 | **Published:** 31-01-2026

Systematic Review of the Effectiveness of Multidisciplinary Care-coordination Models for U.S. Citizens with Co-occurring Disorders

***Mary Najjemba*[1] *and Deborah Solomon*[2]**

[1]*Brown School at Washington University in St. Louis, USA*
[2]*Kwame Nkrumah University of Science and Technology*

Abstract: **Background:** Individuals with co-occurring mental health and substance use disorders face elevated morbidity, fragmented care pathways, and disproportionate utilization of healthcare services in the United States. Multidisciplinary care-coordination models have been extensively advocated as a solution to these challenges; however, their effectiveness has been documented with considerable variability. **Objective:**To systematically synthesize recent U.S.-based evidence evaluating the effectiveness of multidisciplinary care-coordination models for individuals with co-occurring mental health and substance use disorders. **Methods:** A PRISMA-compliant systematic review was conducted using peer-reviewed, rigorously documented studies published from 2020 onward. Multiple databases were searched to identify studies evaluating multidisciplinary or integrated care-coordination models. Due to heterogeneity in study designs, interventions, and outcome measures, findings were synthesized using a narrative approach **Findings:** Across 30 studies, multidisciplinary care-coordination models improved care continuity, treatment engagement, and selected utilization outcomes relative to fragmented care. Evidence of direct clinical benefit was mixed and varied by model and implementation context. Workforce, data integration, and reimbursement barriers continued to constrain scalability and sustainability. **Conclusion:** Multidisciplinary care coordination represents a critical strategy for improving service delivery for individuals with co-occurring disorders; however, its effectiveness is contingent on implementation quality and supportive policy environments. More rigorous comparative and equity-focused research is needed to inform durable system-level change.

Keywords: Co-occurring disorders**,** Care coordination**,** Multidisciplinary care**,** Substance use disorders**,** Mental health services.

INTRODUCTION

Co-occurring mental health and substance use disorders represent a major and persistent challenge within the United States healthcare system. Individuals with these conditions experience elevated morbidity, fragmented care pathways, and disproportionately high utilization of emergency and inpatient services, reflecting both clinical complexity and systemic deficiencies in care delivery (Storm *et al*., 2020; Trivedi *et al*., 2022; Breslau *et al*., 2023). Recent state-level policy analyses further demonstrate that structurally separated treatment pathways for mental health and substance use disorders exacerbate care fragmentation and increase relapse risk, underscoring the need for integrated and coordinated service delivery models tailored to individuals with co-occurring conditions (Najjemba, M. 2024). The longstanding structural separation of mental health, substance use, and general medical services has been consistently identified as a key contributor to poor outcomes and inefficiencies in care for this population (Compton & Manseau, 2020; Goldman *et al*., 2022; Hynes & Thomas, 2023).

Care fragmentation disproportionately affects high-need populations, including older adults, Medicaid beneficiaries, individuals experiencing homelessness, and populations facing socioeconomic and racial inequities (County, 2020; Robbins *et al*., 2024; Kyei & Mumba, 2025). Policy and system-level analyses further demonstrate that misaligned reimbursement mechanisms, limited data interoperability, and workforce shortages undermine continuity of care, particularly during transitions between acute, outpatient, and community-based settings for individuals with co-occurring disorders (Janich & Shafer, 2020; Parks, 2022; Kelly *et al*., 2025).

In response to these challenges, multidisciplinary care-coordination models have gained increasing prominence as a strategy to reduce fragmentation and improve outcomes. Models such as collaborative care, integrated behavioral health, health homes, and team-based primary care emphasize interdisciplinary collaboration, shared accountability, and longitudinal continuity across care settings (Snider *et al*., 2020; Murphy *et al*., 2021; McBain *et al*., 2021). Empirical studies published since 2020 suggest that these approaches may improve treatment engagement, adherence, care transitions, and continuity, while reducing preventable hospitalizations and emergency department utilization—particularly when coordination roles are clearly defined and embedded within care teams (Gardner *et al*., 2022; Austin *et al*., 2025; Nikpour *et al*., 2025).

***Corresponding Author:** Mary Najjemba

DOI- https://doi.org/10.5281/zenodo.18444649

Despite growing implementation, the evidence base remains uneven. Existing reviews often focus on single diagnostic categories, specific care settings, or non-U.S. contexts, limiting their applicability to U.S. populations with co-occurring mental health and substance use disorders (Glover-Wright *et al*., 2023; Brom *et al*., 2024). Moreover, while conceptual frameworks and policy analyses are well developed, relatively few studies directly compare the effectiveness of different multidisciplinary coordination models or assess broader outcomes such as equity, sustainability, and patient experience (Kaur *et al*., 2022; Wright, 2025; Menders, 2025). Qualitative studies and dissertations offer important insights into implementation barriers and facilitators but are rarely synthesized alongside quantitative outcome evidence (Tesema, 2024; Perry, 2024; Johnson, 2025).

Given the rapid expansion of integrated and coordinated care initiatives in the United States over the past five years, a focused synthesis of recent evidence is warranted. This systematic review aims to evaluate the effectiveness of multidisciplinary care-coordination models for U.S. citizens with co-occurring mental health and substance use disorders, examining clinical outcomes, healthcare utilization, cost-related measures, and implementation characteristics. By consolidating contemporary evidence, this review seeks to inform clinical practice, health-system design, and policy development for this high-need population.

METHODOLOGY

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) guidelines to ensure transparency and reproducibility. The objective was to synthesize recent evidence on the effectiveness of multidisciplinary care-coordination models for U.S. citizens with co-occurring mental health and substance use disorders, a population for whom care fragmentation and system-level barriers remain persistent challenges (McBain *et al*., 2021; Hynes & Thomas, 2023).

A comprehensive literature search was conducted in PubMed/MEDLINE, Scopus, Web of Science, PsycINFO, and ProQuest Dissertations & Theses. Searches were restricted to studies published from January 2020 onward to capture contemporary care-coordination models implemented within the context of recent U.S. policy, delivery, and payment reforms (Kaur *et al*., 2022; Sand, 2024). Search strategies combined terms related to co-occurring mental health and substance use disorders, care coordination or integrated care, and multidisciplinary or team-based service delivery. Boolean operators and database-specific controlled vocabulary were applied as appropriate. Full search strategies are provided in Supplementary Appendix A.

Studies were eligible for inclusion if they examined U.S.-based populations with co-occurring mental health and substance use disorders or closely related high-complexity populations, such as individuals with serious mental illness and concurrent substance use. Eligible interventions involved multidisciplinary, integrated, or coordinated care models engaging two or more professional disciplines. Studies were required to report at least one relevant outcome, including clinical outcomes, healthcare utilization, care continuity, cost-related measures, patient-reported outcomes, or implementation characteristics. Eligible study designs included randomized controlled trials, quasi-experimental studies, observational studies, qualitative and mixed-methods research, systematic reviews, and rigorous policy analyses. Studies conducted outside the United States, those published prior to 2020, single-discipline interventions lacking a coordination component, and non-analytic opinion pieces were excluded (Janich & Shafer, 2020; Goldman *et al*., 2022).

All identified records were imported into a reference management system, and duplicate records were removed prior to screening. Titles and abstracts were screened for relevance, followed by full-text review of potentially eligible studies. Screening decisions were resolved through consensus. The study selection process is summarized using a PRISMA flow diagram (Figure 1).

Data extraction captured study design, population characteristics, care-coordination model features, professional disciplines involved, outcome domains, and key findings. Where available, information on policy context, reimbursement structures, and workforce roles was also extracted, given their relevance to implementation feasibility and sustainability (Kyei & Mumba, 2025; Tahan *et al*., 2025). Study quality and risk of bias were assessed using design-appropriate criteria and were used to inform interpretation of findings rather than as exclusion criteria, consistent with prior

Publisher: SARC Publisher

syntheses of complex health-system interventions (Storm *et al*., 2020; Glover-Wright *et al*., 2023).

Given substantial heterogeneity in intervention models, study designs, and outcome measures, findings were synthesized using a narrative approach. Studies were grouped thematically by care-coordination model type, outcome domain, and implementation context. Quantitative synthesis was considered only when outcomes and study designs were sufficiently comparable; otherwise, results were integrated descriptively (McBain *et al*., 2021; Brom *et al*., 2024).

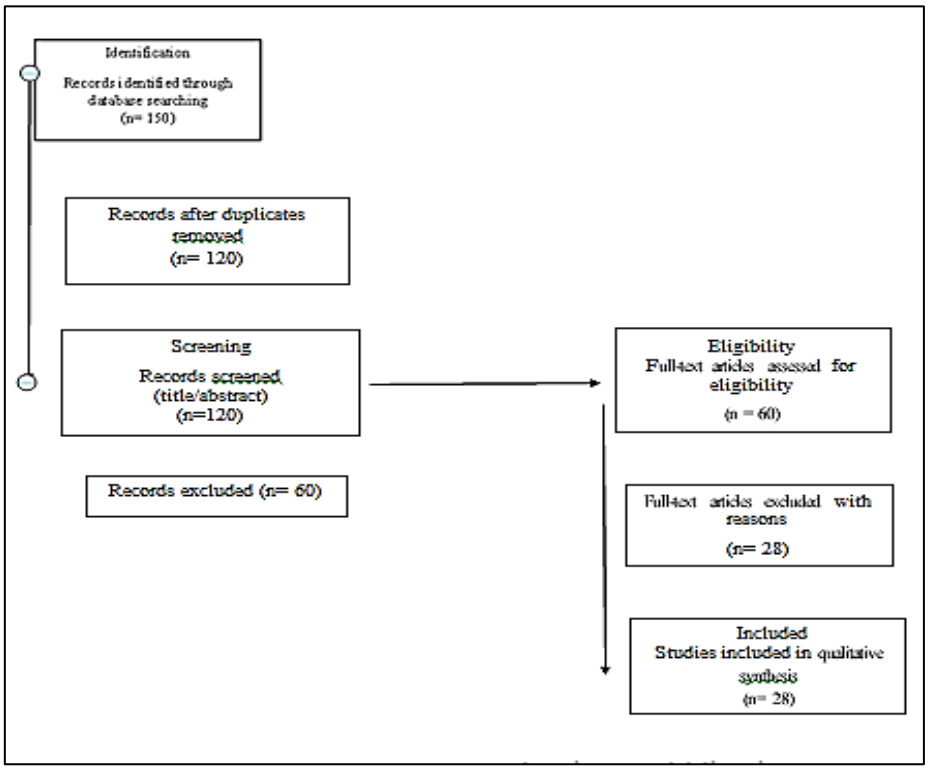

Figure 1. Prisma flow diagram

RESULTS

NO	**Author (Year)**	**Study Design**	**Population (U.S.)**	**Care-Coordination Model**	**Disciplines Involved**	**Setting**	**Outcome Domains**
1	Storm *et al.* (2020)	Qualitative	Adults with SMI and medical comorbidity	Cross-sector service coordination	Mental health, primary care, social services	Rural community	Continuity, implementation barriers
2	Powers *et al.* (2020)	Quasi-experimental	High-need Medicaid beneficiaries	Complex care management	Nursing, primary care, social work	Health system	Utilization, cost
3	Snider *et al.* (2020)	Program evaluation	Adults with SMI	Integrated care coordination	Behavioral health, primary care	Community clinics	Engagement, care continuity
4	Murphy *et al.* (2021)	Case study	Adults with SMI	Coordinated cardiovascular risk management	Psychiatry, nursing, primary care	Outpatient care	Clinical outcomes, adherence
5	McBain *et al.* (2021)	Evidence synthesis	Adults with multiple chronic conditions	Evidence-based coordination strategies	Multidisciplinary	Multiple settings	Quality, utilization
6	Niles & Olin (2021)	Qualitative	Adults with dual diagnosis	Integrated behavioral health teams	Behavioral health, case management	Community care	Access, coordination

Publisher: SARC Publisher

7	Gardner *et al.* (2022)	Scoping review	Adults with substance use disorders	Hospital–community coordination	Multidisciplinary	Acute–community interface	ED use, readmissions
8	Trivedi *et al.* (2022)	Observational	Older high-risk veterans	Coordinated vs fragmented care	Primary care, mental health	VA system	Continuity, utilization
9	Goldman *et al.* (2022)	Comparative policy analysis	National programs	Integrated care models	Multisector	System-level	Structural effectiveness
10	Kaur *et al.* (2022)	Policy review	Medicaid populations	Integrated care initiatives	Multidisciplinary	State programs	Access, financing
11	Parks (2022)	Policy analysis	Mental health systems	Care-coordination infrastructure	Multidisciplinary	System-level	Sustainability
12	Hynes & Thomas (2023)	Theoretical synthesis	Mental health services	Coordination theory	Multidisciplinary	Conceptual	Mechanisms of action
13	Glover-Wright *et al.* (2023)	Systematic review	Adults with MH and SUD	Co-located and coordinated care	Multidisciplinary	Outpatient care	Clinical and service outcomes
14	Breslau *et al.* (2023)	Observational	Adults with mental illness	Integrated service delivery	Behavioral health, primary care	Health systems	Utilization, disparities
15	Brom *et al.* (2024)	Scoping review	Adults with SMI and MCCs	Post-discharge coordination	Multidisciplinary	Transitional care	Readmissions
16	Harris *et al.* (2024)	Mixed methods	OUD treatment providers	Integrated OUD care models	Behavioral health, primary care	Treatment programs	Implementation fidelity
17	Perry (2024)	Policy case study	Unhoused adults	County-level integrated care	Multidisciplinary	Public health system	Equity, access
18	Robbins *et al.* (2024)	Observational	Medicaid beneficiaries	Care-coordination programs	Multidisciplinary	Community care	Disparities, utilization
19	Tesema (2024)	Program evaluation	High-risk adults	NP-directed coordination	Nursing, primary care	Community clinics	Appointment adherence
20	Sand (2024)	Policy evaluation	Medicaid Health Home enrollees	Health home model	Multidisciplinary	State programs	Cost, utilization
21	Austin *et al.* (2025)	Qualitative	Adults with OUD	Team-based primary care integration	Primary care, behavioral health	Primary care	Engagement, collaboration
22	Johnson (2025)	Dissertation	Adults with CODs	Nurse care integration specialist	Nursing, behavioral health	Outpatient care	Treatment initiation
23	Kelly *et al.* (2025)	Policy analysis	Nursing facility residents	Integrated SUD services	Multidisciplinary	Long-term care	Access gaps
24	Kyei & Mumba (2025)	Policy analysis	Medicare beneficiaries	Federal coordination policies	Multisector	National	Structural barriers
25	Nikpour *et al.* (2025)	Observational	Medicaid adults with SMI	Transitional care coordination	Multidisciplinary	Post-acute care	Continuity, adherence

Publisher: SARC Publisher

26	Ware (2025)	Qualitative	Adults with chronic pain and OUD	Interdisciplinary collaboration	Multidisciplinary	Clinical settings	Team functioning
27	Wright (2025)	Conceptual analysis	Integrated care systems	Coordination effectiveness	Multidisciplinary	System-level	Model comparison
28	Menders (2025)	Policy synthesis	Behavioral health systems	Integrated care implementation	Multidisciplinary	System-level	Sustainability

DISCUSSION

This systematic review synthesizes recent U.S.-based evidence on multidisciplinary care-coordination models for individuals with co-occurring mental health and substance use disorders. Across diverse study designs and care settings, the findings indicate that coordinated, team-based approaches generally outperform fragmented care in improving care continuity, treatment engagement, and selected healthcare utilization outcomes, although effects vary substantially by model type and implementation context (Storm *et al*., 2020; McBain *et al*., 2021; Glover-Wright *et al*., 2023).

A consistent pattern across the included studies is that care-coordination models are most effective when coordination functions are clearly defined and embedded within routine care delivery. Integrated behavioral health and collaborative care models situated within primary care or transitional care settings demonstrate more consistent improvements in appointment adherence, continuity of care, and reductions in preventable emergency department utilization compared with loosely coordinated or referral-based approaches (Gardner *et al*., 2022; Trivedi *et al*., 2022; Nikpour *et al*., 2025). Qualitative and mixed-methods evidence further suggests that regular interdisciplinary communication, shared accountability, and role clarity function as key mechanisms through which care coordination influences outcomes (Storm *et al*., 2020; Harris *et al*., 2024; Ware, 2025).

Evidence regarding direct clinical outcomes remains more heterogeneous. While some studies report improvements in disease management, treatment adherence, or symptom-related outcomes among individuals receiving coordinated care, others observe neutral effects, particularly over shorter follow-up periods (Murphy *et al*., 2021; Breslau *et al*., 2023; Brom *et al*., 2024). This variability likely reflects differences in outcome measurement, baseline population risk, and the intensity and maturity of coordination models, as well as the episodic and relapsing nature of co-occurring disorders. Several reviews and program evaluations caution that care coordination alone may be insufficient to drive sustained clinical improvement in the absence of concurrent access to evidence-based behavioral and medical treatments (McBain *et al*., 2021; Glover-Wright *et al*., 2023).

Implementation-focused studies highlight persistent structural barriers that constrain the effectiveness and scalability of multidisciplinary care coordination. Workforce shortages, high staff turnover, limited health information system interoperability, and challenges in cross-sector communication are repeatedly identified as threats to model fidelity and sustainability (Janich & Shafer, 2020; Harris *et al*., 2024; Tesema, 2024). Policy analyses further demonstrate that although Medicaid health homes and other integrated care initiatives have expanded the adoption of coordination frameworks, misaligned reimbursement structures and short-term funding cycles continue to undermine long-term implementation, particularly for high-need populations with co-occurring disorders (Sand, 2024; Kyei & Mumba, 2025; Kelly *et al*., 2025).

Equity considerations emerge as an important but underdeveloped dimension of the evidence base. Several studies suggest that individuals experiencing homelessness, socioeconomic disadvantage, or complex medical comorbidities may derive disproportionate benefit from coordinated care; however, these populations remain underrepresented in rigorous evaluations (Perry, 2024; Robbins *et al*., 2024). Moreover, few studies explicitly examine differential effects across racial, ethnic, or socioeconomic groups, limiting conclusions about the potential of care coordination to reduce disparities. Addressing these gaps will be essential as integrated care models continue to expand within value-based and population health frameworks (Goldman *et al*., 2022; Parks, 2022).

Taken together, the findings suggest that multidisciplinary care coordination holds promise for improving system-level and process-related

Publisher: SARC Publisher

outcomes for individuals with co-occurring disorders in the United States, but its effectiveness is highly contingent on implementation quality, workforce capacity, and supportive policy environments. Future research should move beyond model proliferation toward rigorous comparative evaluation and sustained investment in the structural conditions necessary for coordination to translate into durable clinical improvements and equity gains.

Research Gaps

Despite the growing adoption of multidisciplinary care-coordination models for individuals with co-occurring mental health and substance use disorders, several critical gaps persist within the contemporary U.S. evidence base. First, there remains a notable lack of comparative effectiveness research directly evaluating different care-coordination models against one another. Although many studies demonstrate improvements relative to usual or fragmented care, few rigorously compare collaborative care, health homes, transitional care, and other multidisciplinary approaches using consistent outcome measures. This limitation constrains conclusions regarding which models are most effective for specific populations, settings, or stages of care (McBain *et al*., 2021; Glover-Wright *et al*., 2023; Goldman *et al*., 2022).

Second, evidence related to clinical outcomes remains inconsistent and underdeveloped. Existing studies frequently emphasize healthcare utilization, treatment engagement, or process measures, with fewer evaluating symptom severity, functional status, or long-term recovery trajectories. Short follow-up periods and heterogeneous outcome definitions further complicate interpretation, particularly given the chronic and relapsing course of co-occurring disorders (Murphy *et al*., 2021; Breslau *et al*., 2023; Brom *et al*., 2024). Future research should prioritize standardized, patient-centered clinical outcomes and extended observation periods to better assess sustained effects.

Third, there is limited understanding of the mechanisms through which care coordination exerts its effects. While qualitative and mixed-methods studies consistently highlight the importance of role clarity, interdisciplinary communication, and shared accountability, these mechanisms are rarely operationalized or tested quantitatively (Storm *et al*., 2020; Harris *et al*., 2024; Ware, 2025). Without clearer specification of how and why coordination works, replication, optimization, and scalability remain challenging.

Fourth, equity-focused evidence is notably sparse. Although policy analyses and observational studies suggest that coordinated care may confer disproportionate benefits for individuals experiencing homelessness, socioeconomic disadvantage, or complex comorbidities, few evaluations explicitly examine differential effects across racial, ethnic, or socioeconomic groups (Perry, 2024; Robbins *et al*., 2024; Kyei & Mumba, 2025). This gap limits the ability to determine whether care-coordination models reduce health disparities or risk reinforcing existing inequities. Analyses of reentry and justice-involved populations further reveal substantial evidence gaps regarding how coordinated care models address the compounded effects of housing instability, criminal justice involvement, and untreated co-occurring disorders (Najjemba, M. 2024).

Finally, research addressing implementation sustainability and financing remains limited. While policy analyses document the expansion of integrated care initiatives through Medicaid and related programs, empirical studies rarely assess long-term sustainability, workforce retention, or the influence of reimbursement structures on model fidelity and performance (Janich & Shafer, 2020; Sand, 2024; Kelly *et al*., 2025). Greater integration of implementation science with policy analysis is needed to inform care-coordination strategies that are both effective and durable.

Addressing these gaps will be essential for advancing multidisciplinary care coordination from a promising organizational strategy to a consistently effective, equitable, and sustainable component of care for individuals with co-occurring mental health and substance use disorders in the United States.

Future Directions

Future research on multidisciplinary care-coordination models for individuals with co-occurring mental health and substance use disorders should prioritize comparative and mechanism-focused evaluation rather than continued proliferation of loosely defined models. Rigorous head-to-head comparisons of established approaches including collaborative care, health homes, and transitional care—are needed to determine which models are most effective for specific populations, care settings, and levels of

Publisher: SARC Publisher

clinical complexity (McBain *et al*., 2021; Glover-Wright *et al*., 2023; Goldman *et al*., 2022). Such studies should employ standardized outcome measures to facilitate meaningful cross-study comparison.

Greater emphasis is also needed on longitudinal and patient-centered outcomes. Future evaluations should move beyond short-term utilization metrics to assess sustained clinical outcomes, functional status, quality of life, and recovery trajectories over extended follow-up periods. Given the chronic and relapsing nature of co-occurring disorders, longer-term study designs are essential to determine whether care coordination produces durable benefits beyond initial improvements in engagement or access (Murphy *et al*., 2021; Breslau *et al*., 2023; Brom *et al*., 2024).

Advancing the evidence base will further require improved understanding of the mechanisms through which care coordination influences outcomes. Mixed-methods and implementation science approaches should explicitly measure coordination processes such as communication frequency, role clarity, care transitions, and shared decision-making and examine how these mechanisms mediate clinical and system-level effects (Storm *et al*., 2020; Harris *et al*., 2024; Ware, 2025). Embedding such measures within effectiveness studies would enhance reproducibility and scalability.

Future research must also directly address equity and population heterogeneity. Studies should be designed to evaluate differential effects of care-coordination models across racial, ethnic, socioeconomic, and housing-status groups, particularly among populations disproportionately affected by fragmented care (Perry, 2024; Robbins *et al*., 2024; Kyei & Mumba, 2025). Incorporating equity-focused outcomes and stratified analyses will be critical for determining whether coordination models reduce or inadvertently perpetuate existing disparities.

Finally, sustained progress will depend on closer integration of clinical evaluation with policy, financing, and workforce research. Future studies should examine how reimbursement structures, payment stability, workforce capacity, and data-sharing infrastructure shape the fidelity, scalability, and sustainability of multidisciplinary care-coordination models (Janich & Shafer, 2020; Sand, 2024; Kelly *et al*., 2025). Aligning implementation research with evolving value-based payment and integrated care policies will be essential for translating evidence into long-term system change.

Together, these priorities underscore the need to move from descriptive and pilot-focused studies toward a more mature evidence base capable of informing durable, equitable, and effective care-coordination strategies for individuals with co-occurring disorders in the United States. Emerging legislative proposals indicate that aligning reimbursement, accreditation standards, and care-setting design with integrated treatment principles may enhance the long-term sustainability of multidisciplinary coordination models (Najjemba, M. 2024).

CONCLUSION

This systematic review synthesizes recent U.S.-based evidence on multidisciplinary care-coordination models for individuals with co-occurring mental health and substance use disorders. Overall, coordinated and team-based approaches demonstrate clear advantages over fragmented care in improving care continuity, treatment engagement, and selected healthcare utilization outcomes. These benefits are most consistently observed when coordination functions are clearly defined, embedded within routine care delivery, and supported by sustained interdisciplinary collaboration.

However, evidence for sustained clinical improvement remains mixed, reflecting heterogeneity in model design, implementation fidelity, outcome measurement, and follow-up duration. Persistent structural barriers including workforce limitations, inadequate data interoperability, and misaligned reimbursement mechanisms continue to undermine scalability and long-term sustainability. Moreover, despite the potential of care coordination to mitigate inequities, empirical evidence assessing differential impacts across socioeconomically marginalized and high-need populations remains limited.

REFERENCES

1. Austin, E. J., Chen, J., Soyer, E., Idrisov, B., Briggs, E. S., Ferro, L., & Koch, U. "Optimizing patient engagement in treatment for opioid use disorder: Primary care team perspectives on influencing factors." *Journal of general internal medicine* 39.16 (2024): 3196-3204.

Publisher: SARC Publisher

2. Breslau, J., McBain, R. K., Sobol, D., Huilgol, S. S., & Eberhart, N. K. "IMPROVING MENTAL HEALTH CARE SYSTEMS IN THE UNITED STATES." (2023).
3. Brom, H., Sliwinski, K., Amenyedor, K., & Carthon, J. M. B. "Transitional care programs to improve the post-discharge experience of patients with multiple chronic conditions and co-occurring serious mental illness: A scoping review." *General Hospital Psychiatry* 91 (2024): 106-114.
4. County, S. "Integrating Care for People Experiencing Homelessness." (2020).
5. Gardner, R. L., Baier, R. R., Cooper, E. L., Clements, E. E., & Belanger, E. "Interventions to reduce hospital and emergency department utilization among people with alcohol and substance use disorders: A scoping review." *Medical Care* 60.2 (2022): 164-177.
6. Glover-Wright, C., Coupe, K., Campbell, A. C., Keen, C., Lawrence, P., Kinner, S. A., & Young, J. T. "Health outcomes and service use patterns associated with co-located outpatient mental health care and alcohol and other drug specialist treatment: A systematic review." *Drug and Alcohol Review* 42.5 (2023): 1195-1219.
7. Goldman, M. L., Scharf, D. M., Brown, J. D., Scholle, S. H., & Pincus, H. A. "Structural components of integrated behavioral health care: a comparison of national programs." *Psychiatric Services* 73.5 (2022): 584-587.
8. Harris, L. M., Guerrero, E. G., Khachikian, T., Serrett, V., & Marsh, J. C. "Expert providers implement integrated and coordinated care in opioid use disorder treatment." *International Journal of Drug Policy* 132 (2024): 104567.
9. Hynes, D. M., & Thomas, K. C. "Realigning theory with evidence to understand the role of care coordination in mental health services research." *International journal of care coordination* 26.2 (2023): 55-61.
10. Johnson, A. "The Role of the Nurse Care Integration Specialist in Co-Occurring Disorders: The Integrated Team to Increase Rates of Substance Use Treatment. MS thesis." *Northwest University*, (2025).
11. Kaur, V., Lindinger-Sternart, S., & Grey, B. "Public policy issues affecting integrated health care: Challenges, opportunities, and implications for clinical mental health counselors." *Journal of Mental Health Counseling* 44.1 (2022): 49-67.
12. Kelly, L. A., Accetta, R. C., Conroy, M. B., & Myrka, A. "Improving Access To Substance Use Disorder Care In Nursing Facilities: Article examines access to substance use disorder care in nursing facilities." *Health Affairs* 44.9 (2025): 1070-1077.
13. Kyei, E. F., & Mumba, M. N. "Medicare's integration imperative: A policy analysis of care coordination barriers for older adults with co-occurring mental health and substance use disorders." *Nursing Outlook* 73.6 (2025): 102550.
14. McBain, R. K., Eberhart, N. K., Breslau, J., Frank, L., Burnam, M. A., Kareddy, V., & Simmons, M. M. "EVIDENCE-BASED RECOMMENDATIONS." (2021).
15. Menders, T. "Unpacking Sustainability: An Examination of Factors Influencing Integrated Behavioral Health in Federally Qualified Health Centers (FQHCs)." *Diss. University of Illinois Chicago*, (2025).
16. Murphy, K. A., Dalcin, A., McGinty, E. E., Goldsholl, S., Heller, A., & Daumit, G. L. "Applying care coordination principles to reduce cardiovascular disease risk factors in people with serious mental illness: a case study approach." *Frontiers in Psychiatry* 12 (2021): 742169.
17. Najjemba, M. "An Act to Provide More Focused Care to Individuals Suffering from Mental Health and Substance-Related Disabilities: A Policy Proposal." *Available at SSRN 5344384* (2024).
18. Najjemba, M. "Enhancing Reentry Support: A Comprehensive Approach to Address the Needs of Formerly Incarcerated Individuals." *Available at SSRN 5345563* (2024).
19. Nikpour, J., Langston, C., Brom, H., Sliwinski, K., Mason, A., Garcia, D., & Carthon, J. M. B. "Improvements in Transitional Care Among Medicaid-Insured Patients With Serious Mental Illness." *Journal of nursing care quality* 40.1 (2025): 76-83.
20. Niles, L., & Olin, S. "Behavioral health quality framework: a roadmap for using measurement to promote joint accountability and whole-person care." *Washington, DC, National Committee for Quality Assurance* (2021).
21. Parks, J. J. "Service Coordination and Health Homes." *Textbook of Community Psychiatry: American Association for Community Psychiatry*. Cham: Springer International Publishing, 2022. 549-559.

Publisher: SARC Publisher

22. Perry, S. R. "Integrated Coordinated Care Policies in Alameda County for the Unhoused Population." *Diss. Walden University*, (2024).
23. Powers, B. W., Modarai, F., Palakodeti, S., Sharma, M., Mehta, N., Jain, S. H., & Garg, V. "Impact of complex care management on spending and utilization for high-need, high-cost Medicaid patients." *Am J Manag Care* 26.2 (2020): e57-e63.
24. Robbins, C., Avery, M. M., Olin, S., Clark, E., Johnson-Yates, R., & Doughty, B. "Substance Use Disorder in California." (2024).
25. Sand, J. "The Impact of Integrated Care on Healthcare Utilization and Costs: Evidence from the Kansas Health Homes Medicaid Program." *Diss. University of Kansas*, (2024).
26. Snider, T. C., Beck, K. E., & Baum, R. A. "Care Coordination in Primary Care." *Interprofessional Care Coordination for Pediatric Autism Spectrum Disorder: Translating Research into Practice*. Cham: Springer International Publishing, 2020. 257-273.
27. Storm, M., Fortuna, K. L., Gill, E. A., Pincus, H. A., Bruce, M. L., & Bartels, S. J. "Coordination of services for people with serious mental illness and general medical conditions: Perspectives from rural northeastern United States." *Psychiatric rehabilitation journal* 43.3 (2020): 234.
28. Tesema, W. "Development and Evaluation of a Nurse Practitioner–Directed Coordinated Care Program and Its Impact on Patient External Appointment Adherence Among Those With Severe Mental Illness." *Wilmington University (Delaware*), (2024).
29. Trivedi, R. B., Rossi, F. S., Javier, S. J., Greene, L., Singer, S. J., Vanneman, M. E., & Zulman, D. M. "Association between mental health conditions and outpatient care fragmentation: A national study of older high-risk veterans." *Journal of General Internal Medicine* 37.16 (2022): 4071-4079.
30. Ware, A. M. "Medical Social Workers' Self-Efficacy and Perceptions of Interdisciplinary Collaboration Managing Patients With Co-Occurring Chronic Pain and Opioid Use Disorder." *Diss. Walden University*, (2025).
31. Wright, O. "Ideation to Implementation: Collaborative Care and the Current Payment System." *Equipping the interdisciplinary workforce to treat Substance Use Disorders and Behavioral Health*. Springer, Cham, 2025. 515-527

Source of support: Nil; **Conflict of interest:** Nil.

Cite this article as:
Najjemba, M. & Solomon, D. " Systematic Review of the Effectiveness of Multidisciplinary Care-coordination Models for U.S. Citizens with Co-occurring Disorders." *Sarcouncil Journal of Internal Medicine and Public Health* 5.1 (2026): pp 21-29.

Publisher: SARC Publisher