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ARISE: A Method for Engaging Reluctant Alcohol- and Drug-Dependent Individuals in Treatment

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Abstract—A method, the Albany-Rochester Interventional Sequence for Engagement (ARISE), is described for engaging highly ambivalent alcohol- and/or drug-dependent individuals in treatment. A three stage interventional sequence is presented, which begins when a family member or concerned other contacts a treatment program regarding a substance abuser who needs help. At that point a process is set in motion for collaboration with significant others toward client enrollment. Staff move to the next stage in a graduated operating procedure if initial, less demanding efforts do not succeed. The final stage, if needed, is a modified Johnson Institute Intervention. The overall procedure is designed to maximize the probability of patient recruitment, while minimizing the amount of time and energy required of staff. The method compares favorably with results obtained with other approaches, such as coercion (legal, employer) and client self-referral. © 1997 Elsevier Science Inc.

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IN THE FIELD of chemical dependency, a dynamic tension has developed at the interface between (a) managed care's limitations on the use of inpatient treatment, and (b) the increased demand for treatment (Garnick, Hendricks, Dulski, Thorpe, & Horgan, 1994; Mechanic, Schlesinger, & McAlpine, 1995). A clear trend toward

outpatient approaches has emerged (Wexler, 1993), partly due to questions of efficacy (Miller & Hester, 1986), and partly in reaction to the reputed abuse and overuse that has prevailed with inpatient programs (Armstrong, 1993; Levant, 1993). The field is, thus, being challenged to rethink many of its traditional practices in order to thrive in a managed care environment in which capitation and other shared risk reimbursement contracts are proliferating.

In ironic contrast, evidence indicates that 90–95% of those actively abusing alcohol and/or illicit drugs do not get into either treatment or self-help groups, such as Alcoholics Anonymous or Cocaine Anonymous, within any given year (Frances, Miller, & Galanter, 1989; Kessler et al., 1994; Nathan, 1990). Consequently, the need is apparent for methods that take maximum advantage of those instances when someone contacts a treatment pro-

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gram for help, either for him- or herself, or for another who is abusing substances. It was in response to the second category—contact by a “concerned other,”—that the Albany-Rochester Interventional Sequence for Engagement (ARISE) was developed.

BACKGROUND AND LITERATURE

A number of different approaches have been developed for getting substance abusers into treatment (Stanton, 1996). These will be briefly described here, along with any pertinent outcome research. For a given case, a “successful” outcome is defined as one in which the substance abuser in question actually becomes enrolled in a program.

Intervention Outcome Studies

Over the past 25 years, the mainstay approach for engaging chemically dependent individuals in treatment has been the “Intervention” method developed by the Johnson Institute (Johnson, 1980). It involves convening as many people as possible who care about, and are considered important to, the abuser. These may include not only family members, but friends, co-workers, the abuser’s boss, and so on. This group, in secrecy, delineates ways in which the abuser is important to each of them, and ways in which he or she has become a problem to each. Rehearsals are then held, in which members practice how they will present this information to the chemically dependent person (CDP). Subsequently, a meeting is scheduled, commonly in the CDP’s home, in which all of them gather to confront the CDP. They read aloud letters which explain their caring and concerns. They then voice ultimatums, such as “If you do not get into treatment, I will leave you (or have no contact with you, or fire you, or the like).”

Despite its widespread use, very little research has been undertaken on Intervention. Literature searches of *Psychological Abstracts* and *Dissertation Abstracts International*, scanning the years since 1980, located only two studies, both of a preliminary nature (Liepman, 1993). David Wilmes, Director of Training and Evaluation for the Johnson Institute, was also consulted but he knew of no other published studies, whether with inpatient or outpatient populations (Wilmes, personal communication, February 11, 1994).

The two Johnson Intervention studies differed considerably in the extent to which they succeeded in inducing clients into an inpatient program. Neither reported on the proportion of clients who, once they had entered treatment, actually completed it. The two studies are described below.

Using a quasi-experimental design, Liepman, Nirenberg, and Begin (1989) reported on 24 cases in which an average of four people per case took part in pre-Intervention counseling and/or confrontation of the alcoholic. Six

of the seven substance abusers who were actually confronted entered treatment. However, 17 cases never reached the point of confrontation and none of those were engaged in treatment. In other words, the approach was successful in engaging 25% of the total number of cases in treatment.

Logan (1983) combined Intervention methods with the social network therapy approach of Speck and Attneave (1973) and Garrison (Callan, Garrison, & Zerger, 1975; Garrison, Kulp, & Rosen, 1977). Each intervention network involved the 8 to 12 individuals deemed most important to the alcoholic. Of the 60 Interventions attempted over a one year period, 54 (90%) resulted in the alcoholic entering treatment.

Other Approaches to Engagement

In addition to Intervention and ARISE, at least five other approaches have been developed for utilizing family and significant others to engage a CDP in treatment.

Community Reinforcement Training (CRT). This method spun off the original Community Reinforcement Approach (CRA) of Azrin and colleagues (Azrin, 1976; Azrin, Sisson, Meyers, & Godley, 1982; Meyers & Smith, 1994; Hunt & Azrin, 1973). CRT involves seeing the distressed family member the day of the initial telephone call for help. It also requires being available during non-working hours and off days in case the family member reaches a crisis point when the drinker requests help. Sisson and Azrin examined the effectiveness of this approach with 12 cases: 7 in which the family member received CRT and 5 in which the person received traditional (AI-Anon) type counseling. In 6 of the 7 CRT cases the alcoholic entered treatment, while none of the traditional cases did. No report was done on rates of treatment completion.

Berenson’s Approach. David Berenson developed a method for working with the most motivated family members to get the alcoholic into treatment and AA (Berenson, 1976; see also Stanton, 1981b, for more detail). He strategizes with the spouse and works toward helping him or her “detach” from the drinker. While this approach has several fairly clear cut stages and a number of specific techniques which could be manualized, no research has yet been undertaken with it.

Unilateral Family Therapy. Developed by Thomas and associates (Thomas & Ager, 1993; Thomas, Santa, Bronson, & Oyserman, 1987; Thomas & Yoshioka, 1989), this approach combines CRA and Intervention. The therapist meets with the spouse over some months, with a focus on spousal coping, reducing the abuser’s drinking, and inducing the alcoholic to enter treatment. By the fifth month some open attempt or series of attempts is made to get the drinker into treatment. At six months from the first spouse contact, 39% of the drinkers in this group en-

tered treatment compared to 11% of the drinkers entering treatment when spouses treatment was delayed. No treatment outcome was reported.

Co-operative Counseling. Yates (1988) describes an experimental program in England involving the use of family members to enlist alcoholics in treatment. This program used a media campaign to induce family members to come to the treatment center for coaching if they were concerned about a loved one's drinking problem. Of the 19 cases where the caller actually came (out of 30 who called), 21% of the alcoholics entered treatment and another 26% reduced their drinking as the result of family concern. In other words, 47% of the alcoholics either entered treatment or showed improvement in functioning if their "affected other" showed up.

Strategic Structural-Systems Engagement. A method for engaging adolescent, mostly Hispanic, substance abusers (and their families) has been developed by Szapocznik, Perez-Vidal, Foote, Santisteban, Hervis, and Kurtines (1988). In 90% of their call-ins the caller was the mother of the adolescent drug abuser, so the telephone conversation usually concerned how she could get the adolescent and other family members in. Using this method, Szapocznik et al. were able to get 93% of the targeted adolescents to come to the clinic with their families for an intake meeting, compared to 42% for an "engagement as usual" condition.

THE ARISE MODEL

The model described in the present paper has been developed over the past eight years. It places Johnson-style Interventions within an overall interventional continuum.

The Johnson Intervention evolved from a set of observations and conclusions about chemical dependence and its relation to alcoholic family functioning. Some of these conclusions are: (a) families are powerful; (b) alcoholic families usually operate in a predictable, enabling fashion; (c) chemical dependency functions on a unidimensional plane, with an anticipated progression of symptoms and dysfunctional behavior; (d) chemical dependency affects families in a more or less linear, cause-and-effect fashion; (e) surprise is a necessary component to successful Interventions because of the denial, rationalizations and euphoric recall of the alcoholic; (f) the intervention group members must agree upon a serious consequence to be carried out if the CDP refuses treatment; and (g) inpatient treatment is (or was) the preferred modality with Interventions. This model has the attractiveness of being predictable and orderly.

ARISE Assumptions

The ARISE model supplements Intervention with concepts and methods developed within family and systems

theory—particularly social network therapy (Speck & Attneave, 1973), the Rochester model of Transitional Family Therapy for family treatment (Landau-Stanton, 1990; Landau-Stanton, Clements, Stanton, & Griep, 1993; Seaburn, Landau-Stanton, & Horwitz, 1995; Stanton, 1981a, 1984), and Galanter's network approach to substance abuse treatment (Galanter, 1993). First, it notes that family dynamics look very different when viewed from close up than when viewed from a distance. The observer draws distinctive conclusions about alcoholic family functioning depending on how the behavior is observed (Steinglass, Bennett, Reiss, & Wolin, 1987). What at first looks chaotic and dysfunctional, can be seen to possess pattern and purpose when carefully explored. For example, a pattern of substance abuse which seems inexplicable when taken in context of the nuclear family, can make implicit sense—in how and why it developed—when viewed in relation to three, four, or more generations (Landau-Stanton & Stanton, 1996).

Second, systems theory introduced the notion that the family is both affected by chemical dependency and effects the course of chemical dependency. This is a circular notion about cause or causality—A leads to B, and B leads back to A.

Third, it is important for therapists and counselors to appreciate that families are capable of doing much of the therapy work on their own, due to resilience and family strengths (Landau-Stanton, 1986). There is trust in an inherent ability of families to heal themselves (Seaburn et al., 1995).

Fourth, family patterns of loyalty (Boszormenyi-Nagy, 1973), power dynamics and hierarchies (Haley, 1980), boundaries (Minuchin & Fishman, 1981), communications (Satir, 1988; Whitaker & Keith, 1981), intergenerational dynamics (Bowen, 1978; Framo, 1976; Paul, 1965) and protectiveness make families more "powerful" than treaters to effect change (Landau-Stanton et al., 1993; Seaburn et al. 1995).

Fifth, many situations do not call for the CDP to be threatened with consequences as a condition of entering treatment. A more flexible model of intervention allows the network to decide on what, if any, consequences will be used. The network members know the CDP, and they will incorporate in their decision-making discussions any fears of intrusion the CDP might be expected to harbor.

Sixth, whenever possible, outpatient treatment is the preferred modality for use with an intervention continuum (Loneck, Garrett, & Banks, 1996a,b). Because it effects change within the real world in which the family members reside, it will more readily generalize than will inpatient treatment.

This model takes into account the reciprocal interaction of chemical dependency. The family and friends of the chemically dependent person affect the development of addiction and the chemically dependent person affects family and friends. Chemical dependency is a spectrum disorder and interventions must take into account the full

complex of the etiology, systems adaptation and progression of the disease.

The ARISE model is a three stage, graduated continuum of intervention designed to utilize the concern of the chemically dependent person's family and friends toward maximizing both engagement and, hopefully, retention in chemical dependency treatment. Each stage involves an increased commitment of therapeutic and familial/network resources, compared to the stage which precedes it (Prochaska & Di Clemente, 1986).

As opposed to a full-fledged Intervention, and all that it demands, a graduated method is more responsive to the fears, worries, guilt and controlling behaviors of those who have lived with the addiction. Its intent is to meet these people "where they are." In other words, treatment professionals attune themselves to the rationalization, protection and denial systems of family and friends, and consequently offer as flexible an intervention strategy as possible. In this way, allowance is made for inclusion of even the most resistant family members in the process of family recovery.

In addition, the graduated intervention continuum of the ARISE model takes into account the potential of a negative, or "down side," such as separation/divorce, violence, or a suicide attempt. Potential negatives are addressed at each stage of the intervention continuum. Depression, violence, and suicidality are screened for in the process of working with the intervention network. These discussions take into account fearfulness of network members, as well as the anticipated response of the CDP. The likely reaction of the CDP to shame and guilt becomes a major factor in determining what level of intervention the group agrees to proceed to. In all levels of the intervention continuum it is the therapist's responsibility to have a plan developed which addresses the most serious negative behaviors of the CDP, such as violence or suicide attempt. This includes preparation for emergency actions—for example, determining when to (and who should) take the CDP to a medical emergency department, contact a mobile crisis team, or call the police. It is also the therapist's responsibility to either continue working with the network (or a subgroup) or refer them to another therapist for longer-term therapy, should such be indicated.

The three stages are: I Telephone Coaching; II Mobilizing the Network to Engage the CDP, and III The ARISE Intervention.

Stage One: Telephone Coaching

A concerned person calls the clinic ("The First Call"), perhaps in response to a community education/outreach effort or perhaps to a friend's recommendation. He or she is worried about a family member or acquaintance who has a substance abuse problem and has not sought help and/or refuses to do so. The caller wants the person to enter treatment, and may even request a formal Intervention. Upon hearing the caller's request, the reception-

ist contacts the therapist or counselor designated to handle such matters, who either takes the call or arranges to get back to the caller later that day.

The therapist's goal at this stage is to turn the caller's concern, frustration and confusion into motivation to intervene. Obviously, in order for the telephone conversation to reach a successful conclusion, the counselor must be committed to the ARISE intervention continuum. He/she should also have access to, and confidence in, a comprehensive treatment system. The therapist also needs to acknowledge the trouble the caller has gone to in making a phone call to talk with a complete stranger about a problem he or she is having with a loved one, friend or co-worker.

Structuring the Call-in. The telephone "coaching" described here is usually done over a 10 to 15 minute time period. It normally follows the following steps:

1. Identify the current "crisis" that precipitated this phone call.
2. Obtain the caller's permission to ask pertinent information which will help to formulate an answer to the "why now" question (Stanton, 1992), that is, why is the call coming *now*, rather than 6 months earlier or 12 months hence? This will also allow development of a therapeutic "reframe," a way to re-construct the reason for calling and make it work to motivate the caller to action.
3. Get an overview of the chemically dependent person's abuse history and current level of use.
4. Get a brief treatment history—including self-harm risk, history of violence or mental illness.
5. Construct a preliminary genogram—a kind of family map (McGoldrick & Gerson, 1985).
6. Find out what has been said to the CDP—and what has been tried in the past—to get the person to stop using.
7. Describe the intervention continuum, emphasizing how important family and friends can be to the recovery process, and explaining that initial motivation may have little to do with eventual outcome in treatment—that a key variable may be, rather, consistent involvement by the people in the CDP's network.
8. Obtain a commitment from the caller to talk with other concerned people, so there is a group committed to coming in for the first (evaluation) interview—using the argument, "on a one on one basis, the abuser always wins."
9. Instruct the caller to ask the CDP to come to the first appointment, which will be an "evaluation" session. Address caller ambivalence about approaching the CDP. Let the caller know that you are willing to take a call from the CDP to address questions about the session.
10. Schedule the evaluation interview, in terms of time and place.

11. Reinforce that the caller and the network group are to come to the appointment regardless of whether the CDP comes in and warn the caller not to engage in an argument with the CDP after the invitation to the evaluation is made.
12. Support the caller by telling him or her that you are available to address any problems that surface—that you can be reached by phone.

Sometimes this phase of Stage One takes more than one telephone conversation, but rarely more than two.

Rationale for Inclusiveness. Why does ARISE attempt to include such a large number of people from the beginning, especially since some approaches, such as CRT and the Unilateral method, tend to work only with one person, usually the spouse? There are several reasons. One of them is leverage. When one works solely with the spouse, for instance, one is subject to the tensions and emotional vicissitudes surrounding her or his relationship with the CDP. For example, if a male CDP and his spouse are in the midst of an all-out marital battle, her leverage to get him to do her bidding, that is, to enter treatment at her behest, is negligible. She may also have begun to feel the most helpless of anyone in the family, at least in this area. Thus we advocate placing eggs in more than one basket. Further, it takes no more time to work on bringing in the network than to strategize with the wife on how she, alone, can get him in. By including a larger system, one is not constrained by the limitations of a single dyadic relationship. In addition, there is greater strength, and greater creative potential, in numbers (Lan-dau-Stanton & Clements, 1993; Speck & Attneave, 1973).

CASE EXAMPLE: MIKE AND JOHN

Mike placed a call to the first author (JG), stating he had heard about the interventions JG did with families. He summarized his concern for a 25-year-old younger brother, John, who had been in a car accident the previous weekend and had left the scene of the accident on foot, abandoning his sister's car in a snow bank with a smashed front end. Mike stated his family was becoming increasingly concerned about John and they wanted to undertake an Intervention. JG asked what the family had previously done in regard to John's drinking and drug problem. Mike replied that his mother had taken John to a drug counselor when he was 18 because of an arrest and suspension from high school. In addition, two of the older siblings had individually talked to John. The family had not done anything as a unit to express their concerns. In fact, a number of family members were not concerned about John's substance use because they saw him as functioning better than in previous years, since he was holding a full time job, participating in an apprentice program, owning a car, completing his college education and maintaining an apartment on his own. Mike indi-

cated that John is the 8th of 10 children and that he thought he could get all of the siblings, his mother and three in-laws to participate in an intervention. JG told Mike that he would be interested in working with the family and described the intervention continuum.

Describing the ARISE Model (Telephone Coaching).

Mike had done some reading about Interventions and had talked to a friend who participated in a Johnson style Intervention. He was surprised and initially skeptical about doing an intervention another way. JG described the intervention continuum and the rationale for taking the intervention in stages. Mike asked a number of questions about the ARISE model and eventually understood that we would use a progressively more confrontational approach until the desired outcome (getting his brother into chemical dependency treatment) was achieved. There were five key factors that convinced him to go along with the ARISE continuum:

1. Because the family as a whole had not approached the problem, John's resistance could not be adequately assessed. On a one-to-one basis, the chemically-dependent person always wins by manipulating the other person. This type of manipulation resembles an instinctual response to a threat and does not reflect the degree of ambivalence the CDP is struggling with.
2. The most common complaint CDPs have about Interventions is that they feel like they were never given adequate opportunity to address the problem. Regardless of whether this perception is true or clouded by the denial process, it must be taken into account because of the potential anger, defiance and rebelliousness which result from mismatched confrontation. The element of surprise and the critical nature of the confrontation often result in a defiant backlash and relapse, which can be avoided by the ARISE model (Loneck, Banks, & Garrett, 1996 a,b). When a family has not discussed the problem openly over a period of time, the CDP often is secretly relieved by an invitation to discuss the problem with everyone present. Further, it sometimes helps to remind members that most people do not like to be absent when they are going to be the topic of discussion.
3. Mike was helped to understand that the intervention continuum would take into account the fears and ambivalence of some of the siblings, therefore allowing the family to function as a whole unit. The strength of operating as a unified body would compensate for the lessened degree of confrontation.
4. The family was the one making a commitment to change at this time, not John, himself. The intervention continuum would allow for the members to continue the process of change regardless of what John decided.
5. The recovery process is long term and is aided by ongoing family support and involvement. The CDP is

better able to involve the family and use its support when the level of confrontation matches the resistance. In addition, the family is better able to reduce its enabling behaviors, as well as continue to support the changes the chemically dependent person is going through.

Preparing for the Social Network Meeting. Mike agreed to discuss the ARISE model with his family and get back to JG if they were interested in working with him on the intervention. He called back 2 days later and said his family agreed to use the intervention continuum model and asked if we could do it on a Saturday morning, because most of the family had to come in from out of town. JG agreed to meet on a Saturday at the home of John's older sister. Given that John's mother lived out of town, JG hypothesized that the oldest sister was functioning in a surrogate parental role, and having it at her house would be reassuring to the family, and allow them to support each other in their natural environment: This hypothesis turned out to be true. The telephone planning continued, with JG emphasizing the work the family could do on their own, accompanied by telephone "coaching" when necessary.

The next question regarded how the family was to prepare for the session. JG described how he would facilitate the session: First, he would arrive early to meet the family and address any questions they had about the session (at this point JG had decided it was not necessary to meet the family in person prior to the session, since they were capable of doing so much of the preparatory work on their own). Once John came to his sister's home, JG would briefly introduce himself to him, state what the purpose of the meeting was and ask him to listen while each of his family members described what he or she saw as the problem. John would be given an opportunity to respond when all of the others had spoken. Because of their familiarity with the Johnson style Intervention, Mike asked on behalf of the family whether they should write intervention letters and undergo a role-play preparation session beforehand. It was explained that the ARISE model uses an informal, unrehearsed format in the first meeting. JG stressed that the power of the family's unity and their concern and love for John were the influential factors. He did not think it necessary for them to add both time and expense to the intervention process. The only preparation was therefore for them to (a) think of time when John's drinking/drug use had created problems, (b) be prepared to discuss these with John, including how these incidents had effected them, and (c) let him know he would have their support for entering treatment.

John's insurance was verified and, because it was with an HMO, JG instructed Mike on how to deal with the pre-authorization process. John worked for a union, so Mike was also instructed to contact the benefits/EAP coordinator. As an aside, the issue of confidentiality is bypassed because the family is making the phone calls

and having the discussions, not the therapist. Therefore, the benefits of involving a broader network are not compromised by the constraints of therapist/patient confidentiality. In this case, the health benefits/EAP coordinator was able to act as an advocate for the pre-authorization because this HMO had a reputation for not approving inpatient referrals. The HMO pre-authorized 7 days in an inpatient rehabilitation facility.

The last issue concerned how the family might get John to the session. JG suggested a direct approach by letting him know that the whole family was coming together for a meeting to discuss their concerns about his drinking and drug use. JG suggested the invitation come from either his mother or his oldest sister. (Subsequently, the family decided to have the oldest sister extend the invitation.)

The family was concerned about what kind of shape John would be in on the Saturday morning of the session, especially since a good friend's bachelor party was scheduled for Friday night, and the wedding for Sunday. Through Mike, the family was reassured that, if a crisis occurred prior to the intervention, they were to call JG who would move up the time of the intervention to capitalize on the momentum of the crisis. JG instructed Mike to meet with the bride and groom, in confidence, to let them know that John would not be attending their wedding and to let them know why. This was done to remove any excuses John might use not to go directly into inpatient rehabilitation from the intervention session.

JG's final preparation was to complete the preliminary genogram. This was done in the same phone conversation with Mike. JG was cautious to screen for any family background of psychiatric problems, history of depression or suicide, and history of violence. Nothing of significance was revealed by Mike.

This example highlights three foundational principles in the ARISE model: (a) Build on family strengths, (b) Families are more powerful than the therapist, and (c) Families are capable of completing much of the work by themselves, thus simplifying the therapist's job.

As noted earlier, the therapist decided to do the intervention session without meeting any of the family face-to-face. This option is only recommended when the therapist is trained in this intervention model.

As opposed to more or less starting from scratch, as happened with the Mike/John case, the case below illustrates a situation where a certain amount of groundwork had already been undertaken by a caller before he even contacted the clinic. Such instances are not uncommon, partly because people are more sophisticated these days and may have already had exposure to, or read about, treatment or Intervention.

CASE EXAMPLE: TOM AND MARGE

Tom, Jr., a 34-year-old mechanic, called the facility expressing concern for his wife due to her cocaine and al-

cohol abuse. The receptionist recognized that his frustrations and worry about not being able to help his wife made him an appropriate candidate for referral to the ARISE process. She asked him if he would like to talk to a therapist who was skilled at doing Interventions. He said he worked around the corner from the facility and, due to the seriousness of the situation, would like to come by on his lunch break that day. He was told to stop in and the therapist would be able to spend 10 to 15 minutes with him.

Tom arrived at noon for his initial face-to-face session. He expressed concern that his 30-year-old wife, Marge, was getting progressively worse and he thought her use of cocaine and alcohol might be part of the problem. A crisis had occurred two nights earlier, after his wife came home 4 hours late and “under the influence” from her 4 to 11 shift job as a supervisor in a banking computer operation. Tom had not been able to sleep due to his worry and increasing anger at his wife’s lateness. He confronted her when she arrived and the confrontation led to a verbal argument, smashed dishes in the kitchen and threats by both parties to divorce. Their two children had been awakened by the fight and could not get back to sleep due to their fear. Tom decided something must be done.

The therapist (JG) assured Tom that he had been correct to take action. The therapist also reframed Marge’s deteriorated behavior as an indirect request for help. Tom readily agreed to set up an appointment for later that day to complete a full evaluation.

In this initial interview, the therapist was attempting to formulate an understanding as to why Tom was taking action at this particular time— “why now?” Tom had indicated that Marge’s mother had died 2 years ago and “Marge has been going downhill ever since. That’s when the drugs started and she got worse.” JG hypothesized that health issues might provide an entry point into treatment, given what Marge went through with her mother’s death from cancer. Also considered was the issue of stopping the cycle of addiction from going to the next generation, since Marge’s family had a three-generational history of alcoholism and, as noted below, Tom and Marge’s children had developed acting out problems.

This meeting provided an opportunity to learn more detail from Tom about Marge’s history of drug and alcohol abuse, the couple’s functioning and marital problems, past treatment history. The therapist was also able to complete a full three-generational genogram, and assess the use of the ARISE model for an intervention. Marge had no prior treatment. The couple had been married for 10 years. Their two children were exhibiting symptomatic behavior: the 6-year-old had begun to act out in kindergarten and had recently been tested for attention deficit disorder but found not to have this diagnosis; the 4-year-old had regressed to wearing diapers again and had to be taken out of daycare due to not being toilet trained. Tom reported the marriage was in serious trouble, noting that they had not had sex in over 4 months, which was highly unusual

for them. They argued regularly when Marge came home from work and Tom was increasingly resentful of weekends because “they turn into one long argument.” He was confused about the role of alcohol and drugs in his problems, as well as Marge’s accusations that *he* was the problem due to his controlling and angry behavior. He described Marge as a daily drinker consuming 10 to 18 bottles of beer. He was uncertain of her cocaine use due to her secretiveness and not doing it at home. He had overheard phone conversations when she described smoking crack the night before and being unable to stop. He noted they were having increasingly serious financial problems and Marge could not account for where she was “spending between \$100 and \$300 per week.”

This brief 10 to 15 minute contact was analogous to the initial phone conversation a therapist might have with a significant other. Phone calls are, of course, more common than stop by visits such as Tom’s.

The Invitation. Tom indicated that Marge had an older brother who had 7 years of recovery from alcoholism and an older sister who had just over 1 year recovery from alcoholism and opiates. She also had two friends who were supportive of her and would come to a session if invited. Tom stated his parents and sister would also come to a session if invited because they liked Marge and were also worried about her. Tom struggled with loyalty toward Marge because, “I don’t want her to be embarrassed in front of family and friends.” At this point in the interview he was asked about inviting Marge by himself and only the two of them coming in (describing the second stage of the intervention continuum under the ARISE model). He readily agreed to do this but asked for more direction to help him with the “invitation to come for an evaluation” so he could avoid getting into a fight with his wife. The following instructions were written out for Tom and an appointment set up for the next morning to see the couple:

Instructions for Inviting Marge. “Maintain a calmness when approaching her, this is an invitation not a lecture. Only approach her when you know she has not been drinking. Put the following points into your own words:

1. Drinking is affecting the whole family.
2. I realize both of us need to make changes and that is why I went to a therapist. I can only change myself.
3. The therapist asked for both of us to see him because he wants to get both sides of the story.
4. Tell her when the appointment is set for, give her the therapist’s name and phone number and let her know that she can call the therapist at any time if she has any questions.
5. Expect an angry reaction and avoid responding to her anger. Let her know that you are supportive and you have done this out of love for her.
6. You keep the appointment regardless of whether she comes.”

Instructing Tom to come to the session regardless of whether his wife decided to come was an important feature of this process. It lets the CDP know that change will nonetheless be occurring and the old pattern of drug and alcohol use will not be tolerated.

Stage Two: Mobilizing the Network to Engage the CDP

The initial part of this first meeting is conducted as an evaluation. Participants are each asked to explain why they are present and what they see as the problem to be addressed. While this session might involve only the initial caller, preferably it will include a number of significant others.

If the CDP is present, this evaluation meeting evolves into a motivational session in order to get a commitment to (a) begin treatment, and (b) meet with the network group in one week to report on progress. A network contract is signed outlining the responsibilities of both the CDP and the network group (see Appendix: The Network Contract). The network then continues to meet with the CDP once or twice a month over the first 3 months, for a total of two to five sessions. This process allows for the initial confrontation to evolve into support.

If the CDP is not present, the evaluation is done in a similar manner, with each person describing what the problem is and deciding, as a group, on the next best step to engage the CDP in treatment. In both scenarios, that is, whether the CDP engages in treatment or not, the support network may continue to meet biweekly or monthly for the period noted above. While it might seem surprising that families would continue as long as 2 or 3 months without the CDP's entering treatment, it is our experience that families tend to continue because of the positive changes they are making.

The hallmark of this phase of the intervention continuum is the work that is done by the network group. If the CDP has initially refused to participate in an evaluation, the network mobilizes its strength to pressure him or her toward that end. Each network meeting has the following components (Garrett et al., 1996):

1. Join each member of the network.
2. Elicit a problem statement from each member of the network with the permission of the CDP.
3. Review efforts to engage CDP—integrating information from the first call.
4. Determine the patterns of alliance.
5. Discuss options for addressing engagement problems.
6. Develop strategies to motivate CDP's engagement.
7. Prepare the group for handling possible crises.
8. Schedule the next session.

If the CDP engages in treatment at some point in this phase, the network group continues to meet on the same schedule as outlined above. If the CDP does not engage

in treatment the network group members must decide whether or not to undertake a more formal Intervention. The ARISE process and major stages are presented more graphically in Fig. 1.

Mike and John (Continued)

The therapist arrived at the oldest sister's house one half hour before the time scheduled for the full meeting. John's mother was among the first to greet JG and he asked her to introduce him to the rest of the family. She shared a short vignette about each of her children. Once introduced, JG reviewed the plan for the session and addressed questions from the family. This preparation was meant to reduce their anxiety and to encourage them to be genuine and spontaneous with John once the session started. The therapist also prepared them for the likely emotions that would evolve from the session and gave them permission openly to express their feelings. However, he cautioned he would not allow verbal abuse or overt violence at any time in the session. Further, he arranged for John's mother and next youngest sister to sit on either side of him once he came into the room to sit down. This was done because of the respect John was described as having for his mother, along with the "big brother" relationship he had with the next youngest sister. The role of these two women was, then, to encourage and support him as he began to experience the pain coming from the truth about how he had been hurting his family and himself.

John arrived about 10 minutes late and appeared well groomed and distant as his family greeted him. JG introduced himself and began the session by asking each of the immediate family and three in-laws to address John directly. In turn each person spoke. Within 5 minutes a number of the siblings were crying. John began to cry as well when his next oldest brother began to speak, got up from his chair and asked John to stand up with him so he could give him a hug. At that point, the combination of tenderness, firmness, compassion, and unmistakable love between the two brothers embracing in the middle of the family circle had the whole group in tears. The therapist then became confident that the rest of the session was a mere formality, because John had no choice but to enter the recommended treatment program.

A number of themes evolved from the messages to John. First was his increasing isolation from the family. Second was his distancing from his nieces and nephews—related to his siblings letting him know that they didn't want their children growing up influenced by drug and alcohol use. Third was the continued deterioration toward self-defeating, unsafe behavior and attitudes. (For example, he had been driving without a license—due to his third DWI—and without insurance on his vehicle.) The fourth theme regarded the siblings' consistent messages that they wanted their brother back functioning in a

healthy, open fashion and that they were willing to do whatever was necessary for this to occur.

John expressed both his anger at the family for holding such a session and his gratitude for their concern. He openly admitted that "my life is out of control." He had begun to use cocaine in the past year in addition to the cannabis and alcohol. He had been fighting the loss of control over his drug and alcohol use for the past couple of years and was relieved that his family had done what they had done because, "my false pride would have gotten in the way of doing it for myself." As anticipated, he brought up going to the wedding the next day and concern about the security of his job. When told both had been taken care of he was openly relieved, surprised by how thorough his family had been. He said he was ready to go to the rehabilitation facility. The facility was called and notified of John's decision to enter. His mother and one brother then drove him there.

A half hour debriefing took place after John left. The family expressed gratitude for the process, congratulated each other on the openness they had shared and the many risks they had taken, and said they felt relieved about John's safety. The family was instructed how to deal with John if he wanted to leave the facility against medical advice. They were encouraged to attend Al-Anon and the family program at the facility. The family also agreed

to meet monthly once John got out so they could continue the intervention process by supporting his recovery.

Tom and Marge (Continued)

Meeting Marge. Tom came alone to the evaluation session. Predictably, Marge had become angry and verbally abusive when Tom had told her he had seen a therapist and that the therapist had invited both of them to the next session because "he wanted to get both sides of the story." Tom related that Marge would not come to a session. She did agree, however, that her drug and alcohol use had become a problem, but that she "had stopped since their big fight two nights ago and she would be able to continue on her own." The therapist expressed concern for her medical safety if she stopped so abruptly and asked if he could call her on a speaker phone to discuss this concern. Tom was surprised by the concern for his wife's health and agreed to the call.

Marge was caught off guard by the call. After the introduction, the therapist took a "one down" and apologetic approach for making the call, but felt "responsible for the current state of affairs" and having to be "conscientious about potential medical problems." After some discussion about the therapist's concerns for her health, she asked, "Oh, is that what they have these detoxification places

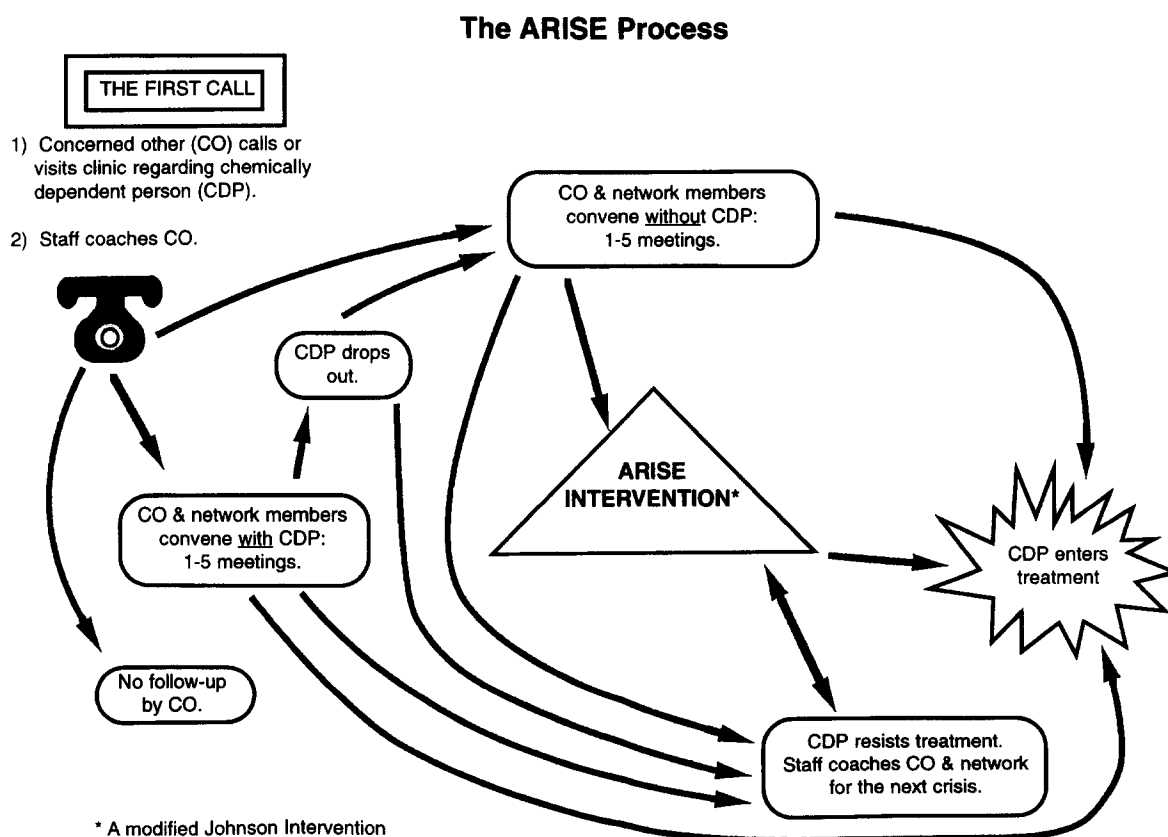


FIGURE 1. The ARISE Process.

for?" The therapist indicated that she was exactly right with this insight and asked if she would be willing to join with her husband for an evaluation because he was also worried about her health and safety. She agreed to be screened later in the day, before she left for work.

The Screening. Marge and Tom met at the facility for the agreed upon screening. Marge indicated at the start of the session that she had called her sister in recovery (who also is an RN) to discuss the therapist's earlier call. Her sister was encouraging and supportive for Marge to attend and to be evaluated for referral to a hospital detoxification unit. Marge informed Tom and the therapist that she remained committed to abstinence. The therapist determined her history did not warrant an inpatient referral. It had been nearly 48 hours since her last use of alcohol and 5 days since her last use of cocaine. She agreed to daily monitoring for the next week and to start couples treatment "because I know we have serious problems." She also agreed to develop a support network and invite its members to a session as part of her treatment.

Marge's Complaint. Despite the fact that Marge was engaged in treatment by using the first steps of the ARISE model, thus avoiding a more confrontative Johnson style Intervention, Marge complained to her husband about wishing, "you would have let me do it myself." She was appreciative of his concern for her and his frustration with her drug and alcohol use, and she readily saw the love behind his actions. However, Marge's complaint underscores the usefulness of the ARISE model, because it balances the desire by the family to help with the need of the CDP to maintain dignity in the process of recovery. Had Marge not been willing to enter treatment, the progressive nature of the ARISE model would have given her multiple opportunities to enter treatment "on her own." Even if the situation had progressed to a Johnson style Intervention, the participants and the CDP would know that there had been multiple times for less coercive treatment engagement and therefore be more understanding of the nature and necessity of the confrontative approach as the end stage of a process.

Stage Three: The ARISE Intervention

By the time this stage is reached, the network group would have met between two and five times and employed various strategies to engage the CDP in treatment. The CDP's resistance is well defined by this point. In spite of the network's confrontation, encouragement, support and understanding, the chemically-dependent person has refused to stop using and enter treatment. Clearly, the CDP's self-deception and denial system result in choosing a drug over the love and support from family and friends. Network members must address a central question at this point. Are they willing to both

"develop a bottom line," and enforce serious consequences for the CDP if he or she continues to refuse treatment? Armed with the knowledge that 7 out of 10 chemically-dependent people enter treatment after a confrontative intervention, are they, as a group, ready to establish consequences and support each other regardless of the outcome? In other words, are they ready to face the reality that the addiction may have progressed beyond the point of treatment engagement and the best thing they can do is to support each other in the enforcement of consequences and the grieving of the loss? If the CDP chooses to deteriorate and die from addiction, the question is how many people will the CDP "take down with him (or her)?"

The group must be educated to understand that the next step in the intervention continuum—the Johnson style Intervention—is the most powerful procedure used in the addiction treatment field. If the group chooses to move forward with it, then formal training and rehearsal is done, including videotaping sessions so the network can refine its final approach and build in as much potency as possible. This final phase is emotionally demanding and exhausting to all participants. It often means making very difficult decisions regarding how much and what type of future personal contacts the network group will have with the CDP. For example, an adult child may restrict contact by the chemically dependent parent with the grandchildren due to the continued use. Such concerns are written in individual letters to the CDP, consequences are established, and a forum is decided upon for the group to meet with the CDP, regardless of his or her willingness. This usually means the meeting is a surprise, even though he or she has been invited to numerous previous sessions. The preceding invitations are important because, after an Intervention, CDP's frequently complain that they did not like the surprise and would have preferred knowing the planning was going on and been given an opportunity to participate.

The intervention continuum makes it easier for both the family and the CDP to engage in and complete treatment. Network members are comforted to know their intervention will be adjusted to the level of confrontation necessary to get the job done. The CDP is strengthened by a built-in network which he/she will be held accountable to, and supported by, throughout the course of treatment.

ARISE EFFECTIVENESS: SOME DATA

Recently, the first author (JG) and colleagues (Loneck, Garrett, & Banks, in press a,b) completed a retrospective analysis and comparison of 331 clients in terms of engagement and retention rates. The clients were randomly selected from one of three approaches: (a) the ARISE procedure; (b) coerced referrals (e.g., court mandated); or (c) self referrals. To our knowledge it is the first published research to demonstrate that intensive

outpatient programs are both viable and an effective modality for referrals involving interventions. Of the total client sample, 14% required some level of hospitalization before eventually completing outpatient treatment. Among the three approaches, the ARISE group (by definition highly resistant and initially brought into treatment by their families) had a high treatment engagement rate, that is, 70% versus 75% for coerced and 68% for self referral. ARISE also had a treatment completion rate of nearly 90% for a 16 week intensive outpatient program, which was equivalent to patients who entered due to coercion and significantly greater than the 48% rate obtained for self referrals (who by definition came into treatment without their families). The authors concluded that interventions are powerful motivators due to both the support and pressure of a network on the chemically dependent person to enter and complete treatment.

SUMMARY

Managed care is requiring programs to document effectiveness and work effectively with clients in the least restrictive setting possible. The ARISE model addresses these managed care requirements, in that it is committed both to improving quality of care and delivering cost-effective treatment.

The ARISE model integrates systems theory with the power of Interventions. It has the flexibility to match level of intervention to a given family's unique characteristics and history and to move at a pace that is consonant with maintaining support network confidence. Confidence and commitment by the support network are highly correlated with treatment engagement by the CDP.

It should be noted that, because it is designed to respond to *any* call in, ARISE spreads its net widely. Thus it increases the chances of inducting more people who are at earlier stages in their addictive careers. By effecting treatment engagement as soon as possible, cases will be prevented from progressing to more severe levels of addiction. Like most other early interventions, then, ARISE can serve to reduce health care costs.

The intervention continuum puts into practice the notion that the CDP affects the family and the family affects the CDP. This "both/and" (as opposed to "either/or") approach opens up new opportunities for the chemical dependency treatment field to strengthen its ability to engage and retain resistant clients in treatment. In addition, the ARISE model presents a number of challenges to the field. These challenges include: (a) maintaining openness to new approaches, (b) developing confidence in the effectiveness of outpatient treatment, (c) learning to work with relapse in an outpatient setting, (d) training supervisors in systems theory, and (e) restructuring outpatient programs to operationalize research-based treatment approaches.

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APPENDIX

ARISE

SOBER SUPPORT NETWORK CONTRACT

CHEMICALLY DEPENDENT PERSON'S AGREEMENT	SOBER SUPPORT NETWORK AGREEMENT
1. I agree to abstain from all mood-altering substances, including the cancellation of addictive prescription medication.	1. I agree to remove all mood-altering substances from the home for a minimum of six months.
2. I will agree to B.A.C. or urine testing requested by my therapist and/or support network.	2. I will be available to the client for support of the treatment plan throughout withdrawal and early recovery.
3. I will participate with the treatment providers and the Sober Support Network to develop realistic early recovery goals.	3. I will collaborate with the client and the treatment providers to develop realistic early recovery goals.
4. I will expect/accept consequences of my behavior.	4. I will allow natural consequences to take place.
5. I will contact _____ and/or _____ if I relapse and will attend an emergency Sober Support Network session.	5. I will call/attend an emergency network session if there is a relapse by contacting the outpatient provider.

ARISE

SOBER SUPPORT NETWORK CONTRACT (Page 2 of 2)

In case of an emergency, I will call:

_____ # _____

or _____ # _____

I have read and understand the obligations and responsibilities. In addition, I make a personal commitment to follow the agreed upon recovery goals.

Client signature: _____ Date: _____

Sober Support Network Signatures:

_____	Relationship to Client	Date: _____
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_____	Relationship to Client	Date: _____
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_____	Relationship to Client	Date: _____
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_____	Relationship to Client	Date: _____
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_____	Relationship to Client	Date: _____
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Witness:

_____	Title	Date: _____
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