**CONTEXT:**

**Five pages introduce the models of addiction,treatment and case management. Identify and discuss the model (s) of addiction used to plan a treatment approach for working with Marge. Include a rationale for use and discuss strengths and limitations of chosen model (s) of treatment used. Include rationale for use and discuss strengths and limitations of chosen model (s) of case management use, Include a rationale for use and discuss strengths and limitations of chosen model (s)**

**The main models of addiction**

Throughout history we have tried to understand the concept of drug use and why only certain people get addicted. There have been developed overtime that provide us with explanations for drug use. Some of these theories were developed into models which help us define a problem or situation so we can understand it more easily.

The models listed below are among the most influential in the development of drug treatment and policies

**1. Disease model of addiction.**

The most common model of addiction and one that most treatment places in the united states use are the disease model of addiction. The disease model of addiction believes that addiction is an illness and is a result of the impairment of healthy neurochemical and behavioral processes. This model assumes that addiction lies within the individual and that addiction is disease. It says that addicted people cannot control their intake of any substance. They are powerless over stopping themselves.

**2. The moral of addiction**

The moral model of addiction states that addiction is a result of the person being weak and having defects of character. Those who believe in this model believe there is no biological basis addiction. This model says if the person has greater moral strength or will power they could break an addiction. The moral model is widely applied to dependency on illegal substances, but no longer has any therapeutic value.

**3. The temperance model of addiction**

The temperance model of addiction started back in the 19th century with prohibition. It states that there is no such thing as moderation and that abstinence is the only alternative. The core belief of this model is that the addictive and destructive power of the drug is strong and it is the drug itself that's the problem.

**4. The genetic model of addiction**

The genetic model of addiction believes there is a genetic predisposition to certain behaviors. It states that certain addictions run in the family. Research is continuing to be done to explore genetic influence but there is strong evidence that genetic predisposition is often a factor in dependency.

**5.The opponent process model of addiction**

This model states that for every psychological event there is an opposite psychological event. For instance, for every pleasurable experience, there is an unpleasurable experience. For example, someone takes heroin and feels a euphoric high from it, this is followed by an opponent process of experiencing withdrawal symptoms. Another example would be someone experiencing terror before jumping out of a plane, the opposite effect would be them experiencing pleasure when the parachute opens.

**6. The personality model of addiction**

The personality model of addiction views substance abuse as having abnormalities in personality. It states that the person has an addictive personality, lacks impulse control, has low self-esteem, the inability to cope with stress, is egocentric, has manipulative traits and has a need for control and power while feeling impossible and powerless. This model also believes that substantial restructuring of their personality is necessary for successful treatment.

**7. The social education model of addiction**

This model believes that addiction is learned behavior that comes from cognitive processes, modeling influence and genetic behavioral influences. Theorists emphasize human environment interactions as the key to shaping addiction behavior. They believe that imitating behavior one has observed as well as being influenced by role models is part of forming for behavior and treating it.

**8. The cultural model of addiction**

The cultural model of addiction says that the influence of addiction says that the influence of a person's culture is a strong factor as to whether or not they fall prey to certain addictions. In some countries alcohol is prohibited so therefore alcoholism is rare there. Gambling addictions have increased dramatically over the last two decades of the 20th century. Studies show that half of those with alcoholism are born into families with alcoholism. This suggests that genetic and familiar influence play a vital role in the development of addiction or alcoholism.

**Models of case management**

Case management is a set of social service functions that helps clients access the resources they need to recover from a substance abuse problem. This include assessment, planning, linkage needs of treatment or agency setting.

The listed below are the models of case management.

**1**. **Brokerage/ generalist:**

This model seek to identify clients needs and help clients access identify resources. Planning maybe limited to the clients early contact with the case manager rather than an intensive long term relationship ongoing monitoring. This model is sometimes disparaged in discussion of case management because of the limited nature of client case manager relationship and absence of advocacy. Nonetheless this approach shares the basic foundation of case management and his provide useful in selected situations.

**2. Assertive community treatment:**

The program of assertive community treatment model, originally developed in Wisconsin (**Stein and Test, 1980** ) emphasizes the following components, making contact with clients in their homes and natural setting, focusing on the practical problems or daily living, assertive advocacy, frequent contact care manager and client, team approach with shared case list and long term commitment to clients.

The model deviated from the usual approach to dealing with substance abuse clients in two ways. First manager sought out clients to come to service,when they hit bottom case manager sought clients through process known as enforced contact. Second case managers and the services team acknowledge the chronic nature of the client condition and sought to modify the cause of the condition and the alleriate suffering. These clients are not required to pledge a goal of abstinence.

**3. Strengths based perspective:**

This model was originally developed at the University of Kansas school of social welfare to help a population of persons with persistent mental illness make the transition from institutionalized care to Independent living. It has been selected to work because of three reasons. First is case management usefulness in helping them access the resources they need to support recovery. Second the strong advocacy component that characterizes the strengths approach counter the wide spread belief that substance abusers are in denial or morally deficient. Perhaps unworthy of need service ( **Bander et al.1987. Ross and Darke.1992).** Last the emphasis on helping clients identify their strength, assets and abilities supplements treatment. This model can a times cause stress between a case manager and other members of the treatment team (**Rapp et al.1994)** despite this there is evidence that the approach can be integrated with the disease model of treatment and that is presence leads to improved actions of clients

**4. Clinical/ rehabilitation approaches:**

This model has case management where therapy and resource acquisition activities are joined together and address by the case manager. It has been suggested that the separation of these two activities is not feasible over an extended period of time and that of case manager must be trained to respond to client focused. This include providing psychotherapy to clients, treating specific skills and family therapy. Beyond the usual repentance of case management functions. The case manager should be aware of numerous issues including tranferency,countertransference, how clients internalize what they observe and theories of ego functioning. These programs use this model in which the same treatment professional provides at least coordinate,both therapy and case management activities. Such approach is frequency driven by staffing considerations. It is more economical to have one treatment professional provide all services them to have separate clinic and case managers deliver them.

**Reference**

1. National institutes of health (gov)

Https://www.nabi.nlm.nih.gov

2. Rural health information hub

Https://www.ruralhealthinfo.org

3. Evoke wellness Http://www.evokewellness.com