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

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

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

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).

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 □

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 □

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?

REFERENCES

Dissanayake, U., et al. (2024). Understanding case management models: Consumer experiences of the strengths model of case management. International Journal of Mental Health Nursing, 33(1), 45-58. Federal Guidelines for Opioid Treatment Programs. (2024). Substance Abuse and Mental Health Services Administration, Publication No. PEP24-02-011. Frontiers in Psychiatry. (2024). Recovery-supportive interventions for people with substance use disorders: A scoping review. Frontiers in Psychiatry, 15, 1352818. https://doi.org/10.3389/fpsyt.2024.1352818 International Certification & Reciprocity Consortium. (2024). IC&RC core functions for addiction counseling and case management. IC&RC. McGahan, P., et al. (2023). Comparative effectiveness of different models of case management for substance-abusing populations. Addiction Science & Clinical Practice, 18(1), 14. National Association of Social Workers. (2024). Code of Ethics: Core values and ethical principles for social work practice. NASW. National Institute on Drug Abuse. (2024). Principles of substance abuse treatment (NIDA, 2024) for criminal justice populations: A research-based guide. NIH Publication No. 24-NA-7. Substance Abuse and Mental Health Services Administration Library. (2024). TIP 27: Comprehensive case management for substance abuse treatment (NIDA, 2024). Retrieved from https://library.samhsa.gov/product/tip-27-comprehensive-case-management-substance-abusetreatment-sma15-4215 Substance Abuse and Mental Health Services Administration. (2020). Comprehensive case management for substance use disorder treatment. Treatment Improvement Protocol (TIP) Series, Publication No. PEP20-02-02-013. Substance Abuse and Mental Health Services Administration. (2024). Using motivational interviewing in substance use disorder treatment: A treatment improvement protocol approach. SAMHSA. Substance Abuse and Mental Health Services Administration. (2025). Draft 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. SAMHSA. Substance Abuse and Mental Health Services Administration. (2025). Federal guidelines clarifying case management incentives: Contingency management up to $750 per patient annually. SAMHSA Advisory. UNC Center for Excellence in Community Mental Health. (2024). Assertive Community Treatment (ACT): Evidence-based practices for community mental health. University of North Carolina at Chapel Hill

Ghafouri, M., Meyerhoefer, T., Ali, D. N., Gregory, J., Taylor-Desir, M., Rummans, T. A., & Correa da Costa, S. (2026). Outreach models for substance use disorder in homeless populations: A systematic review and network meta-analysis. Psychiatric Services, 77(1), 58-65. https://doi.org/10.1176/appi.ps.20250118

Hamilton, J., Ti, L., Korchinski, M., & Nolan, S. (2022). Peer support specialists: An underutilized resource in the criminal justice system for opioid use disorder management? Journal of Addiction Medicine, 16(2), 132-134. https://doi.org/10.1097/ADM.0000000000000866

Headid, R. J., Doane, T. C., Cohen, B. D., Smith, E. C., Redden, D., & Stoner, A. M. (2024). Identifying components of recovery capital that support substance use disorder treatment completion. Addictive Behaviors Reports, 19, 100538. https://doi.org/10.1016/j.abrep.2024.100538

Knapp, K. S., Kulak, J. A., Homish, D. L., Granfield, R., Homish, G. G., & Kahn, L. S. (2024). Longitudinal trajectories in recovery capital and associations with substance use among adult drug treatment court clients. Drug and Alcohol Dependence, 260, 111343. https://doi.org/10.1016/j.drugalcdep.2024.111343

Mendoza, N. S., Hernandez, N., Clemency Cordes, C., & Berkel, C. (2022). Interdisciplinary training academy for integrated substance/opioid use disorder prevention and health care: A workforce catalyst report. Families, Systems, & Health, 40(4), 552-558. https://doi.org/10.1037/fsh0000743

Osborne, B., & Kelly, P. J. (2023). Substance use disorders, physical health and recovery capital: Examining the experiences of clients and the alcohol and other drug workforce. Drug and Alcohol Review, 42(6), 1410-1421. https://doi.org/10.1111/dar.13689

Scott, K., Salas, M. D. H., Bayles, D., Sanchez, R., Martin, R. A., & Becker, S. J. (2022). Substance use workforce training needs during intersecting epidemics: An analysis of events offered by a regional training center from 2017 to 2020. BMC Public Health, 22(1), 1063. https://doi.org/10.1186/s12889-022-13500-6

World Health Organization. (2023). Mental, neurological and substance use disorders: Clinical guidelines and evidence synthesis. World Health Organization

