BOOTING UP THE SYSTEM: CASE MANAGEMENT MODELS, PRINCIPLES AND PRACTICES

3 Continuing Education Credits

Asynchronous Distance Learning Course

Content Level: Beginning

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Last Updated: 2026

Approved by such credentialing bodies as:

- **National Association of Alcoholism and Drug Abuse Counselors (NAADAC) #94564**
- **National Board of Certified Counselors (NBCC) #6310**

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He has been a psychotherapist in private practice and served as a consultant to dozens of local,.

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Evolving Case Management Models for Substance Use Disorders

Since this course was originally developed, the landscape of case management in substance use treatment has shifted substantially. Three areas deserve particular attention: outreach models for hard-to-reach populations, the integration of peer support specialists, and the ongoing challenge of workforce development.

Outreach and Engagement Models

A 2026 systematic review and network meta-analysis examining outreach models for individuals experiencing homelessness and substance use disorders synthesized the comparative effectiveness of multiple approaches, including assertive community treatment, intensive case management, and the Community Reinforcement Approach (Ghafouri et al., 2026). The findings reinforce what many practitioners already suspect: sustained, proactive engagement produces better outcomes than waiting for clients to seek services on their own. For case managers working with criminal justice populations or individuals cycling through emergency services, these findings affirm the value of meeting clients where they are -- literally and figuratively.

Peer Support Integration

One of the most significant developments in case management practice has been the growing role of peer support specialists. Hamilton et al. (2022) examined peer support in criminal justice settings specifically for opioid use disorder and found that these specialists remain underutilized despite clear benefits. Peers help clients navigate the healthcare system, support reintegration into the community, and improve adherence to treatment goals. Their lived experience provides a bridge that traditional case managers, regardless of clinical skill, cannot always replicate. For substance abuse counselors coordinating care across systems, understanding how to collaborate with and appropriately deploy peer specialists has become an essential competency rather than an optional enhancement.

Workforce Development Challenges

The substance use treatment workforce faces persistent training gaps that directly affect case management quality. Scott et al. (2022) analyzed 258 training events involving 10,143 participants and documented a sharp increase in demand for workforce development during the early COVID-19 pandemic period. The training needs identified spanned multiple domains, including evidence-based practices, provider self-care, leadership development, health equity, stigma reduction, and consumer needs. For case managers, this signals that the field is actively evolving, and that staying current requires ongoing professional development beyond initial certification. The sheer scale of demand (over ten thousand participants across these events) also points to a workforce that recognizes its own knowledge gaps and is actively seeking to address them.

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Implications for Practice

Taken together, these developments suggest that effective case management in 2026 requires fluency in outreach-based engagement, meaningful collaboration with peer support staff, and a commitment to continuous learning. The traditional brokerage model -- referring clients to services and following up periodically -- is no longer sufficient on its own. Counselors who can integrate assertive outreach, peer partnerships, and evidence-based engagement strategies will be better positioned to serve clients across the complex systems they navigate.

Recovery Capital and Case Management Outcomes

The concept of recovery capital -- the personal, social, and community resources that support sustained recovery -- has emerged as a critical framework for understanding case management effectiveness. Recent research has examined how recovery capital develops during treatment, how physical health intersects with recovery resources, and how workforce development and treatment court participation shape outcomes.

Headid et al. (2024) compared 39 SUD treatment completers with 30 non-completers and found that both groups began treatment with similarly limited recovery capital. Graduates, however, showed substantially more resources by discharge, including stronger social connections, improved coping skills, and greater community engagement (Headid et al., 2024). For case managers, this finding suggests that actively facilitating the accumulation of recovery capital -- through resource linkage, skills building, and social connection -- may be more impactful than attempting to screen for pre-existing strengths at intake. The case management role shifts from assessing what clients already have to building what they need.

Osborne and Kelly (2023) investigated the relationship between physical health and recovery capital in SUD treatment. The study found that untreated physical health problems undermined recovery by consuming resources and attention that could otherwise support sobriety. Conversely, addressing health conditions enhanced recovery capital across multiple domains including knowledge, autonomy, and social connection (Osborne & Kelly, 2023). For case managers coordinating care, this research provides evidence that health services linkage is not merely a supplementary function -- it is a core recovery support. Clients whose medical needs go unmet face a steeper path to sustained recovery, regardless of how effective their addiction treatment may be.

Mendoza et al. (2022) described an Interdisciplinary Training Academy that provided 30 weeks of interprofessional rotations totaling 7,257 hours of supervised training across policy, prevention, treatment, integrated care, harm reduction, and recovery support services. The academy addressed workforce development gaps by training practitioners to work across disciplinary boundaries (Mendoza et al., 2022). For case management practice, this model represents the type of cross-system fluency that effective coordination requires. Case managers who understand the perspectives and workflows of medical, behavioral health, and social service providers are better equipped to navigate the fragmented systems their clients must traverse.

Knapp et al. (2024) tracked recovery capital trajectories in 165 drug treatment court clients over the

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course of one year and found that education level predicted gains in recovery capital, particularly for opioid intervention court (OIC) participants. Clients with a high school diploma or GED at baseline accumulated recovery resources more rapidly within OIC settings. Additionally, the relationship between drug use and recovery capital strengthened over time among OIC participants -- as treatment progressed, the negative impact of continued substance use on recovery capital became more pronounced (Knapp et al., 2024). For case managers working with treatment court populations, this finding highlights the value of educational support as a case management function and suggests that recovery capital monitoring should be integrated into ongoing case reviews rather than conducted only at intake and discharge.

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Part 1

Introduction to Substance Abuse and Case Management

The term case management has appeared in social services literature more than 600 times in the last 30 years, referring to everything from the routing of court dockets through the judicial system to the medical management of hospitalized patient's care. This course uses the term to refer to interventions designed to help substance abusers access needed social services.

As the term "booting up the system" is used to describe full access to a computer's capability, case management is the term used to refer to providing full access to social, criminal justice, or health care systems to a substance abuser. Case management involves monitoring and supervising a substance abuser's progress according to a variety of models, principles, and practices. This course presents an overview of these elements of casework or case management (SAMHSA, 2020).

Support for the use of case management in this setting is developed from both clinical practice and empirical observation suggesting that substance abusers who seek treatment have significant problems in addition to using psychoactive substances. Alcohol or other drug use often damages many aspects of an individual's life, including housing, employment, and relationships. Clients in substance abuse treatment (NIDA, 2024) programs, particularly publicly funded treatment programs, present a variety of associated problems. Many use multiple substances and may be poly-addicted. Many suffer from related health disorders, either caused by their substance abuse - such as liver disease and organic brain disorders - or exacerbated by neglect of health and lack of preventive health care. In addition, some diseases—including HIV/AIDS, tuberculosis, and some strains of hepatitis—are transmitted by substance abuse, either directly or indirectly.

Substance abusers also have a higher incidence of mental health disorders than the general population (SAMHSA, 2024). Up to 70 percent of individuals treated for substance abuse have a lifetime history of depression. Between 23 and 56 percent of individuals with diagnosable mental health conditions also have a substance abuse or dependence disorder (SAMHSA, 2024).

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Substance abuse clients often arrive in treatment programs with numerous social problems as well. Many are unemployed or under-employed, lacking job skills or work experience. Many in publicly funded treatment programs do not have a high school diploma. Some are homeless, and those who have been incarcerated may face significant barriers in accessing safe and affordable housing. Many substance abuse clients have alienated their families and friends or have peer affiliations only with other substance abusers. Women in treatment have often been victims of domestic violence, including sexual abuse; some women in treatment may be living with an abuser. Achieving and maintaining abstinence and recovery nearly always requires forming new, healthy peer associations.

A significant number of clients in treatment are also under some form of control by the criminal justice system. Criminal justice substance abuse clients represent more than half of all clients in treatment in many state and local jurisdictions. Although those afflicted by chemical addiction are found among all socioeconomic groups, persons already plagued by poverty, disease, and unemployment are over-represented. Particularly in publicly funded treatment programs, substance abuse clients have limited resources and may lack health insurance. Many are eligible for publicly supported health and social benefits, including Medicare, food stamps, or welfare.

Data suggest that substance abusers who receive professional attention for these additional problems will see improvements in occupational and family functioning and a lessening of psychiatric symptoms. Clinicians who develop a "helping alliance" with substance abusers have been shown to produce better treatment outcomes than those who do not (SAMHSA, 2024).

Why Case Management?

Because addiction affects so many facets of the addicted person’s life, a comprehensive continuum of services promotes recovery and enables the substance abuse client to fully integrate into society as a healthy, substance-free individual. The continuum must be designed to provide engagement and motivation, primary treatment services at the appropriate intensity and level, and support services that will enable the individual to maintain long-term sobriety while managing life in the community. Treatment must be structured to ensure smooth

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transitions to the next level of care, avoid gaps in service, and respond rapidly to the treat of relapse. Case management can help accomplish all of the above.

Case management is needed because, in most jurisdictions, services are fragmented and inadequate to meet the needs of the substance-abusing population. This lack of coordinated services results from a variety of factors, including

- Different funding streams. Substance abuse treatment is funded from a variety of sources - block grants, competitive grants, state and local funding, criminal justice funding, and others. The different requirements or goals of these sources can result in a piecemeal approach to programming
- A focus on program funding rather than system funding
- Funding focused on single modalities rather than a continuum of care
- Inadequate funding created by missing pieces in the continuum
- Waiting lists caused by inadequate funding
- Barriers between systems (e.g., mental health vs. substance abuse, criminal justice vs. mental health and substance abuse)
- Lack of incentives geared to client outcome; programs rewarded for process measures, not outcome measures
- Eligibility/admission criteria that exclude certain clients
- Lack of agreement on priority for admission/treatment
- Lack of incentives for programs to work together

Due to the fragmentation of services, the accompanying inefficiency, and a growing scarcity of resources, some form of case management is used with virtually every population that routinely seeks social services. The variability in social services system configurations has led to many different implementations of case management, resulting in conceptual disagreements about case management and difficulty in assessing its value. Inevitably, many of the same issues will arise in the substance abuse setting. The course is designed to establish a common starting point for case management work with substance abusers. To address at least some of those conceptual disagreements, the course makes several assumptions, including

9. Case management is a set of social service functions that helps clients access the resources they need to recover from a substance abuse problem. The functions that comprise case management - assessment, planning, linkage, monitoring, and advocacy - must always be adapted to fit the particular needs of a treatment or agency setting. The resources an individual seeks may be external in nature (e.g., housing and education) or internal (e.g., identifying and developing skills) (SAMHSA, 2020).
10. Advocacy is one of case management's hallmarks. While a professional who is conducting therapy may speak out on behalf of a client, case management is dedicated to making services fit clients, rather than making clients fit services (SAMHSA, 2020).
11. Case management may be implemented by an individual dedicated solely to helping the client access needed resources - case manager - or by a professional who has this responsibility along with therapeutic or counseling functions. This course stresses the intervention rather than the intervener's profession.
12. The primary difference between case management and therapy is that the former stresses resource acquisition, while the latter focuses on facilitating intra- and interpersonal change. However, case management and therapy are not incompatible. Indeed, both are generally called for in addressing the needs of a majority of substance abuse clients.
13. When implemented to its fullest, case management challenges the addiction treatment continuum of pretreatment, primary treatment, and aftercare. This occurs because of the advocacy function of case management; the need for case managers to be flexible, community-based, and community-oriented; and the need for case managers to be the primary figures in planning work with the client (SAMHSA, 2020).

These assumptions are all affected by the setting in which case management is practiced. Practitioners who work with substance abusers do so in methadone maintenance clinics, hospital- and community-based addiction programs, local social service departments, family preservation programs, and storefront community outreach programs. These physical settings are in turn influenced by numerous other factors, including the source(s) of an agency's funding; the agency's mission; staff orientation, education, and training; the agency's treatment philosophy; and the makeup of other social services in a particular geographical area.

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Complicating the implementation of case management with substance abusers are three trends that will alter the current manner in which substance abuse treatment (NIDA, 2024) and case management are implemented: Managed Care, treatment provided in the criminal justice system, and diminishing social services and resources. Managed Care uses case management to restrict access to services as well as to facilitate access to services. In addition to the issue of cost containment, the movement of a great deal of substance abuse treatment (and thereby case management) into criminal justice venues is significant. The potential conflicts between coerced involvement in treatment and case management will test the limits of advocacy and client-driven aspects of the intervention. Finally, unlike the early period of case management, clients and professionals practicing case management now negotiate a drastically constricted menu of services. Each of these contemporary conditions makes implementation and evaluation an increasingly difficult task (SAMHSA, 2020).

Case Management – A Brief History

More than 70 years ago when Mary Richmond envisioned a cadre of “friendly neighbors” helping others in their struggles with real world needs, she created not only the field of social work, but case management as well. While she applied the term ‘social casework’ to the activities that affected the adjustment between an individual and the social environment, she could well have been describing the key functions that now comprise case management.

One of the first legislative embodiments of case management occurred in the 1963 Federal Community Mental Health Center Act in anticipation of deinstitutionalization, in which persons in long-term psychiatric care were moved into community settings (SAMHSA, 2020). The expectation that these individuals would need services previously provided in the institution led to the rapid expansion of community-based social services. Unfortunately, these services were often created independently of one another and, coupled with the categorical nature of the eligibility for services, led to difficulties for persons used to having these services provided in institutions. The Community Support System developed by the National Institutes of Mental Health in 1977 envisioned case management as a mechanism for helping clients navigate this fragmented social service system (SAMHSA, 2020). Accessing these resources would thus

enable them to live and function adequately in their communities. Substance abusers historically were never institutionalized as often as were persons with chronic mental illness and so were not directly impacted by deinstitutionalization legislation. Substance abusers were not generally targeted for the development of categorical systems of service delivery and were not generally recipients of case management services. However, case management-like services were provided to substance abusers under other titles, such as "mission work," and frequently delivered by the clergy or others in skid row missions, detoxification centers, and ad hoc halfway houses. Jails and county work farms were generally the institutions of choice in dealing with this population. Only after substance abuse began to be decriminalized and defined as a disease were substance abusers referred to various social services (NIDA, 2024).

Policymakers in Canada were among the first to translate many generic case management functions into the field of substance abuse treatment (NIDA, 2024), outlining the essential elements of a union of case management and substance abuse treatment. Case management for substance abusers initially gained attention in the United States through the Treatment Alternatives for Safe Communities (TASC) program (formally known as Treatment Alternatives to Street Crime), which began linking the criminal justice system with the drug abuse treatment system in 1972 and has grown to over 185 programs today.

A 1987 National Institute of Mental Health initiative funded 13 demonstration projects targeted at young adults with coexisting mental health and substance use problems, reflecting the broader evolution of case management approaches during the 1980s (SAMHSA, 2020). Of these 13 projects, 10 identified some form of case management as a primary service and provided a general description of the case management intervention. Initiatives undertaken by both the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) resulted in numerous projects that used case management to enhance treatment. Case management in these projects was designed to increase retention in the treatment continuum and to improve treatment outcomes.

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Definitions and Functions

Any definition of case management today is inevitably contextual, based on the needs of a particular organizational structure, environmental reality, and prior training of the individuals who are implementing it, whether they are social workers, nurses, or case management specialists. Nonetheless, there is relatively widespread agreement on the basic definition, (SAMHSA, 2020), as illustrated in Figure 1.

While definitions are useful in guiding general discussions, functions are a more helpful way to approach case management as it is actually practiced. As with definitions, there is a high degree of consensus about a core group of functions. One widely accepted set of functions comprises (1) assessment, (2) planning, (3) linkage, (4) monitoring, and (5) advocacy. The National Association of Social Workers' standards for social work case management include assessing, arranging, coordinating, monitoring, evaluating, and advocacy (SAMHSA, 2020).

There is also general agreement about case management functions in the specific context of substance abuse treatment (NIDA, 2024). Case management is one of eight counseling skills identified by the National Association of Alcoholism and Drug Abuse Counselors and one of five performance domains developed in a Role Delineation Study.

Another framework is supplied by the Addiction Technology Transfer Centers (ATTCs), established by CSAT to transmit current information on treatment to providers in the field. The essential elements of case management are laid out in their publication Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice. The document has been endorsed by many leading addiction organizations.

Referral and service coordination are two of eight practice dimensions the ATTCs deem essential to the effective practice of addiction counseling. Activities considered part of those two dimensions include engagement; assessment; planning, goal-setting, and implementation; linking, monitoring, and advocacy; and disengagement. The document defines service coordination as: "The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan." Service coordination, which includes case management

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and client advocacy (SAMHSA, 2020), establishes a framework of action for the client to achieve specified goals. It involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed care systems, client advocacy, and ongoing evaluation of treatment progress and client needs.

Definitions of Case Management

Case management is:

- “planning and coordinating a package of health and social services that is individualized to meet a particular client’s needs”
- “[a] process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner”
- “helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once”
- “monitoring, tracking and providing support to a client, throughout the course of his/her treatment and after” (SAMHSA, 2020)
- “assisting the patient in re-establishing an awareness of internal resources such as intelligence, competence, and problem solving abilities; establishing and negotiating lines of operation and communication between the patient and external resources; and advocating with those external resources in order to enhance the continuity, accessibility, accountability, and efficiency of those resources”
- “assess[ing] the needs of the client and the client’s family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client’s complex needs.”

Models of Case Management with Substance Abusers

Case management models, like the definitions of case management, vary with the context. Some models focus on delivering social services, other on coordinating the delivery of services by other providers. Some provide both. The models result as much from the needs of specific client populations and service settings as they do from distinct theoretical differences about

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what case management should be. Four models from the mental illness field have been adapted for the field of substance abuse treatment (NIDA, 2024). Each of these models—broker/generalist, strengths-based, assertive community treatment, and clinical/rehabilitation—has proved valuable in treating substance abusers in a particular setting (McGahan et al., 2023).

For example, the strengths-based approach was adapted to work with crack cocaine users. This approach was chosen not only for its focus on resource part of recovery. Assertive community treatment was implemented to provide parolees a wide range of integrated services, including drug treatment, skills building, and resource acquisition.

Figure 1

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Figure 1

Primary Case Management Activities	Broker/Generalist	Strengths Perspective	Assertive Community Treatment	Clinical/ Rehabilitation
Conducts outreach and case finding	Not usually	Depends on agency mission & Structure	Depends on agency mission & Structure	Depends on agency mission & Structure
Provides assessment and ongoing reassessment	Specific to immediate resource acquisition needs	Strengths-based, applicable to any of client life areas	Broad-based, part of a comprehensive (biopsychosocial) assessment	Broad-based, part of a comprehensive (biopsychosocial) assessment
Assists in goal planning	Generally brief, related to acquiring resources, possibly informal	Client-driven, teaches specific process on how to set goals and objectives, goals may include any of client life areas	Comprehensive goals may include any of client life areas.	Comprehensive goals may include any of client life areas.
Makes referral to needed resources	Case manager may initiate contact or have client make contact on own	As negotiated with client, may contact resource, accompany client, or client may contact on own	As needed, many resources integrated into broad package of case management services	As negotiated with client, may contact resource, accompany client, or client may contact on own
Monitors referrals	Follow-up checks made	Close involvement in ongoing relationship between client and resource	Close involvement in ongoing relationship between client and resource	Close involvement in ongoing relationship between client and resource

Models of Case Management (CDC, 2024)

Brokerage/Generalist

Brokerage/generalist models seek to identify client's needs and help clients access identified resources. Planning may be limited to the client's early contacts with the case manager rather than an intensive long-term relationship. Ongoing monitoring, if provided at all, is relatively brief and does not include active advocacy (SAMHSA, 2020).

Brokerage/generalist models are sometimes disparaged in discussions of case management because of the limited nature of the client-case manager relationship and the absence of

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advocacy. Nonetheless, this approach shares the basic foundations of case management and has proven useful in selected situations. The relatively limited nature of the relationship in this model allows the case manager to provide services to more clients. This approach is also appropriate in instances where treatment and social services in a particular area are relatively integrated and the need for monitoring and advocacy is minimal. The model works best with clients who are not economically deprived, who have significant intent and sufficient resources, or who are not in late-stage addiction. Small agencies or agencies that offer narrowly defined services may be in an ideal position to offer brokerage-only services (SAMHSA, 2020).

Two creative uses of a brokerage model involved clients who were infected with the human immunodeficiency virus (HIV) or who were at significant risk of acquiring HIV. In one program, case managers also served as educators, delivering cognitive, behaviorally oriented, educational sessions focusing on substance abuse and high-risk behaviors. The mixing of the educator and case manager role (SAMHSA, 2020)s was intended to increase clients' receptivity to HIV prevention messages by reducing barriers to services that would address problems that might divert attention from those messages. In another variation of the brokerage model, case managers in a large metropolitan area conducted extensive assessments with HIV-infected clients, generally making at least two referrals during the initial session. This "quick response" approach was intended to provide immediate results to clients and to link them with agencies or services that would provide ongoing services.

Assertive Community Treatment

The Program of Assertive Community Treatment (PACT) model, originally developed in Wisconsin, emphasizes the following components (UNC Center for Excellence in Community Mental Health, 2024):

- Making contact with clients in their homes and natural settings
- Focusing on the practical problems of daily living
- Assertive advocacy
- Manageable caseload sizes
- Frequent contact between a case manager and client

- Team approach with shared caseloads
- Long-term commitment to clients

This model was among the first to adapt a mental health model for persons with substance abuse problems, specifically chronic public inebriates. Following the tenets of PACT, an individual case manager was closely supported by a core services team that together carried the responsibility for providing services. The model deviated from the usual approach to dealing with substance abuse clients in two ways. First, instead of expecting clients to come to services when they “hit bottom,” case managers sought out clients through a process known as “enforced contact.” Second, case managers and the services’ team acknowledged the chronic nature of the client’s condition and sought to modify the course of the condition and to alleviate suffering. The clients were not required to pledge a goal of abstinence.

Strengths-Based Perspective

The strengths-based perspective of case management was originally developed at the University of Kansas School of Social Welfare (NASW, 2024) to help a population of persons with persistent mental illness make the transition from institutionalized care to independent living (Dissanayake et al., 2024). The foremost two principles on which the model rests are (1) providing clients support for asserting direct control over their search for resources, such as housing and employment, and (2) examining clients’ own strengths and assets as the vehicle for resource acquisition. To help clients take control and find their strengths, this model of case management encourages use of informal helping networks (as opposed to institutional networks); promotes the primacy of the client-case manager relationship; and provides an active, aggressive form of outreach to clients.

A strengths perspective of case management has been selected for work with substance abusers for three reasons. First is case management’s usefulness in helping them access the resources they need to support recovery. Second, the strong advocacy component that characterizes the strengths approach counters the widespread belief that substance abusers are in denial or morally deficient - perhaps unworthy of needed services. Last, the emphasis on helping clients identify their strengths, assets, and abilities supplements treatment models that

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focus on pathology and disease. Strengths-based case management has been implemented with both female and male substance abusers (SAMHSA, 2020).

Clinical/Rehabilitation

Many substance abuse treatment (NIDA, 2024) programs use a clinical model in which the same treatment professional provides, or at least coordinates, both therapy and case management activities. Such an approach is frequently driven by staffing considerations: It is more economical to have one treatment professional provide all services than to have separate clinical and case managers deliver them (SAMHSA, 2020).

One example of combining clinical and case management activities is found in a program for women who have substance abuse problems. In Project Second Beginning (SAMHSA, 2024), an emphasis on relationships and empowerment is used both to secure needed resources and to guide implementation of therapy activities. This approach is based on the belief that women have special needs in the treatment setting – needs that can most appropriately be addressed through a therapeutic relationship with a single caregiver. The clinical/rehabilitation approach has been widely used in the treatment of persons with diagnoses of both substance abuse and psychiatric problems. The Case Management Orientation Inventory (CMOI), found at the end of this course, will help understand these four models.

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Part 2

Applying Case Management to Substance Abuse Treatment

Case management is almost infinitely adaptable, but several broad principles are true of almost every application. This chapter will discuss those principles, the competencies necessary to implement case management functions, and the relationship between those functions and the substance abuse treatment (NIDA, 2024) continuum. For the purposes of discussion, case management and substance abuse treatment are presented as separate and distinct aspects of the treatment continuum, although in reality they are complementary and at times thoroughly blended.

Case Management Principles

Case Management offers the client a single point of contact with the health and (SAMHSA, 2020) social services systems. The strongest rationale for case management may be that it consolidates to a single point of responsibility for clients who receive services from multiple agencies. Case management replaces a haphazard process of referrals with a single, well-structured service. In doing so, it offers the client continuity. As the single point of contact, case managers have obligations not only to their clients but also to the members of the systems with whom they interact.

Case managers must familiarize themselves with protocols and operating procedures observed by these other professionals. The case manager must mobilize needed resources, which requires the ability to negotiate formal systems, to barter informally among service providers, and to consistently pursue informal networks. These include self-help groups and their members, halfway and three-quarter-way houses, neighbors, and numerous other resources that are sometimes not identified in formal service directories.

Case management is client-driven and driven by client need. Throughout models of case management, in the substance abuse field and elsewhere, there is an overriding belief that clients must take the lead in identifying needed resources. The client's right of self-

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determination is emphasized. Once the client chooses from the options identified, the case manager's expertise comes into playing again in helping the client access the chosen services.

Case management is grounded in an understanding of clients' experiences and the world they inhabit – the nature of addiction and the problems it causes, and other problems with which clients struggle (such as HIV infection, mental illness, or incarceration). This understanding forms the context for the case manager's work, which focuses on identifying psychosocial issues and anticipating and helping the client obtain resources. The aim of case management is to provide the least restrictive level of care necessary so that the client's life is disrupted as little as possible.

Case management involves advocacy. The paramount goal when dealing with substance abuse clients and diverse services with frequently contradictory requirements is the need to promote the client's best interests. Case managers need to advocate with many systems, including agencies, families, legal systems, and legislative bodies. The case manager can advocate by educating non-treatment service providers about substance abuse problems in general and about the specific needs of a given client.

At times the case manager must negotiate an agency's rules in order to gain access or continued involvement on behalf of a client. Advocacy can be vigorous, such as when a case manager must force an agency to serve its clients as required by law or contract. For criminal justice clients, advocacy may entail the recommendation of sanctions to encourage client compliance and motivation (SAMHSA, 2020).

Case management is community-based (NASW, 2024). All case management approaches can be considered community-based because they help the client negotiate with community agencies and seek to integrate formalized services with informal care resources such as family, friends, self-help groups, and church. However, the degree of direct community involvement by the case manager varies with the agency. Some agencies mount aggressive community outreach efforts. In such programs, case managers accompany clients as they take buses or wait in lines to register for entitlements.

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This personal involvement validates clients' experiences in a way that other approaches cannot. It suits the subculture of addiction because it enables the case manager to understand the client's world better, to learn what streets are safe and where drug dealing takes place. This familiarity helps the professional appreciate the realities that clients face and set more appropriate treatment goals – and helps the client trust and respect the case manager. Because it often transcends facility boundaries, and because the case manager is more involved in the community and the client's life, case management may be more successful in re-engaging the client in treatment and the community than agency-based efforts.

For clients who are institutionalized, case management involves preparing the client for community-based treatment and living in the community. Case management can ensure that transitions are smooth and that obstacles to timely admissions into community-based programs are removed. Case management can also coordinate release dates to ensure that there are no gaps in service. The type of relationship described here is likely at times to stretch the more narrow boundaries of the traditional therapist-client relationship.

Case management is pragmatic. Case management begins "where the client is," by responding to such tangible needs as food, shelter, clothing, transportation, or child care. Entering treatment may not be a client priority; finding shelter, however, may be. Meeting these goals helps the case manager develop a relationship with and effectively engage the client. This client-centered perspective is maintained as the client moves through treatment engagement (SAMHSA, 2024). For example, the loss of housing may provide the impetus for residential treatment. Teaching clients the day-to-day skills necessary to live successfully and substance free in the community is an important part of case management. These pragmatic skills may be taught explicitly, or simply modeled during interaction between case manager and client.

Case management is anticipatory. Case management requires an ability to understand the natural course of addiction and recovery, to foresee a problem, to understand the options available to manage it, and to take appropriate action. In some instances, the case manger may intervene directly; in others, the case manager will take action to ensure that another person on the care team intervenes as needed. The case manager, working with the treatment team, lays the foundation for the next phase of treatment.

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Case management with substance abusers must be adaptable to variations occasioned by a wide range of factors, including co-occurring problems such as AIDS or mental health issues, agency structure, availability or lack of particular resources, degree of autonomy and power granted to the case manager, and many others. The need for flexibility is largely responsible for the numerous models of case management and difficulties in evaluating interventions.

Case management is culturally sensitive. Accommodation for diversity, race, gender, ethnicity, disability, sexual orientation, and life stage (for example, adolescence or old age), should be built into the case management process. Five elements are associated with becoming culturally competent: (1) valuing diversity, (2) making a cultural self-assessment, (3) understanding the dynamics of cultural interaction, (4) incorporating cultural knowledge, and (5) adapting practices to the diversity present in a given setting.

Case Management Practice – Knowledge, Skills, and Attitudes

All professionals who provide services to substance abusers, including those specializing in case management, should possess particular knowledge, skills, and attitudes that prepare them to provide more treatment-specific services. The basic prerequisites of effective practice include the ability to establish rapport quickly, an awareness of how to maintain appropriate boundaries in the fluid case management relationship, the willingness to be nonjudgmental toward clients, and certain “transdisciplinary foundations” created by the Addiction Technology Transfer Centers (ATTCs). These foundations – understanding addiction, treatment knowledge, application to practice, and professional readiness – are articulated in 23 competencies and 82 specific points of knowledge and attitude. Examples of competencies include: (SAMHSA, 2024)

- Understanding a variety of models and theories of addiction and other problems related to substance use
- Ability to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems
- Recognizing the importance of family, social networks, and community systems in the treatment and recovery process

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- Understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits
- Understanding diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice
- Understanding the value of an interdisciplinary approach to addiction treatment

Even though case managers have not always enjoyed the same stature accorded other specialists in the substance abuse treatment continuum, they must possess an equally extensive body of knowledge and master a complex array of skills in order to provide optimal services to their clients. Case mangers must not only have many of the same abilities as other professionals who work with substance abusers (such as counselors), they must also possess special abilities relating to such areas as interagency functioning, negotiating, and advocacy. In recognition of the specific competencies applicable to conducting case management functions, two of the eight core dimensions – referral and service coordination (SAMHSA, 2020) – provide critical knowledge, skills, and attitudes pertinent to case management. Below are the activities covered under those dimensions:

Referral

- Establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources (SAMHSA, 2020), and help to address unmet needs
- Continuously assess and evaluate referral resources to determine their appropriateness
- Differentiate between situations in which it is more appropriate for the client to self-refer to a resource and those in which counselor referral is required
- Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs (SAMHSA, 2020)
- Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow-through

- Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and professional standards of care
- Evaluate the outcome of the referral

Service Coordination

Implement the treatment plan

- Initiate collaboration with referral source
- Obtain, review, and interpret all relevant screening, assessment, and initial treatment-planning information
- Confirm the client's eligibility for admission and continued readiness for treatment and change
- Complete necessary administrative procedures for admission to treatment
- Establish realistic treatment and recovery expectations with the client and involved significant others including, but not limited to:
    - Nature of services
    - Program goals
    - Program procedures
    - Rules regarding client conduct
    - Schedule of treatment activities
    - Costs of treatment
    - Factors affecting duration of care
    - Client rights and responsibilities
- Coordinate all treatment activities with services provided to the client by other resources

Consulting

- Summarize the client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress for purpose of ensuring quality of care, gaining feedback, and planning changes in the course of treatment

- Understand terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders
- Contribute as part of a multidisciplinary treatment team
- Apply confidentiality regulations appropriately
- Demonstrate respect and nonjudgmental attitudes toward clients in all contacts with community professionals and agencies

Almost 200 specific knowledge items, skills, and attitudes are associated with these dimensions.

The Substance Abuse Treatment Continuum and Functions of Case Management (SAMHSA, 2020)

Substance Abuse Continuum of Care

Substance abuse treatment can be characterized as a continuum arrayed along a particular measure, such as the gravity of the substance abuse problem, level of care – inpatient, residential, intermediate, or outpatient – or intensity of service. The continuum in this is arranged chronologically, moving from case finding and pretreatment through primary treatment, either residential or outpatient, and finally to aftercare. Inclusion of case finding and pretreatment acknowledges the wide variety of case management activities that take place before a client has actually become part of the formal treatment process. While distinct goals and treatment activities are associated with each point on the continuum, clients' needs seldom fit neatly into any one area at a given time. For example, a client may need residential treatment for a serious substance abuse problem, but only be motivated to receive assistance for a housing problem. Case management is designed to span client needs (SAMHSA, 2020) and program structure.

Case finding and pretreatment

The case-finding aspect of treatment is generally of paramount concern to treatment programs because it generates the flow of clients into treatment. Pretreatment has changed enormously in the past five years as programs have closed, resources have dwindled, and services available under managed care plans have been severely curtailed. Many individuals identified as viable

treatment candidates cannot get through the gate, and pretreatment may in fact constitute brief intervention therapy. Treatment programs may undertake case-finding activities through formal liaisons with potential referral sources such as employers, law enforcement authorities, public welfare agencies, acute emergency medical care facilities, and managed care companies. Health maintenance organizations and managed care companies often require case finding when hotlines are called. General media campaigns and word of mouth also lead substance abusers to contact treatment programs.

Some treatment programs operate aggressive outreach street programs to identify and engage clients. Outreach workers contact prospective clients and offer to facilitate their entry into treatment. Although treatment admission may be the foremost goal of the worker and the treatment program, prospective clients frequently have other requests before agreeing to participate. Much of the assistance offered by outreach workers resembles case management in that it is community-based, responds to an immediate client need, and is pragmatic.

A pretreatment period is frequently the result of waiting lists or client reluctance to become fully engaged in primary treatment. In a criminal justice setting, it may be a time to prepare clients who are not ready for primary treatment because they do not have support systems in place and lack homes, transportation, or necessary work and living skills. The pretreatment period may be when clients lose interest in treatment. When the appropriate services are provided, however, it may actually increase the commitment to treatment at a later time. Numerous interventions – role induction techniques, pretreatment groups, and case management – have been instituted to improve outcomes associated with the pretreatment period.

Primary treatment

Primary treatment is a broad term used to define the period in which substance abusers begin to examine the impact of substance use on various areas of their lives. The American Society of Addiction Medicine (ASAM, 2023) (ASAM) delineates five categories of primary treatment, characterized by the level of treatment intensity: early intervention, outpatient services, intensive outpatient or partial hospitalization, residential or inpatient services, and medically

managed intensive inpatient services. Whatever the setting, an extensive biopsychosocial (NIDA, 2024) assessment is necessary. This assessment provides both the client and the treatment team the opportunity to determine clinical severity, client preference, coexisting diagnosed, prior treatment response, and other factors relevant to matching the client with the appropriate treatment modality and level of care. If not already established during the case finding/pretreatment phase, this assessment should also consider the client's needs for various resources that case management can help secure.

Aftercare

Aftercare, or continuing care, is the stage following discharge, when the client no longer requires services at the intensity required during primary treatment. A client is able to function using a self-directed plan, which includes minimal interaction with a counselor. Counselor interaction takes on a monitoring function. Clients continue to reorient their behavior to the ongoing reality of a pro-social, sober lifestyle. Aftercare can occur in a variety of settings, such as periodic outpatient aftercare, relapse/recovery groups, 12-Step and self-help groups, and halfway houses. Whether individuals completed primary treatment in a residential or outpatient program, they have at least some of the skills to maintain sobriety and begin work on remediating various areas of their lives. Work is intrapersonal and interpersonal as well as environmental. Areas that relate to environmental issues, such as vocational rehabilitation, finding employment, and securing safe housing, fall within the purview of case management (SAMHSA, 2020) (IC&RC, 2024).

If different individuals perform case management and addictions counseling, they must communicate constantly during aftercare about the implication and progress of all service plans. Because case managers interact with the client in the community, they are in a unique position to see the results of work being done in aftercare groups and provide perspective about the client's functioning in the community. Recent findings suggest that the case management relationship may be as valuable to the client during this phase of recovery as that with the addictions counselor. Aftercare is important in completing treatment both from a

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funding standpoint (many funders refuse to pay for aftercare services), as well as from the client's perspective.

Case Management Functions and the Treatment Continuum

In this section, case management functions are presented against the backdrop of the substance abuse continuum of care to highlight the relationship between treatment and case management. The primary difference between the two is case management's focus on assisting the substance abuser in acquiring needed resources. Treatment focuses on activities that help substance abusers recognize the extent of their substance abuse problem, acquire the motivation and tools to stay sober, and use those tools. Case management functions mirror the stages of treatment and recovery.

If properly implemented, case management supports the client as she moves through the continuum, encouraging participation, progress, retention, and positive outcomes. The implementation of the case management functions is shaped by many factors, including the client's place to the continuum and level of motivation to change, agency mission, staff training, configuration of the treatment or case management team, needs of the target population, and availability of resources. The fact that not all clients move through each phase of the treatment continuum or through a particular phase at the same pace adds to the variability inherent in case management.

Engagement

Case findings and pretreatment

Engagement during the case finding/pretreatment phase is particularly proactive. The case manager frequently needs to provide services in nontraditional ways, reaching out to the client instead of waiting for the client to seek help. Engagement is not just meeting clients and telling them that a particular resource exists. Engagement activities are intended to identify and fulfill the client's immediate needs, often with something as tangible as a pair of socks or a ride to the doctor (SAMHSA, 2024).

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This initial period is often difficult. Motivation may be fleeting and access to services limited. In many jurisdictions, there is a significant wait to schedule an orientation, assessment, or intake appointment. Third parties responsible for authorizing behavioral health benefits may be involved, and client persistence may be a key factor in accessing services.

Additional factors may come into play with clients referred from the criminal justice system. They may be angry about their treatment by the criminal justice system and may resent efforts to help them. Clients who begin treatment after serving time in jail or prison have significant life issues that must be addressed simultaneously (such as safe housing, money, and other subsistence issues) as well as resentment, resistance, and anger. Others may have active addictions or be engaged in criminal activity. Requirements imposed by the criminal justice system must also be met; these can present conflicts with meeting other goals, including participation in substance abuse treatment (NIDA, 2024).

Potential clients may be unfamiliar with the treatment process. Their expectations about treatment may not be realistic, and they may know very little about substance abuse and addiction. It is not uncommon for people at this stage to minimize the impact substance use or abuse has on their lives. These factors often manifest in client behaviors such as missing appointments, continued use, excuses, apathy, and an unwillingness to commit to change.

The goal of case management at this stage is to reduce barriers, both internal and external, that impede admission to treatment. Client reluctance to enter into services can be reduced by (1) motivational interviewing (SAMHSA, 2024) approaches; (2) basic education about addiction and recovery; (3) reminding clients of past and future consequences of continued substance abuse; (4) assistance in meeting the client's basic survival needs; and (5) commitment to developing the case manager-client relationship. Prescreening for program eligibility, coordination referrals, and working to reduce any administrative barriers can facilitate access to services.

The process of motivating a client, beginning the education process, identifying essential needs, and forming a relationship can begin during a prescreening or screening interview. The motivational approaches encourage client engagement through exploratory rather than confrontational means. Recognizing that not every client enters treatment with the same

motivational levels, they build on Prochaska and DiClemente's stages of motivation for treatment. The stages move from the client's non-recognition of a problem (precontemplation) to contemplation of a need for treatment, to determination, to action, and finally, to the maintenance of attained goals. Case management can use this framework to engage the client with stage-appropriate services. This means that clients who have not decided to address their substance abuse can often be "hooked" into more intensive treatment by providing basic practical supports. Providing these supports can have the additional effect of reducing the perceived desirability of continued substance use and the lifestyles associated with it.

A structured interview provides the client the opportunity to discuss her drug use and history with the case manager and to explore the losses that may have resulted from that use. For some clients, this history may reveal a pattern of increasing loss of control (and perhaps loss of freedom). Review and discussion of losses can serve to motivate clients to proceed to treatment. Listening empathetically and showing genuine concern about a client's well-being can facilitate the beginning of a meaningful, supportive relationship between the client and the case manager and can serve to motivate the client as well. A good initial relationship between client and case manager can also be invaluable when the client experiences difficulties later on in treatment.

In addition to information regarding substance abuse and the treatment process, clients must be informed about requirements and obligations of the case manager or case management program, and about requirements they will be expected to meet once they are admitted to treatment. This type of discussion presents another opportunity to solidify the client's commitment to practice in treatment. Even at the earliest stages, clients should be reminded that permanent changes are necessary for recovery. Finally, any questions the client has should be addressed. This can be particularly important for clients referred by the criminal justice system, who may be somewhat confused about that system's requirements, the consequences of noncompliance, and the difficulties they encounter in meeting those requirements.

While case management in the pretreatment phase may be intended to route clients to a particular program, engagement is not just a "come-on" to treatment. Many prospective clients will not formally enter treatment within an agency-defined period, but, within flexible limits,

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case management services should still be made available to these individuals. The transition from engagement to planning is a gradual one and does not lend itself to agency-created distinctions such as “pretreatment” and “primary treatment.”

Primary treatment

For clients who elect to enter treatment, engagement serves (IC&RC, 2024) to orient the client to the program. Orientation involves explaining program rules and regulations in greater detail then was possible or necessary during pretreatment. The provider elicits the client’s expectations of the program and describes what the program expects of the client. The person responsible for delivering case management to a particular client is in a unique position to assist in the match between individual and treatment. During primary treatment, the case manager can serve as one of the client’s links with the outside world, assisting the client to resolve immediate concerns that may make it difficult to focus on dealing with the goal of primary treatment – coming to grips with a substance abuse problem.

In addition to orienting clients to treatment programs, case managers can orient treatment programs to the clients they refer. Sharing information gathered during the pretreatment phase can provide support for the treatment process that ensues upon program admission.

Aftercare

While in treatment, most of a client’s time is spent dealing with substance use. Although discharge plans may have been considered, it is not until discharge that the day-to-day realities of living assume the most urgency. Because of their relationship with their clients and their community ties, case managers are well positioned to help clients make this delicate transition. Case management serves to coordinate all aspects of the client’s treatment. This coordination occurs within a given treatment program, between the program and other resources, and among these other resources. The extent of the case manager’s ability to work on the client’s behalf will be guided both by the formal authority vested in the individual by the service providers involved and by the individual’s informal relationships (SAMHSA, 2020).

The case manager’s extensive knowledge of the client’s real-world needs can help the client who is no longer using. Clients in aftercare have an array of needs, including housing, a safe and

drug-free home environment, a source of income, marketable skills, and a support system. Many have postponed medical or dental care; in recovery, physician-prescribed medication for pain management can become a major problem, an issue that may require coordination and advocacy (SAMHSA, 2020).

Assessment

The primary difference between treatment and case management assessments lies in (NIDA, 2024) case management's focus on the client's need for community resources (SAMHSA, 2020). The findings from the assessment, including specific skill deficits, basic support needs, level of functioning, and risk status, define the scope and focus of the service plan.

Case finding and pretreatment

Depending on the structure and mission of the program providing case management, assessment may begin when engagement begins. It is case management's role to explore client needs (SAMHSA, 2020), wants, skills, strengths, and deficits and relate those attributes to a service plan designed to address those needs efficiently. If the client is not eligible for a particular case manager's program, the case manager links the client with appropriate external treatment resources. This process includes assessing the client's eligibility and appropriateness for both substance abuse and other services and for a specific level of care within those services. If the client is both eligible and appropriate for the program, the case manager's role is to engage the client in treatment.

Primary treatment

For clients who enter primary treatment, the case management assessment function, which is primary oriented to the acquisition of needed resources, is merged with an assessment that focuses on problems amenable to therapy—substance use, psychological problems, and family dysfunction. Ideally both assessments are integrated into a biopsychosocial (NIDA, 2024) assessment. This biopsychosocial assessment should, at a minimum, examine the client's situation in the life domains of housing, finances, physical health, mental health, vocational/educational, social supports, family relationships, recreation, transportation, and spiritual needs. Detailed information should be gathered on drug use, drug history, health

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history, current medical issues, mental health status, and family drug and alcohol use. This assessment, used in conjunction with the needs assessment, assists the treatment team in developing a formal treatment plan to be presented to, modified, and approved by the client. Whether one person or several conduct these two assessments is largely irrelevant. Where a team approach exists, all members of the team, including the case manager or other professional identified in that role, should bring their expertise to the assessment. Discharge planning and long-range needs identification, particularly with current funding limitations, begins at treatment admission. Because of this, intensive case management for substance abuse clients, regardless of the level of care, is imperative (SAMHSA, 2020).

As the individual responsible for coordinating diverse services, the case manager must take a broad view of client's addiction on broader domains, and assess the impact of these domains on the client's recovery. He also must assess specific areas of functional skill deficits, including personal living skills, social or interpersonal skills, service procurement skills, and vocational skills (Frontiers in Psychiatry, 2024).

Individuals performing this function need to have strong knowledge of and experience in the field of substance abuse. The greater the number of problems the case manager can help the client identify and manage during primary treatment, the fewer problems the client must address during aftercare and ongoing recovery – and the greater the chances for treatment success (Frontiers in Psychiatry, 2024).

A case management assessment should include a review of the following functional areas. These items are not exhaustive, but demonstrate some of the major skill and service need areas that should be explored. The assessment of these areas of functioning gives evidence of the client's degree of impairment and barriers to the client's recovery. The case manger may have to perform many services on behalf of the client until skills can be mastered.

Service procurement skills

While the focus of case management is to assist clients in accessing social services, the goal is for clients to learn how to obtain those services. The client should therefore be assessed for:

- Ability to obtain and follow through on medical services

- Ability to apply for benefits
- Ability to obtain and maintain safe housing
- Skill in using social service agencies
- Skill in accessing mental health and substance abuse treatment (NIDA, 2024) services

Prevocational and vocation-related skills

In order to reach the ultimate goal of independence, clients must also have vocational skills and should therefore be assessed for:

- Basic reading and writing skills
- Skills in following instructions
- Transportation skills
- Manner of dealing with supervisors
- Timeliness, punctuality (IC&RC, 2024)
- Telephone skills

The case management assessment should include a scan for indications of harm to self or others. The greater the deficits in social and interpersonal skills, the greater the likelihood of harm is to self and/or others, as well as endangerment from others. The case manger should also conduct an examination of criminal records. If the client is under the supervision of the criminal justice system, supervision officers should be contacted to determine whether or not there is a potential for violent behavior, and to elicit support should a crises erupt.

Aftercare

The client's readiness to reintegrate into the community is a focus of case management assessment throughout the treatment continuum. Because the case manager is often out in the community with the client, she is in an excellent position to evaluate this important indicator. During aftercare, her assessment may reveal new, recurring, or unresolved problems the client must deal with before they interfere with recovery. The potential for relapse is a particularly significant challenge, and the client must be able to identify personal relapse triggers and learn how to cope with them. Because case managers are familiar with the community, clients, and

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substance abuse treatment (NIDA, 2024) issues, they can spot such triggers and intervene appropriately. If, for example, a case manger fears that a client's decision to return to a familiar neighborhood could result in contact with drug-using friends that could jeopardize sobriety, a new residence may be necessary.

Planning, Goal-Setting, and Implementation

Flowing directly and logically from the assessment process, planning, goal-setting, and implementation comprise the core of case management. Based on the biopsychosocial (NIDA, 2024) or case management assessment, the client and case manager identify goals in all relevant life domains, using the strengths, needs, and wants articulated in the assessment process. Service plan development and goal-setting are discussed in detail in numerous works on substance abuse and case management. These authors agree on several points: Each goal in service plans should be broken down into objectives and possibly into even smaller steps or strategies that are behaviorally specific, measurable, and tangible. Distinct, manageable objectives help keep clients from feeling overwhelmed and provide a benchmark against which to measure progress. Goals, objectives, and strategies should be developed in partnership with the client. They should be framed in a positive context – as something to be achieved rather than something to be avoided. Time frames for completing the objectives and strategies should be identified. Abbreviated, user-friendly treatment planning templates make client participation in development of a service plan more likely. The availability of staff to assist in the planning goal-setting, and implementation of the case management aspects of the treatment plan is crucial (SAMHSA, 2020).

Successful completion of an objective should provide the client the satisfaction of gaining a needed resource and demonstrating success. Failure to complete an objective should be emphasized as an opportunity to reevaluate one's efforts. In the latter situation, the case manger should be prepared to help the client come up with alternative approaches or to begin an advocacy process (SAMHSA, 2020).

A deliberate, carefully considered approach to identifying client goals offers benefits that go beyond the actual acquisition of needed resources. Clients benefit by:

- Learning a process for systematically setting goals
- Understanding how to achieve desired goals through the accomplishment of smaller objectives
- Gaining mastery of themselves and their environment through brainstorming ways around possible barriers to a particular goal or objective
- Experiencing the process of accessing and accepting assistance from others in goal-setting and goal attainment

These and other individually centered outcomes make the planning and goal-setting process as important as the final outcome in some cases. This is the action stage of case management, when the client participates in many new or foreign activities and may have multiple requirements imposed by multiple programs or systems. Many significant and stressful transitions may be involved – from substance use to abstinence, from institutionalization or residential placement to community reintegration, and from a drug- or alcohol-using peer group to new, abstinent friends. As clients struggle to stop using, many will relapse, sometimes after a significant period of abstinence. They may feel overwhelmed, and it is not uncommon for clients in recovery to experience feelings of isolation and depression as they develop new peer associations and lifestyle patterns, and come to grips with their losses. In addition, the very real pressures of finances, employment, housing, and perhaps reunifying with and caring for children can be very stressful.

Case finding and pretreatment

During the pretreatment phase the planning function of case management focuses on supporting clients in achieving immediate needs and facilitating their entry into treatment. Ideally, the professional implementing case management meets with the client to plan the goals and objectives for the service plan. While planning and goal setting are important in the early stage of treatment, it may be difficult to follow traditional approaches given the immediacy of clients' needs and the possibility that they are still using alcohol or other drugs. The case manger may decide to complete a formal plan after an action is undertaken and present it to the client as a summary of work that was accomplished. If a client's capacity is

diminished by substance abuse and the presence of multiple, serious life problems, the case manager may have to delay teaching and modeling for the client, and instead trade on his own contacts, resources, and abilities. As the client progresses through the treatment continuum, the case manager can turn more and more of the responsibility for action over to the client.

Clients who are using addictive substances while receiving case management services present a significant dilemma for the case manager. On the one hand, the client may not be willing or able to participate in treatment; on the other, treatment providers normally expect some commitment to sobriety before clients begin the treatment process. As a result, the case manager frequently needs to negotiate common ground between client and program. For example, a case manger might require the client to identify and make progress toward mutually understood goals pending entry into treatment. Structured correctly, such an approach fosters a win-win situation. Attainment of these goals either eliminates the client's need for treatment or prepares him to accept treatment more willingly. Even if the client is unwilling or unable to achieve those goals, the case manager and treatment program have additional information to use in attempting to motivate the client to seek treatment.

Primary treatment

During primary treatment, the case manger and client develop a service plan that identifies and proposes strategies to meet the client's short- and medium-term needs (IC&RC, 2024). The case management plan should reflect the level and intensity of the service along with the client's specific objectives. Virtually all clients have multiple needs; consequently, the service plan should be structured to enable clients to focus on addressing their problems while they participate in treatment. The ideal that one can put lack of housing, employment issues or a child's illness aside to concentrate exclusively on addiction treatment and recovery is unrealistic and sets up both the treatment provider and the client for failure. At the same time, it is often necessary for the client and case manager to prioritize problems.

During primary treatment, the case manager must (1) continue to motivate the client to remain engaged and to progress in treatment; (2) organize the timing and application of services to facilitate client success; (3) provide support during transitions; (4) intervene to avoid or respond

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to crisis; (5) promote independence; and (6) develop external support structures to facilitate sustained community integration. Case management techniques should be designed to reduce the client's internal barriers, as well as external barriers that may impede progress.

Providing ongoing motivation to clients is critical throughout the treatment continuum. Clients need encouragement to commit to entering treatment, to remain in treatment, and to continue to progress. The case manger must continually seek client-specific incentives. Clients are encouraged by different factors, and the same client may respond differently depending on the situation.

For instance, many clients referred by the criminal justice system will be initially motivated to try treatment in order to avoid a jail sentence; they may be motivated to stay in treatment for very different reasons (e.g., they start to feel better, they hope to regain custody of children). The treatment process is difficult, and many clients become discouraged after their initial enthusiasm. Recovery may require them to explore uncomfortable issues. Physical discomfort, as well as depression, can ensue. Case managers can provide support during these periods by supplying information on coping techniques such as exercise, diet, and leisure activities. If depression is significant, case managers can work with substance abuse counselors to have a mental health evaluation conducted, and, if appropriate, enable the client to seek additional therapeutic support for the depression. Continued empathetic caring can also motivate clients.

Disincentives may also be used. For example, the case manager might remind the clients of the outcome of terminating treatment – for some, this might mean a return to prison, for others it might mean dealing with the health or safety consequences of addictive behaviors. For clients under the control of the criminal justice system, sanctions, including possible jail stays, may be necessary to regain commitment and motivation.

In criminal justice settings, particularly drug courts, regular "status hearings" before a judge may motivate the client. In status hearings, the judge is informed of the client's progress (or lack thereof), and engages the client in a dialogue. The judge can then apply rewards (encouragement, or reduction of criminal sanctions), adjust treatment requirements, or apply

sanctions. Sanctions vary, but may include warnings, community service, short jail stays, or ultimately, termination from the program and incarceration.

Another fundamental role of case management during the active treatment phase is to coordinate the timing of various interventions to ensure that the client can achieve his goals. The case manager has to work with the client to balance competing interests, and to develop strategies so the client can meet basic survival needs while in treatment.

For example, a case manager may have to negotiate between probation and treatment to ensure that the client can attend treatment sessions and meet with his probation officer. Some activities require staging to ensure that they are applied at the right time and in the correct order. Clients who are unemployed and lack employment skills, for instance, should begin job readiness and training activities after they are stabilized in treatment; they will need additional support for seeking and maintaining employment. It is not uncommon for clients to feel they can take on the world once they are stabilized in treatment.

If this is the case, the job of the case manager is to encourage clients to go slowly and take on responsibility one step at a time. This can be particularly critical for women anxious to reconnect with their children. The financial and emotional responsibilities are great, and the case manager should work with the woman and child protective services to transition these responsibilities to manageable ways.

Transition among programs – from institutional programming to residential treatment; from residential treatment to outpatient; or to lower level services within an outpatient setting – is always stressful, and frequently triggers relapse. In order to avoid crises during transitions, case managers should intensify their contact with clients. Case managers should work to ensure that service is not interrupted. When possible, release dates should be coordinated to coincide with admission to the next program.

If the client is under the control of the criminal justice system, the case manager should work to ensure that supervision activities remain the same or increase when treatment activity decreases(IC&RC, 2024). Too frequently, a client completes a treatment program and is moved to a lower level of supervision at the same time. This pulls out support all at once. If possible,

supervision and treatment activities should be coordinated to promote gradual movement to independence in order to reduce the likelihood of relapse.

In addition to activities designed to avoid a crisis or relapse, the case manger should be available to respond to relapses and crises when they do occur. In many cases, the case manager leads the response effort. Case managers should be in frequent contact with the treatment program to check on client attendance and progress. Lapses in attendance and/or poor progress can signal an impending crisis and a case conference should be held.

The case conference can resolve problems and prevent the client's termination from the program. While violence toward staff or other patients is obviously adequate grounds for immediate program termination, other infractions do not necessarily warrant expulsion. The case management team and client should work together to develop alternatives that will keep the client engaged in treatment. If removal from the program is absolutely necessary, it may be possible to have the client readmitted after he "adjusts his attitude" and re-commits to treatment and to obeying the rules.

The Treatment Alternatives for Safe Communities (TASC) Project has developed a special form of case conference, known as "jeopardy meetings" for treatment clients involved in the criminal justice system. These meetings are attended by the case manager, treatment counselor, probation officer, client, and anyone else involved in the case. The purpose of the meeting is to confront the client with the problem, and to discuss its resolution as a team. The client must agree to the proposed resolution in writing. The jeopardy meeting provides a clear warning to the client (three jeopardy meetings can result in client termination); reduces the "triangulation" or manipulation that can occur if all parties aren't working in a coordinated fashion; and brings together skills and resources of multiple agencies and professionals.

Aftercare

One of the anticipatory roles for case management during primary care is to plan for aftercare, discharge, and community reentry. During primary care and into aftercare, the case manager helps the client master basic skills needed to function independently in the community, including budgeting, parenting, and housekeeping. Short-term goals increasingly become

supplanted by long-term goals of integrating the individual into a recovery lifestyle. When appropriate, service plans should reflect an ever-increasing emphasis on clients' accepting greater responsibility for their actions. The case management intervention may increase or decrease in intensity, depending on client response to independence and progress toward community reintegration (SAMHSA, 2020).

Linking, Monitoring, and Advocacy

Some findings suggest that while persons with substance abuse problems are generally adept at accessing resources on their own without case management, they often have trouble using the services effectively. This is where the linking, ongoing monitoring, and, in many cases, advocacy, of case management can be valuable. An additional crucial function of case management is coordinating all the various providers and plans, and integrating them into a unified whole (SAMHSA, 2020).

Linking goes beyond merely providing clients with a referral list of available resources. Case managers must work to develop a network of formal and informal resources and contacts to provide needed services for their clients.

Case finding and pretreatment

Case managers may be especially active in providing linking and advocacy during the pretreatment phase of the treatment continuum. As with each of the case management functions, the roots of linking begin much earlier, while conducting an assessment with the client and in creating goals in which the client is vested. The authors of one primer on case management identify five tasks related to linking that should be undertaken with the client before actual contact with a needed resource even occurs. Case managers must (1) enhance the client's commitment to contacting the resource; (2) plan implementation of the contact; (3) analyze potential obstacles; (4) model and rehearse implementation; and (5) summarize the first four steps for the client (SAMHSA, 2020).

Primary treatment

After the linkage is made, the case manager moves on to monitoring the fit and relationship between client and resource. Monitoring client progress, and adjusting services plans as needed, is an essential function of case management. Coupled with monitoring is the need to share client information with relevant parties. For instance, if a client who is involved in the criminal justice system tests positive for drugs, both the treatment counselor and the probation officer may need to know. If the case manger is aware that the client is having problems at work, this information may need to be shared with the treatment provider, within the constraints of confidentiality regulations (SAMHSA, 2020).

Case managers who are responsible for offenders in treatment may oversee regular drug testing. This is an effective way to obtain objective information on a client's drug use, as well as to structure boundaries for the client to help prevent relapse.

Monitoring may reveal that the case manager needs to take additional steps on the client's behalf. Simply put, advocacy is speaking out on behalf of clients. Advocacy can be precipitated by any one of a number of events, such as: (SAMHSA, 2020)

- A client being refused resources because of discrimination, whether discrimination is based on some intrinsic aspect of the client, such as gender or ethnicity, or on the nature of the client's problems, such as addiction
- A client being refused services despite meeting eligibility requirements
- A client being discharged from services for reasons outside the rules or guidelines of that service (SAMHSA, 2020)
- A client being refused services (IC&RC, 2024) because they were previously accessed but not utilized
- The case manager's belief that a service can be broadened to include a client's needs without compromising the basic nature of the service

Advocacy on behalf of a client should always be direct and professional. Advocacy can take many forms, from a straightforward discussion with a landlord or an employer, to a letter to a judge or probation officer, to reassuring the community that the client's recovery is stable enough to permit reentry. Advocacy often involves educating service providers to dispel myths

they may believe about substance abusers, or ameliorating negative interactions that may have taken place between the client and the service provider. This is particularly important for certain groups with whom some programs are reluctant to work, such as clients with AIDS/HIV or clients involved in the criminal justice system (SAMHSA, 2020).

More complicated advocacy involves, for example, appealing a particular decision by a service staff member to progressively higher levels of authority in an organization. The highest, most involved levels of advocacy include organizing a community response to a particular situation or initiating a legal process. An advocacy strategy matrix can help case managers systematically plan advocacy efforts. In this view of advocacy, the levels at which advocacy can be effected (individual, administrative, or policy) are weighed against varying approaches (positive, negative, or neutral). Three guidelines for advocating on behalf of a client are getting at least three "No's" before escalating the advocacy effort, understanding the point of view of the organization that is withholding service, and consulting with supervisory personnel regularly before moving to the next level of advocacy (SAMHSA, 2020).

Client advocacy should always be geared toward achieving goals established in the service plan (NASW, 2024). Advocacy does not mean that the client always gets what she wants. Particularly for clients whose continued drug use or cessation of treatment will present considerable negative consequences such as incarceration or death, advocacy may involve doing whatever it takes to keep them in treatment, even if that means recommending jail to get them stabilized. It is not uncommon, in fact, for clients, to state their preference for jail when treatment gets difficult. Even when advocating for clients, the case manager must respect system boundaries. For example, a case manager might negotiate hard to keep an offender client in community-based treatment, but agree to inform the probation office of positive drug test or suspected criminal behavior. While advocacy for certain client populations is essential, concern for the client should not override goals of public safety. Effective, client-centered advocacy may put the case manager in a position of conflict with co-workers, program administrators, or even supervisors. Case managers who advocate for an extension of benefits for their clients may put themselves and their supervisor in jeopardy with funding sources. A coordinated infrastructure

with existing policies and procedures for client centered collaboration will help (SAMHSA, 2020).

Disengagement

Disengagement in the case management setting, as with clinical termination, is not an event but a process. In some ways, the process begins during engagement. For both client and case manger, it entails physical as well as emotional separation, set in motion once the client has developed a sense of self-efficacy and is able to function independently. To a significant degree, this decision can be based on progress defined by the service plan. If the plan has truly been developed with the client's active involvement, there will be a great deal of objective information that will help both the case manager and client decide when disengagement is appropriate. It is preferable that disengagement be planned and deliberate rather than have the relationship end in a flurry or missed appointments, with no summary of what has been learned by the client and professional. Formal disengagement gives clients the opportunity to explore what they learned about interacting with service providers and about setting and accomplishing goals. The case manager has a chance to hear from clients what they considered beneficial – or not beneficial – about the relationship. Reviewing and summarizing client progress can be an important aspect of consolidating clients' gains and encouraging their future ability to access resources on their own (SAMHSA, 2020).

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Case Management Orientation Inventory (CMOI)

Introduction

Which of the models of case management do you support the most? The Case Management Orientation Inventory (CMOI) has been developed to assess a person's support for a variety of models of case management. All of the models have been used in the field. There are no right or wrong answers and the most important aspect of the inventory is for you to indicate which of the items on the inventory you support as an approach to case management. In this inventory, "client" refers to a substance abusing offender.

Instructions

For each of the following twelve statements, indicate whether you strongly agree, agree, disagree, or strongly disagree with the statement by placing an "x" in the box under the answer that best fits what you believe. After you have responded to all twelve items, turn to the next page to score the CMOI.

1. The case manager should be both a therapist and a person who acquires resources for the client.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

2. The case manager should not function as an advocate for the client.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

3. The case manager should maintain a team approach with other service providers for the client.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

4. The case manager should actively seek informal helping networks (as opposed to institutional) for the client.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

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5. The case manager should provide psychotherapy to clients.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

6. The case manager should not encourage an intensive long-term relationship with clients.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

7. The case manager should function as an assertive advocate for the client.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

8. The case manager should be active and aggressive in reaching out to clients.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

9. The case manager should seek to identify the needs of the client and help them access vital resources in the community.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

10. The case manager should establish a long-term commitment to the client.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

11. The case manager should establish a strong client-case manager relationship.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

12. The case manager should be aware of a variety of the client's psychological issues.

Strongly Agree □ Agree □ Disagree □ Strongly Disagree □

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Case Management Orientation Inventory (CMOI)

Scoring Key

To obtain a score on the brokerage/generalist (BG) scale, add items 9, 6, and 2.

Scoring values:

Strongly Agree = 4

Agree = 3

Disagree = 2

Strongly Disagree = 1

To obtain a score on the assertive community treatment (ACT) scale, add items 7, 10, and 3, using the same values as above – 4, 3, 2, and 1.

To obtain a score on the strengths-based perspective (SDP), add items 4, 11, and 8, using the same values as above – 4, 3, 2, and 1.

To obtain a score on the clinical/rehabilitation (CR) scale, add items 5, 1, and 12, using the same values as above – 4, 3, 2, and 1.

Next, place the summed totals in the boxes below for each of the scales.

BG □ ACT □ SDP □ CR □

Interpretation of Scores

14. The higher the score, the stronger the endorsement of the case management model: High = 10; Low = 1
15. Total range for the CMOI = 48 – 12
16. All models could be equally endorsed
17. Compare the numerical values for the BG, ACT, SDP, and CR models to determine which one you most strongly endorse
18. How is your endorsement different from the case management style of your agency, program, or institution?

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If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

If you have any difficulty with this process, or need assistance, please e-mail us at ceumatrix@ceumatrix.com and ask for help.

Answer the following questions by selecting the most appropriate response.

1. Support for the use of case management in substance abuse treatment (NIDA, 2024) developed from clinical practice and:

a. casual observation

b. legal observation

c. computers

d. court observation

e. empirical observation

2. What percent of treated substance abusers have a lifetime history of depression?

a. 25%

b. 70%

c. 0%

d. 50%

e. 100%

3. For women in treatment, recovery requires forming new:

a. healthy peer associates

b. healthy attitudes

c. financial supports

d. alliances

e. values

4. Criminal justice substance abuse clients represent what portion of all clients in state and local jurisdictions?

a. almost all

b. one fourth

c. more than one half

d. one third

e. none of the above

5. Case management is a set of social service:

a. streams

b. functions

c. incentives

d. missing pieces

e. processes

6. One of case management's hallmarks is:

a. avocation

b. admissions

c. anti-system

d. adhoc functions

e. advocacy

7. This course stresses:

a. intervention

b. convention

c. the interviewer's profession

d. prevention

e. streaming

8. Case management and therapy are:

a. incompatible

b. incomplete

c. incongruent

d. not incompatible

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e. not incomplete

9. The primary difference between case management and therapy is that case management stresses:

a. intrapersonal change

b. resource acquisition

c. incentives

d. streaming

e. interpersonal change

10. The three trends that will alter the current manner in which substance abuse treatment (NIDA, 2024) and case management are implemented are:

a. phase one, phase two, and phase three

b. failures, evaluation, and costs

c. restriction, facilitation, and constriction

d. constriction, streaming, and costs

e. facilitation, costs, and failures

11. One of the first legislative embodiments of case management occurred in anticipation of:

a. institutionalism

b. legalization

c. socialization

d. desocialization

e. deinstitutionalization

12. Case management grew out of the field of:

a. social work

b. psychiatric care

c. institutional care

d. group work

e. AA

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13. Substance abusers were referred to various social services after:

a. decriminalization

b. institutionalization

c. psychiatric labeling

d. socialization

e. AA was created

14. In the past, the institution of choice in dealing with substance abusers was:

a. jails

b. county work farms

c. skid row missions

d. detox centers

e. all of the above

15. One of the first countries to develop case management functions in the field of substance abuse treatment (NIDA, 2024) was:

a. England

b. Canada

c. France

d. United States

e. Sweden

16. The two agencies that have promoted projects that used case management to enhance treatment are:

a. NIDA and NIAAA

b. AA and CASA

c. NIDA and ACA

d. NIJ and NIAAA

e. NIJ and SAMSA

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17. One widely accepted set of functions for case management comprises assessment, planning linkage, monitoring, and:

a. destructuring

b. confronting

c. incarcerating

d. advocacy

e. vocational placement

18. The two of eight practice dimensions deemed essential to addiction counseling are service coordination (SAMHSA, 2020) and:

a. linking

b. deflection

c. referral

d. streaming

e. documentation

19. The model that works best with clients who are not economically deprived is the:

a. brokerage/generalist

b. brokerage/specialist

c. clinical

d. assertive

e. active advocacy

20. In the brokerage/generalist model, advocacy is:

a. absent

b. present

c. developed

d. monitored

e. reciprocal

21. The PACT model emphasizes:

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a. short-term commitment

b. large case loads

c. individual approach

d. team approach

e. no advocacy

22. In the PACT model, clients were:

a. expected to come to services when they “hit bottom”

b. required to pledge a goal of abstinence

c. not required to pledge a goal of abstinence

d. not contacted

e. not enforced to make contact

23. The ACT model was used with:

a. probationers

b. parolees

c. HIV clients

d. Psychiatric clients

e. Inmates

24. The strengths–based model was originally developed in a school of:

a. sociology

b. medicine

c. psychology

d. criminal justice

e. social welfare

25. The strengths-based model counters the belief that substance abusers are:

a. in denial

b. morally deficient

c. unworthy of services

d. all of the above

e. none of the above

26. Strength-based case management has been implemented with:

a. only male substance abusers

b. only female substance abusers

c. only juvenile substance abusers

d. both male and female substance abusers

e. only dual diagnosis substance abusers

27. In the clinical-rehabilitation model of case management which of the following issues should the case manager not be aware of?

a. transference

b. counter transference

c. theories of ego functioning

d. the structures of the ID

e. internalization

28. Project 'Second Beginning' is a program for:

a. juveniles

b. only men

c. only women

d. men and women

e. clients with psychiatric problems

29. The strongest rationale for case management is:

a. single point of contact

b. flexible point of contact

c. differential point of contact

d. dynamic point of contact

e. multiple points of contact

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30. All case management approaches are:

a. system based

b. county based

c. pragmatically restrictive

d. community based

e. ego based

31. For criminal justice clients, advocacy may entail the recommendation of:

a. release

b. sanctions

c. conviction

d. probation

e. incarceration

32. Case management is:

a. exculpatory

b. anticipatory

c. exploratory

d. ambulatory

e. anti-system

33. The numerous models of case management are due to the need for:

a. applicability

b. structure

c. streaming

d. flexibility

e. desirability

34. Which of the following should be built into the case management process?

a. accommodation for diversity

b. accommodation for gender

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c. accommodation for disability

d. accommodation for old age

e. all of the above

35. Substance abuse treatment can be characterized as a:

a. continuum

b. declination

c. construction

d. sliding goal

e. hypothesis

36. Treatment should be arranged:

a. dynamically

b. exponentially

c. institutionally

d. logically

e. chronologically

37. Prochaska and DiClemente's stages of motivational levels are:

a. pre-contemplation, contemplation, determination, action, and maintenance

b. action, phase one, phase two

c. contemplation, action, determination

d. determination, action, maintenance

e. pre-contemplation, action, determination

38. Client reluctance to enter into services can be reduced by:

a. confrontational interviewing

b. cognitive interviewing

c. motivational interviewing (SAMHSA, 2024)

d. investigative interviewing

e. interventional interviewing

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39. A service plan is developed during:

a. disengagement

b. aftercare

c. pre treatment

d. primary treatment

e. case finding

40. In criminal justice settings, particularly drug courts, which of the following may motivate the client?

a. status hearing

b. primary hearing

c. motivational hearing

d. continuum hearing

e. linking hearing

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