# Integrative and collaborative care for multimorbidity

Michael McGee MD

Comorbidity and multi morbidity are the expectation rather than the exception. Roughly 40 to 60% of people with a substance use disorder have another mental health condition.[[1]](#endnote-1)[[2]](#endnote-2)[[3]](#endnote-3)

Up to 98% of patients seeking treatment have a history of significant trauma.[[4]](#endnote-4) The differences among clients are matters of severity and types of trauma experience. Women seeking substance use disorder treatment have rates of trauma and physical or sexual abuse approaching 99%.[[5]](#endnote-5)[[6]](#endnote-6)[[7]](#endnote-7)[[8]](#endnote-8) 60% of patients receiving psychiatric care report at least one adverse childhood experience (ACE). In general, the greater the trauma, the greater the illness and impairment.

Comorbidity is even higher in those seeking treatment, with rates exceeding 60% psychiatric and substance use disorder conditions. Rates of co-occurring substance use disorders range from 25% for anxiety disorders to approximately 80% for patients suffering from personality disorders. In general, roughly 30 to 65% of patients with a mental health condition have a cooccurring personality disorder.[[9]](#endnote-9)[[10]](#endnote-10)[[11]](#endnote-11)[[12]](#endnote-12) Many patients have multiple psychiatric conditions, which further enhances comorbidity, impairment, suffering, and risk.

Multimorbidity also extends to medical illnesses. Roughly 60 to 80% of patients with a mental illness have a cooccurring medical condition.[[13]](#endnote-13)[[14]](#endnote-14)[[15]](#endnote-15) , and medical illnesses include cardiovascular disease, diabetes, obesity, respiratory diseases, and infectious diseases. Overall, medical comorbidity leads to reduced life expectancies of 10 to 25 years for patients with chronic mental illnesses.

Multimorbidity is common. An estimated 5 to 15% of patients have impairments in all four domains of substance use disorders, personality disorders, other psychiatric conditions, and physical illness. These patients are a highly complex and vulnerable group that requires comprehensive, integrated, and collaborative care.

A bidirectional relationship exists between different psychiatric and medical conditions, with each worsening the other in a vicious cycle of morbidity. Severity of illness and impairment have a significant impact on response to treatment and the need for severity and breadth of human services, including both social and clinical services. Overall, multimorbidity significantly worsens treatment outcomes and prognosis. Thus, multi morbidity calls for a concerted effort to provide coordinated, integrated, multicomponent care, often over a sustained period consistent with a chronic disease model of care. Multidimensional assessment of clinical, medical, and social service needs, clinicians

Multi morbidity markedly increases complexity and vulnerability, darkens the prognosis of treatment, and increases healthcare costs.[[16]](#endnote-16) To optimize clinical outcomes, clinicians and treatment systems must engage in several concurrent practices:

* Comprehensive assessment, formulation, and treatment planning.
* Provide a hybrid of integrated treatment and collaborative care.
* Collaboration among both clinical service and human service agencies.

We know that integrated and collaborative care produces the best outcomes. Unfortunately, only roughly 6% of patients received treatment for both substance use disorders and other psychiatric conditions in 2021, and only 50% of patients with both conditions received treatment for either disorder.[[17]](#endnote-17)[[18]](#endnote-18)[[19]](#endnote-19) An urgent need exists to find ways to reach these patients and provide them with the integrated care they need.

## Optimizing outcomes for patients with multi morbidity

Patients with multimorbidity require integrated and collaborative care, as no one service agency can meet all the patient’s psychiatric, medical, and social needs. Service providers must provide a hybrid of integrated treatment and collaborative care based on a comprehensive assessment, formulation, and treatment plan that addresses all the patient’s clinical and social service needs. Collaboration therefore needs to occur among psychiatric clinicians, medical service providers and social service agencies.

The evolving standard of care for all mental health agencies calls to provide at least **cooccurring capable** care of substance use disorders and other psychiatric conditions. Some addiction treatment providers and other mental health agencies provide cooccurring enhanced care for patients with more severe substance use disorders or other severe psychiatric conditions.

it is useful to think of the array of clinical and social services as existing a two-dimensional matrix of clinical and social services called the “human service matrix” based on a multidimensional formulation of clinical, medical, and social service needs, clinicians develop a comprehensive treatment plan that provides a combination of integrated and collaborative services to improve psychiatric, medical, and social health.

Since no one agency can be everything to everyone, the development of collaborative capacity is critical. The science of collaboration is evolving, with organizations experimenting with different models, including formal interagency contortia.[[20]](#endnote-20)[[21]](#endnote-21)

Integrated and collaborative care provide multiple benefits including:

* Enhanced continuity of care through continuity of relationships, understandings of patients and their needs, and treatments;
* Promotion of seamless transitions between levels of care and locations of services;
* Integration of psychiatric, biomedical, and social services: and
* Reduction of disincentives for matching patients to the recommended level of care.

These benefits result in improved clinical outcomes, increased patient satisfaction, and reduced healthcare costs.[[22]](#endnote-22) Proactive collaboration also reduces the stressors and risks of transitions, preventing patients from “following through the cracks. “

## Pathways to competency and capability

Agencies must take a multipronged approach to achieving integrated and collaborative care. interventions include:

* Training, supervision, and mentoring;
* Consultation;
* Hiring;
* Structures and systems for ongoing interagency collaboration;
* Funding for integration and collaboration;
* Licensing, payer, and regulatory changes;
* Policy advocacy.

Agencies must overcome several challenges, including:

* Navigating separate funding streams;
* Working with different licensing frameworks;
* Managing workforce challenges;
* Dealing with reimbursement challenges;
* Integrating silo treatment systems;
* Managing organizational change management challenges;
* Reconciling ideological barriers;
* Developing change management expertise;
* Developing competency in collaboration and care coordination skills; and
* Resource allocation to support integration and collaboration activities.

Overcoming these challenges requires significant resources, effort, and expertise driven by strong motivation and a clear vision.

Fortunately, solutions exist to overcome the challenges of integration and collaboration. They include:

* Training;
* Recruitment;
* Clinical service redesign;
* Care coordination;
* Interagency collaboration;
* System efforts to create licensing and reimbursement models to match the continuum of integrated care;
* Implementation science ; and
* Policy advocacy.

## Collaboration

Agencies have multiple options for developing service linkages and partnerships. These include:

* Memorandums of understanding (MOU’s) and business associate agreements (BAA’s);
* Cross consultation agreements;
* Collaboration agreements; and
* Formal interagency consortia.

Payor, regulatory, and governmental agencies can play a role in aligning and promoting incentives for collaboration, assistance with facilitating collaboration, and resources to support collaboration efforts. Agency and professional organization leadership can play a key role in advocating for pro-collaborative policies and support.

Integrated and collaborative care requires significant staff training to develop cooccurring competence capability and care coordination skills. Managers should develop clear delineations of staff collaboration responsibilities. This includes procedures for notification and collaboration in urgent and emergency situations.

Collaboration capability should include formal mechanisms for facilitating information sharing. For example, agencies should implement policies that involve obtaining releases of information for all care providers at the time of intake and sending these releases to those caregivers proactively at the time of intake to facilitate information sharing from the get-go.

All programs should have robust collaborative capabilities with subspecialty, medical, and social services. Examples of good collaboration include Comprehensive, Continuous Integrated Systems of Care (CCISC) developed by Dr. Kenneth Minkoff.[[23]](#endnote-23) CCISC comprehensive, integrated, continuous care implemented systemwide to ensure accessibility for all individuals with cooccurring disorders.

Collaborative efforts should be driven by multidimensional assessment of biological, psychological and social needs. Examples include the ASAM criteria, and the level of care utilization system (LOCUS) developed by the American Association of Community Psychiatrists (AACP).

Transitions in care are times of high risk for patients. Integrated and collaborative care can reduce this risk, but require careful transition preparation and management, including follow-up and warm handoffs.

Agencies providing integrated and collaborative care should do so following principles of the chronic care model (CCM).[[24]](#endnote-24) This model emphasizes self-management support, team-based care with proactive visits and follow-up, community partnerships and advocacy, and long-term engagement and support to the various phases of recurrence and remission of mental illnesses.

### Treating Addictions

Traditional mental health facilities at several compelling reasons to develop the capacity to treat all but the most severe of addictions. Addictions are highly prevalent, being among the three most common mental illnesses, along with depression and anxiety. They are also highly harmful, being the leading cause of preventable death. They are closely intertwined with other psychiatric, healthcare, and social problems, making the integrated treatment of addictions essential. They are also highly treatable, and thus highly rewarding to treat once clinicians have proper training to do so. Since we now know that the integrated treatment of addictions with other mental illnesses optimizes outcomes, we have a mandate to provide integrated care of all psychiatric conditions, accessing subspecialty expertise in the context of severe illness and impairment.

Treating addictions involves several core competencies.[[25]](#endnote-25) While engaging patients in collaborative patient-centered care is important for all conditions, the skill of engagement is especially important when treating addictions, where ambivalence and shame are prominent dynamics.

Clinicians need to develop skills in screening, evaluation, and diagnosis of substance use disorders, including collecting collateral information if possible.

Both prescribers and nonprescribers must develop skills at facilitating withdrawal management, including soothing, reassurance, and support.

As with all psychiatric conditions, clinicians must individualize treatment based on a multidimensional assessment and formulation, and the incorporation of the patient’s preferences. The ASAM criteria provide a good framework for a multidimensional assessment and individualized treatment plan.[[26]](#endnote-26) These dimensions include**:**

* Intoxication, withdrawal, and addiction medications
* intoxication and associated risks
* withdrawal and associated risks
* addiction medication needs
* Biomedical conditions
* physical health concerns
* pregnancy -related concerns
* sleep concerns
* Psychiatric and cognitive conditions
* Active psychiatric symptoms
* persistent disability
* cognitive functioning
* trauma related needs
* psychiatric and cognitive history
* Substance use related risks
* likelihood of engaging in risky substance use
* likelihood of engaging in risky SUD-related behaviors
* Recovery environment interactions
* ability to function effectively in the current environment
* safety in current environment
* support in current environment
* cultural perceptions of substance use and addiction
* Person-centered considerations
* barriers to care
* Patient preferences
* need for motivational enhancement

Ideally, agencies should use psychometrically validated instruments. Clinicians should discern stages of change and obtain collateral input whenever possible. Clinicians should strive to go beyond diagnoses to cocreate a shared formulation with patients of what happened to them, their strengths, their challenges, what they want to achieve in their life and in treatment, and how the clinician and others can help them. This should happen prior to a level of care determination or treatment planning.

Traditional mental health agencies should provide training and support to clinicians to help them learn the ASAM criteria and use them for both level of care determinations and treatment planning. The ASAM criteria also provide detailed guidelines for service components, procedures, and timelines for the different levels of care. These guidelines serve as an invaluable roadmap to managers on their journey to cooccurring capability.

There are many paths to recovery. clinicians must be able to engage patients at their stage of change and consider both abstinence-based and harm reduction interventions. This is an important component of individualizing treatment.

As with all psychiatric conditions, case management is critical to recovery. Because addiction can be so devastating, many patients need case management to restore basic needs such as food and housing to engage in and benefit from treatment.

Clinicians should develop the capacity to provide brief interventions, especially in urgent and emergency care settings such as emergency rooms. Screening, brief intervention and referral to treatment (SBIRT) combined with proactive follow-up significantly improves engagement in treatment outcomes. Since many patients are in a pre-contemplative or contemplative stage of change, brief interventions, including motivational enhancement, may be the most appropriate intervention. When combined with warm, supportive, nonjudgmental engagement, brief interventions can plant a seed for future change in recovery.

Change is difficult, and everyone experiences ambivalence when making changes. This is normal and natural. It is especially true when considering a change in substance use. Clinicians must develop their skills in motivational interviewing to help evoke a patient’s inherent motivation for healing and recovery. Motivational interviewing is a skill that can only be learned with practice and coaching, so agencies need to provide training, coaching, and support for clinicians to practice motivational interviewing skills to become competent in them.

To overcome addictions, patients must learn to manage cravings, urges, and the triggers of cravings, urges, and negative emotional states. Clinicians must develop the ability to teach behavioral coping skills for triggers and cravings. This involves supporting and motivating patients to persist, providing encouragement and support, hope, and shame reduction in the face of episodes of return to use.

Meditation and mindfulness are evidence-based interventions for managing negative emotional states, which are prominent with substance use disorders.[[27]](#endnote-27)[[28]](#endnote-28) Clinicians Should develop the capacity to teach these skills. Coing so requires that clinicians themselves practice meditation mindfulness. Managers can facilitate this by explicitly encouraging and supporting these practices among their clinicians and other staff.

Contingency management (CM) has one of the largest effect sizes as an intervention for substance use disorders, especially when combined with other evidence-based interventions.[[29]](#endnote-29)[[30]](#endnote-30) Apart from allocating resources for this treatment modality and training staff in the effective use of CM, managers must be mindful of potential legal risks, for example kickback concerns, by ensuring compliance with evidence-based practices, documenting contingency management in treatment plans, limiting incentive values, avoiding tying incentives to referrals, having transparency with patients, monitoring the effectiveness and ethical implementation of CM procedures, and considering the use of nonmonetary incentives. Managers should keep in mind state-specific regulations, and advocate for both state and policy regulatory changes to facilitate CM.

Community reinforcement approach (CRA) focuses on modifying the patient’s environment to support recovery.[[31]](#endnote-31)[[32]](#endnote-32) ERA focuses on positive social reinforcements of recovery behaviors and reducing reinforcement for substance use. clinicians help patients bill supportive social environments and focus on social and vocational skill building as well as relapse prevention skills. clinicians encourage “sobriety sampling “ for patients to experience the benefits of a substance free lifestyle. clinicians work with loved ones to create incentives for abstinence ended focus on enhancing the capacity for enjoyment and satisfaction in a life of recovery. An important CRA methodology is Community Reinforcement And Family Training (CRAFT), in which clinicians help family members to promote the recovery of their loved ones. CRAFT emphasizes unconditional kind communication and positive incentives for recovery behavior. This remarkably effective approach can result in up to 80% of people with substance use disorders entering recovery treatment.

Addiction is a biological, psychological, and social illness. Because of this, clinicians must also learn to work with loved ones of patients and other concerned collaterals. Along with CRAFT, clinicians must learn the principles of Network Therapy developed by Mark Galanter.[[33]](#endnote-33) Network Therapy harnesses the power of a patient’s social network to promote recovery by promoting communication, problem solving skills, providing psychoeducation, arranging for ongoing positive reinforcements of recovery behavior, and facilitating long-term support of recovery.

Clinicians treating addictions must also be able to facilitate mutual help group attendance. These include 12 step groups, SMART recovery, and Recovery Dharma. It is helpful for clinicians to be able to explain the benefits of these groups, oversee attendance, and teach patients how to use these groups safely and skillfully. To do this, clinicians should attend these groups themselves to get familiar with them.

Finally, clinicians need to understand the important role of medications for addiction treatment, particularly for opioid use disorder, alcohol use disorder, and tobacco use disorder. Prescribing clinicians should receive training on the use of medications for addiction treatment.

Clinicians providing addiction psychotherapy should be adept in the following skills:

* motivational interviewing;
* relapse prevention skills;
* helping patients with disclosure and emotional resolution of past substance related behaviors;
* craving and trigger management skills;
* unearthing and addressing shame;
* managing painful emotional states and euphoric recall;
* considering limiting therapist self-disclosure;
* managing counter transference regarding past harmful behaviors associated with substance use.

As with playing a musical instrument, clinicians can only develop these skills with feedback, coaching, and practice. Managers should facilitate video recording of sessions and obtain coaches proficient in addiction psychotherapy to provide feedback and coaching.

Where there is addiction, there is also trauma, almost always before the onset of addiction, and always afterwards. All clinicians should be able to treat trauma.

As with other psychiatric conditions, agencies and clinician serve the needs of patients through a combination of developing clinical skills, Collaboration with other service providers and obtaining consultation when needed for more severely ill patients. Agencies should develop the capacity to obtain consultation when needed.

Essential components for providing cooccurring care include:

* A welcoming setting and staff
* Comprehensive screening and assessment;
* Collaboration with existing providers;
* Administering additional assessments as indicated;
* Providing integrated treatment;
* Stage assessment and stage-managed interventions for all conditions/ASAM dimensions;
* Psychoeducation;
* Symptom management skills training;
* Prescriber facilitation;
* Routine discussion of cooccurring mental health concerns;
* Cooccurring friendly recovery culture; and
* Transition preparation and planning for all conditions.

Leadership should ensure these components are put in place to achieve cooccurring capabilities.

To optimize outcomes, we are seeing a gradual shift from a medical model of “evidence-based care” to and outcome-oriented model of “practice-based evidence.” This involves privileging client experience, voice, and choice in treatment, and monitoring real-time outcomes and satisfaction.[[34]](#endnote-34) All mental health agencies, whether cooccurring capable or not, should be engaging in feedback informed treatment (FIT). Doing so can improve outcomes up to 65% and create a platform for using feedback to enhance the ability to provide effective integrated care.

Some agencies have the capacity to provide **cooccurring enhanced** care for patients with very severe distress, risk, and impairment. This would include the capacity to treat patients with severe treatment resistant psychotic illnesses and mood disorders, and patients with severe addictions unresponsive tests standard treatment interventions. Cooccurring enhanced programs have enhanced resources, expertise, and a greater capacity for containment and stabilization.

Cooccurring capable programs should have a welcoming setting with relevant patient- facing materials and signage, relevant treatment curricula, cooccurring competent staff, and a nonstigmatizing, trauma sensitive milieu.

Cooccurring confidence staff receive ongoing cooccurring training, feedback, and coaching, including feedback from patients. Clinicians can provide services either on-site or via tele-medicine as clinically indicated. Staff need access to consultation, mentoring, support, and collaboration to promote both vitality and good outcomes prevent burn out. Agencies must have access to a psychiatric prescriber competent in providing medications for addiction treatment as well as other psychopharmacology. All programs should also have crisis intervention capability.

Regarding staff training and competencies, staff should have an awareness of:

* Evidence-based interventions;
* Harm reduction strategies;
* Specific treatment population needs;
* Recurrence management strategies;
* Stigma reduction strategies; and
* Strategies for supporting effective integrated care.

To create cooccurring capability, leadership must provide several forms of ongoing training;

* Didactic
* On the job training
* Practice supports
* Continuing supervision
* Case consultation
* Mentoring
* Feedback informed Treatment (FIT) consultation
* Deliberate practice coaching

Clinical efficacy results from a combination of knowledge and skill. Skill results from feedback, coaching, and deliberate practice just beyond the bounds of the clinician’s competence. Investment by leadership in deliberate practice is a long-term investment with results accruing over a period of years. Leaders should hire clinicians with a passion for excellence, humility, and an openness to receiving feedback, and support them for engagement in deliberate practice activities.[[35]](#endnote-35)

Clinician cooccurring competencies include:

* Recognizing mental health and substance use disorder concerns;
* Delivering trauma-sensitive assessments and care
* Screening for risk;
* Triage and referral;
* Providing care coordination;
* Providing follow-up;
* Conducing operatively integrated treatment planning;
* Supporting patient engagement and adherence;
* Overcoming systemic barriers to access to care (including stigma);
* Providing individual, family/couples, and group therapy;
* Facilitating access to needed care and services; and
* Providing psychoeducation, including medications for addiction treatment.

Change, growth, and learning new skills can be challenging. It bears repeating that clinicians and other staff require significant support, guidance, coaching, and supervision in the process of developing cooccurring capability. Clinical work can be traumatic, including vicarious trauma. Clinicians need help and oversight regarding setting limits and setting boundaries. Leadership must oversee and monitor clinician wellness and vitality not only for humanistic reasons, but because clinician wellness impacts clinical outcomes.[[36]](#endnote-36)

Since no one agency can be all things to all patients, agencies must provide a hybrid of both integrated and collaborative care by leveraging several resources in the community, including:

* Behavioral health crisis systems;
* Local clinicians;
* Specialized consultation resources; (e.g. Eating disorders, Traumatic brain injury, developmental disorders);
* Psychiatric consultation;
* Psychosocial rehabilitation;
* Medical services
* Social service agencies

Agencies access these resources through a variety of formal and informal collaborative arrangements.

Cooccurring capable agencies should provide the same host of services as other agencies, to include:

* Client-centered, feedback-informed treatment (FIT)
* Group/peer/community supports;
* Case management;
* EBTs (with caveats);
* Trauma sensitive practices;
* Psychoeducation/educational materials;
* Accommodation for cognitive/functional impairment;
* Symptom management;
* Psychopharmacology; and
* Crisis intervention.

The caveat regarding evidence-based therapies is that clinicians privilege client-centered care that is relationally based upon the four components of the therapeutic alliance (understanding of the client and their identity, therapeutic relationship, goals, and the client’s preferences for achieving those goals) over predetermined evidence-based therapies. Evidence-based therapies can be useful tools when used skillfully in the context of patient-centered , outcome informed treatment. This is a requirement of all good treatment agencies, regardless of whether they are cooccurring not.

Documentation standards in integrated treatment settings primarily differ from other settings in the breath and comprehensiveness of documentation. Good documentation practices include:

* Documentation of comprehensive biopsychosocialspiritual assessments and formulations, to include current and historical symptoms and functioning;
* Treatment plans, to include both comprehensive/long term plans and focused/short term plans;
* Documentation of progress/status/interventions/responses; and
* Documentation of communication/collaboration.

While staff responsiveness is important in all service settings, it is especially important for patients suffering from multimorbidity. Staff need to provide flexible and accommodating services and arrange for additional supports through collaborative care. As with all mental health services, it is critical for clinicians to privilege patient preference and engage in shared decision-making, honoring this stage of change of patients and negotiating shared goals through good therapeutic engagement and relationship building. Agencies should arrange for the treatment of specialty needs such as eating disorders, traumatic brain injury, intellectual disability, autism spectrum disorder, and severe and persistent mental illness.

Since extratherapeutic factors account for 40% or more of variance in clinical outcomes,[[37]](#endnote-37) is critical that mental health care leaders advocate for system-level changes to provide a comprehensive integrated healing and recovery experience for patients. This means addressing cooccurring licensing, credentialing, and accreditation standards and regulations, payment models that support integrated care, and linkages with ancillary services such as harm reduction services and sobering centers.

## Conclusion

Since multimorbidity is the rule rather than the exception, all mental health agencies need to develop cooccurring care capacity. Integrated, collaborative care optimizes outcomes for patients with multimorbidity. All facilities should also have specialty expertise available for addressing more severe substance use disorders and other severe mental health conditions. This is achieved through a combination of building both integrated and collaborative capacity.

To achieve this vision, there is a need for both training and additional resources, but also systems level changes with payers, regulators, and human service delivery systems. Leaders can accomplish this through good policy, resource allocation, and the creation of intra-agency consortia.

There is hope. We are at a point where we have a clear vision of what needs to be done and how to do it. There is no doubt that both patients and society will benefit from ongoing efforts to develop our integrative and collaborative care capacity.

1. Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005 Jun;62(6):617-27. doi: 10.1001/archpsyc.62.6.617. Erratum in: Arch Gen Psychiatry. 2005 Jul;62(7):709. Merikangas, Kathleen R [added]. PMID: 15939839; PMCID: PMC2847357. [↑](#endnote-ref-1)
2. Regier DA, Farmer ME, Rae DS, Locke BZ, Keith SJ, Judd LL, Goodwin FK. Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study. JAMA. 1990 Nov 21;264(19):2511-8. PMID: 2232018. [↑](#endnote-ref-2)
3. [↑](#endnote-ref-3)
4. Mueser, K. T., Goodman, L. B., Trumbetta, S. L., Rosenberg, S. D., Osher, F. C., Vidaver, R., ... & Foy, D. W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 66(3), 493-499. DOI:10.1037/0022-006X.66.3.493 [↑](#endnote-ref-4)
5. Hien, D. A., Cohen, L. R., Miele, G. M., Litt, L. C., & Capstick, C. (2004). Promising treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry*, 161(8), 1426-1432. DOI:10.1176/appi.ajp.161.8.1426 [↑](#endnote-ref-5)
6. Jaycox, L. H., Ebener, P., Damesek, L., & Becker, K. (2004). Trauma exposure and retention in adolescent substance abuse treatment. *Journal of Traumatic Stress*, 17(2), 113-121. DOI:10.1023/B:JOTS .0000022617.41299.39 [↑](#endnote-ref-6)
7. Mueser, K. T., Goodman, L. B., Trumbetta, S. L., Rosenberg, S. D., Osher, F. C., Vidaver, R., ... & Foy, D. W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 66(3), 493-499. DOI:10.1037/0022-006X.66.3.493. [↑](#endnote-ref-7)
8. Seal, K. H., Cohen, G., Waldrop, A., Cohen, B. E., Maguen, S., & Ren, L. (2011). Substance use disorders in Iraq and Afghanistan veterans in VA healthcare, 2001–2010: Implications for screening, diagnosis, and treatment. *Drug and Alcohol Dependence*, 116(1-3), 93-101. DOI:10.1016/j.drugalcdep.2010.11.027 [↑](#endnote-ref-8)
9. Torgersen, S., Kringlen, E., & Cramer, V. (2001). The prevalence of personality disorders in a community sample. *The British Journal of Psychiatry*, 179(3), 261-266. DOI:10.1192/bjp.179.3.261 [↑](#endnote-ref-9)
10. Trull, T. J., Sher, K. J., Minks-Brown, C., Durbin, J., & Burr, R. (2000). Borderline personality disorder and substance use disorders: A review and integration. *Comprehensive Psychiatry*, 41(4), 235-252. DOI:10.1053/comp.2000.7431 [↑](#endnote-ref-10)
11. Bender, D. S., Dolan, R. T., Skodol, A. E., Sanislow, C. A., Dyck, I. R., McGlashan, T. H., ... & Gunderson, J. G. (2001). Treatment utilization by patients with personality disorders. *Psychiatric Services*, 52(6), 734-739. DOI:10.1176/appi.ps.52.6.734 [↑](#endnote-ref-11)
12. Zimmerman, M., Rothschild, L., & Chelminski, I. (2005). The prevalence of DSM-IV personality disorders in psychiatric outpatients. *Journal of Clinical Psychiatry*, 66(6), 677-685. DOI:10.4088/JCP.v66n0601, [↑](#endnote-ref-12)
13. Druss, B. G., & Walker, E. R. (2011). Mental disorders and medical comorbidity. *JAMA*, 306(17), 1912-1913. DOI:10.1001/jama.2011.1556 [↑](#endnote-ref-13)
14. De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I., ... & Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications, and disparities in health care. *World Psychiatry*, 10(1), 52-77. DOI:10.1002/j.2051-5545.2011.tb00014.x [↑](#endnote-ref-14)
15. Firth, J., Siddiqi, N., Koyanagi, A., Siskind, D., Rosenbaum, S., Galletly, C., ... & Stubbs, B. (2019). The Lancet Psychiatry Commission: A blueprint for protecting physical health in people with mental illness. *The Lancet Psychiatry*, 6(8), 675-712. DOI:10.1016/S2215-0366(19)30132-4 [↑](#endnote-ref-15)
16. SAMHSA, Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders. SAMHSA; 2002. https://portal.ct.gov./-/media/DMHAS/COSIG/CoOccurring Reportpdf.pdf. [↑](#endnote-ref-16)
17. Center for Behavioral Health Statistics and Quality. (2022). *Results from the 2021 National Survey on Drug Use and Health: Detailed tables.* Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables> [↑](#endnote-ref-17)
18. Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, Bauer MS. Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. Am J Psychiatry. 2012 Aug;169(8):790-804. doi: 10.1176/appi.ajp.2012.11111616. PMID: 22772364. [↑](#endnote-ref-18)
19. Karapareddy V. A Review of Integrated Care for Concurrent Disorders: Cost Effectiveness and Clinical Outcomes. J Dual Diagn. 2019 Jan-Mar;15(1):56-66. doi: 10.1080/15504263.2018.1518553. Epub 2019 Feb 26. PMID: 30806190. [↑](#endnote-ref-19)
20. Warmington, Paul & Daniels, Harry & Edwards, Anne & Brown, Steven & Leadbetter, Jane & Martin, Deirdre & Middleton, David. (2004). Interagency Collaboration: a review of the literature. [↑](#endnote-ref-20)
21. McGee, M.D. (1995). Interagency Collaboration: Improving Outcomes in the Treatment of Addictions. Directions in Substance Abuse Counseling, 3(2). [↑](#endnote-ref-21)
22. Karapareddy V. A Review of Integrated Care for Concurrent Disorders: Cost Effectiveness and Clinical Outcomes. J Dual Diagn. 2019 Jan-Mar;15(1):56-66. doi: 10.1080/15504263.2018.1518553. Epub 2019 Feb 26. PMID: 30806190. [↑](#endnote-ref-22)
23. Minkoff, K., & Cline, C. A. (2004). "Changing the World: The Design and Implementation of Comprehensive Continuous Integrated Systems of Care for Individuals with Co-Occurring Disorders."  
    Psychiatric Clinics of North America, 27(4), 727–743. [↑](#endnote-ref-23)
24. Coleman K, Austin BT, Brach C, Wagner EH. Evidence on the Chronic Care Model in the new millennium. Health Affairs (Project Hope). 2009 Jan-Feb;28(1):75-85. DOI: 10.1377/hlthaff.28.1.75. PMID: 19124857; PMCID: PMC5091929. [↑](#endnote-ref-24)
25. Treating addiction: a guide for professionals. second edition. Miller, WR, Forcehimes, AA, Zweben, A. [↑](#endnote-ref-25)
26. The ASAM criteria, 4th edition, Volume 1, Adult. 2023. Hazelden publishing. [↑](#endnote-ref-26)
27. Bowen, S., Chawla, N., & Marlatt, G. A. (2010). Mindfulness-Based Relapse Prevention for Addictive Behaviors: A Clinician's Guide. New York: Guilford Press. [↑](#endnote-ref-27)
28. Chiesa, A., & Serretti, A. (2014). "Are Mindfulness-Based Interventions Effective for Substance Use Disorders? A Systematic Review of the Evidence." *Substance Use & Misuse, 49*(5), 492-512. [↑](#endnote-ref-28)
29. Higgins, S. T., Silverman, K., & Heil, S. H. (Eds.). (2008). Contingency Management in Substance Abuse Treatment. New York: Guilford Press. [↑](#endnote-ref-29)
30. Prendergast, M., Podus, D., Finney, J., Greenwell, L., & Roll, J. (2006). "Contingency Management for Treatment of Substance Use Disorders: A Meta-Analysis." *Addiction, 101*(11), 1546-1560. [↑](#endnote-ref-30)
31. Smith, J. E., Meyers, R. J., & Miller, W. R. (2001). "The Community Reinforcement Approach to the Treatment of Substance Use Disorders." Alcohol Research & Health, 25(2), 116-121. [↑](#endnote-ref-31)
32. Meyers, R. J., Roozen, H. G., & Smith, J. E. (2011). "The Community Reinforcement Approach: An Update of the Evidence." Alcohol Research & Health, 33(4), 380-388. [↑](#endnote-ref-32)
33. Galanter, M. (2014). "Network Therapy for Addiction: Bringing Family and Peer Support into Office Practice." International Journal of Group Psychotherapy, 64(2), 152–175. [↑](#endnote-ref-33)
34. Prescott, DS, Maeschalck, CL< Miller, SD. Feedback informed treatment in clinical practice; reaching for excellence, 2017. American psychological Association. Washington DC. [↑](#endnote-ref-34)
35. Miller, SD, Show, D, Malines, S, Hublble, M. Field guide to better results: evidence-based exercises to improve therapeutic effectiveness. 2023. American psychological Association. Washington DC. [↑](#endnote-ref-35)
36. Delgadillo, J., Saxon, D., & Barkham, M. (2018). "Associations Between Therapists' Occupational Burnout and Their Patients' Depression and Anxiety Treatment Outcomes." [↑](#endnote-ref-36)
37. Wampold, B. E., & Imel, Z. E. (2015). The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work (2nd ed.). New York: Routledge. [↑](#endnote-ref-37)