

Strength in Numbers: The ARISE Method for Mobilizing Family and Network to Engage Substance Abusers in Treatment

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ABSTRACT

The model described in this paper takes into consideration two key findings: (a) In a given year, the vast majority (90-95%) of active substance abusers do not enter treatment or selfhelp groups. and (b) substance abusers have frequent contact with their families (60-80% either live with a parent or are in daily contact). This paper presents a method for mobilizing and collaborating with families and extended the support system toward working with resistance and getting the substance abuser into treatment. Principles and techniques are provided for convening and structuring intervention network meetings toward that end. This intervention network approach can be used either alone or as part of an overall model, ARISE (A Relational Intervention Sequence for Engagement). The

ARISE model addresses both clinical and programmatic issues in treatment engagement for substance abusers.

Key Words. Addiction; Engagement; Family; Link; Intervention; Network; Outreach; Substance abuse

INTRODUCTION

For some time, society and the addiction field have been overlooking a problem of major proportions: the inordinate number of actively chemically dependent people who do not engage in treatment or self-help. In a given year, 90-95% of substance abusers do not receive treatment or self-help and may never do so (1-4). Meanwhile, the cost of drug and alcohol abuse—including medical care, premature death, unemployment, criminal justice involvement, and addiction treatment—is estimated at over \$165 billion and 50,000 lives per year (5, 6), and treatment has been shown to save \$7 for every \$1 spent (7-12). Despite this, apart from employee assistance programs and criminal justice initiatives, very little has been done to increase the number of substance abusers receiving treatment.

One strategy for enhancing motivation to enter treatment is to use the natural influence of family, friends, coworkers, and other social network members toward getting a substance abuser into treatment. Numerous reports have established that the vast majority of substance abusers are in regular contact—usually daily or weekly—with their parents or the people who raised them (see reviews in Refs. 13-16). According to Stanton, Shea, and Garrett (as cited in Ref. 14), this appears to hold for problem drinkers and alcoholics as well as for drug abusers. In other words, family members are important to substance abusers, and substance abusers are important to their families (15, 17- 20). Further, families and networks have been demonstrated to be beneficial in helping a substance abuser overcome chemical dependency (14, 21-23), while the family itself appears also to be helped in the process.

This paper describes ARISE_ (A Relational Intervention Sequence for Engagement), a manual-driven relational intervention for engaging resistant substance abusers in treatment. It draws on the connectedness, interest, and commitment of concerned other members of the extended family and support system to motivate the substance abuser to enter treatment. The ARISE interventionist collaborates, or "partners," with extended families and networks to have them act as motivational enhancers to get reluctant substance abusers into treatment.

EXTENDED FAMILY AND SUPPORT

NETWORKS AS RESOURCES

In both the sociological and the family therapy/treatment literature, extensive attention has been paid to the importance of social networks as resources to individuals and

families in trouble (e.g., 24, 25). In fact, recognition of the impact of living with alcoholism on families contributed to the emergence of Al-Anon. Starting in the mid-1960s, Speck and associates extended this notion to including social networks in the actual treatment of psychological problems (26, 27). This therapeutic application has been adapted by others (e.g., 28, 29). One such model is Landau's (30) link therapy, which utilizes the network to identify a member, or "link therapist," to serve as the primary intervener in the therapy process. (The link therapist is a member of the network who is highly motivated and best able to connect, with minimal conflict, with other network members in the service of goals established by the network.) Szapocznik et al. (31) developed another model of "one person family therapy" for treating latency-age children and adolescents; the model focuses on the index patient, but involves other members of the family and network in several of the sessions. Since in both these approaches the network members may or may not attend sessions (and in link therapy, the index patient may also be absent), they have particular relevance for the work described in the present paper.

Network treatment has been applied with substance abusers by a number of investigators and clinicians. One of the cases in the original Speck and Attneave (26) book was an adolescent drug abuser. Hamley-Van den Velden and coworkers (32) also describe its use with that population. Garrison and colleagues (33, 34) have applied it with drug-addicted, therapeutic community residents. More recently, Galanter (35,36) has developed a "network therapy" model for substance abusers that utilizes "from one to several persons close to the patient" (36, p.252); its primary focus is on collaboration between therapist and network members toward sustaining the patient's abstinence.

ENGAGEMENT METHODS

A number of other relational approaches, including ARISE (37-43), have been developed for which the task is not treatment, but engagement itself_engaging a resistant substance abuser in treatment or self-help. Since the engagement process occurs before treatment, there is no index patient or client to be identified. There is, therefore, no verifiable diagnosis during this phase of the work. The focus is on concerned other members of the family and support system rather than on the substance abuser.

Berenson (44) developed a method for working with the most motivated family member(s) to get an alcoholic into both treatment and Alcoholics Anonymous, a method he later (45) applied more specifically with motivated spouses.

Another example of utilizing a family member from the network in the engagement effort is the "unilateral family therapy" of Thomas and associates (46,48), who work almost exclusively with the spouse or partner. Barber and Gilbertson (49) also developed a method of unilateral engagement designed specifically for spouses living with active alcoholics. While these five models draw on one or more members of the network, they

deal primarily with dyadic relationships and therefore do not qualify as true network approaches.

Azrin (50), in his community reinforcement approach, involved a distressed family member the day of the initial telephone request for help in inducting an alcoholic in treatment. Community reinforcement training (CRT) and family training (CRAFT) involve working with the spouse for a number of sessions (mean number of sessions = 6) to deal with psychoeducational awareness (51). Checklists are used to assist the spouse in the areas of (a) avoiding physical abuse, (b) encouraging sobriety, (c) encouraging treatment, and (d) assisting in treatment. This approach is generally nonconfrontational and attempts to take advantage of a moment when the drinker is motivated to get treatment by immediately calling the clinic and setting up an appointment, even in the middle of the night.

The Johnson intervention (52, 53) utilizes larger networks toward treatment engagement. Despite its apparent widespread use, however, the Johnson intervention has generated very little outcome research. We are aware of only two studies, both using quasi-experimental designs, that examined its effectiveness: Logan (54) combined Johnson intervention methods with the social network therapy approach of Speck and Attneave (26) and Garrison et al. (34) to engage alcoholics in treatment, obtaining a 90% success rate across 60 cases. In contrast, the intervention efforts of Liepman and colleagues (55), using the Johnson intervention model, worked with networks half as large as Logan's and were successful in only 25% of their 24 alcoholic cases.

Al-Anon provides significant support for spouses and other family members of alcoholics. Despite this, recent studies show that, while it is highly effective at helping individuals deal with issues of codependency, guilt, self-blame, and detachment, it has not proven an effective aid to the family for engaging the alcoholic in treatment (49, 56, 57).

Sisson and Azrin (58) examined the effectiveness of this approach with 12 cases, 7 in which a family member received CRT and 5 in which the person received traditional-type (Al-Anon) counseling. In 6 of 7 CRT cases, the alcoholdependent person entered treatment, while none of the people in the traditional cases did. In 1999, Miller et al. (56) reported on a randomized trial in which concerned others were assigned to Al-Anon, Johnson intervention, or CRAFT:

The Concerned Significant Others who received CRAFT successfully engaged 67% of the resistant drinkers (76% of the resistant DAs) into treatment. This far outweighed the engagement rates of both the Twelve-Step Facilitation (13%) and Johnson Institute (23%) approaches (p. 693).

Despite identifying outcomes with a treatment resistant population, the CRAFT research excluded 75% of the cases coming into the study for such reasons as "insufficient contact," "domestic violence," and "Concerned Significant Other uninterested." While the reported engagement rates are truly impressive, the high exclusion rate limits the capacity of this study to address the question of the model's effectiveness in "real-world" settings.

ARISE NETWORK FOR ENGAGING SUBSTANCE

ABUSERS IN TREATMENT

Specific Features of the ARISE Method

Underlying assumptions. In contrast with the other engagement methods above, ARISE has a number of distinctive features based on the underlying assumptions that members of the social network or community support system (a) are accessible, concerned, healthy, and competent to help the substance abuser; (b) can be made aware of their strengths and resources and empowered to be successful in the engagement process; (c) know, love, and spend more time with the substance abuser than any professional does or should; (d) will use an engagement model that respects their desire for a continued long-term relationship with the substance abuser by maintaining openness and avoiding secrecy; (e) have an investment in the substance abuser's recovery over time; and (i) have greater leverage over the long term than any outsider can.

Operational differences. In addition, there are some major operational differences between ARISE and other engagement models. ARISE interventionists (a) start the process of engagement, by following telephone coaching protocols, from the minute a concerned other member of the family or support system (concerned other) contacts them, rather than embarking on a lengthy educational process prior to any engagement attempt; (b) involve as many members of the extended family and/or natural support network as possible, in person or by telephone or letter (e.g., friends, neighbors, employers, clergy, family physicians) to enhance the engagement endeavor; (c) use the concerned other as a "family link" (30) to mobilize the intervention network, starting from the time of the first contact or telephone call to the interventionist requesting help with a resistant substance abuser; (d) maintains an openness throughout the process by inviting the substance abuser to every scheduled meeting, thereby avoiding unnecessary confrontation, mistrust, and secrecy; (e) applies a staged model that matches effort to substance abuser resistance rather than using a "one-size-fits-all" approach; and (f) invites the intervention network to do the bulk of the work, thereby allowing for engagement at the lowest stage of expenditure of effort by the professional.

The network approach to engagement described in this paper, ARISE, derives from the broader field of network theory and therapy discussed above. However, ARISE is not a form of therapy, but an intervention that may be regarded as "pretreatment," focusing solely on the engagement (i.e., motivating the resistant substance abuser to enter treatment). Once engagement has occurred, treatment or therapy begins, and the work of the ARISE interventionist is over, unless the interventionist chooses to continue with the network as the therapist/counselor.

ARISE developed not only from the wealth of literature on social networks, but also from the theoretical tenets of transitional family theory and therapy (59). It is based on an inherent belief in family loyalty (60); the competence and resilience of individuals, families, and communities (61-68) and their capacity to deal with incomplete individual and family life cycle transitions such as leaving home (67, 68) and unresolved grief (69, 70). Involving the extended family in the process sets the level for resolution across the generations (71-73). Although ARISE is based on principles developed in family theory, it is not a treatment method, and the temptation to resolve these issues is best left until the substance abuser enters treatment. However, the momentum built by the extended family and natural support network during the engagement phase allows for resolution during the course of treatment (74-77).

The ARISE network may be used alone to engage substance abusers in treatment or may be applied as the second level of a three-level engagement sequence—the ARISE process—summarized below and described in detail elsewhere (38-40, 42).

In many addiction agencies/services, if a concerned other from the substance abuser's support network calls for advice about the substance abuser's problem behavior or seeks help with getting him/her into treatment, typical responses might be: (a) "Please have the substance abuser call him/herself"; (b) "We can offer you support and counseling and will send you materials on Al-Anon to read"; and/or (c) "We can provide (or refer you to) an intervention specialist for a formal intervention (usually a formal Johnson intervention)."

Concerned others often have a history of trying to get a member of their family or a friend into treatment by themselves, with the aid of a primary care provider, or even with a formal Johnson intervention (52). They may have experienced initial success in the substance abuser's responding to the pressure by attending a treatment or self-help meeting or stopping using. In these cases, this initial compliance may have been superficial (an effort to "get the concerned other off his/her back"), and the substance abuser failed to follow through. Or, the substance abuser may have been angered at the family for being confronted and coerced. The compliance may have continued for a while, but the substance abuser subsequently "dropped out" and returned to active use. In the face of such events, the concerned other can become frustrated and anxious and sometimes even angry, viewing his or her efforts as a failure (75).

Chronic relapsing diseases, such as addiction, have a major impact on the family. The complex patterns make it difficult for family members to predict the timing and precipitants of success or failure—the Jelinek chart is not a smooth progression (78). Therefore, when a concerned other does call, he or she really needs to be met with encouragement and readiness to help with getting his or her substance abuser into treatment.

The ARISE method offers an alternative that capitalizes on the energy and commitment of the caller, frequently precluding the need for a Johnson intervention. When the concerned other calls an agency, hospital, or private practitioner utilizing the ARISE method, he or she is encouraged to invite those in the network to attend a session. If

possible, the substance abuser is included, but the concerned other is assured that if this is too difficult, as many other members of the network as possible should still attend. These are cases in which the concerned other is clearly ready for change—usually more so than the substance abuser and other family members. The value of the network is in synchronizing the stages of change (79) with the family's readiness, thereby enhancing the substance abuser's readiness for change. In fact, the concerned other may have been going through a parallel set of stages to that described by Prochaska and DiClemente for the substance abuser (41, 42, 80).

For those addiction treatment practitioners and administrators unfamiliar with the techniques and strategies for mobilizing natural support networks, two earlier papers on the ARISE methodology (38, 40) are recommended. The "first call" paper gives specific goals and guidelines for handling an initial contact, including establishing a time and place for the first meeting (40).

ARISE Network Procedures

The ARISE process is a continuum that can be stopped at any point that the substance abuser engages in treatment. The initial ARISE network session might involve only the initial caller, but preferably it would include a number of significant others. The session is initiated by asking participants individually to explain why they are present and what they see as the problem to be addressed. If the substance abuser is present, this initial session evolves into a motivational meeting aimed at getting a commitment from the substance abuser to (a) begin treatment and (b) meet with the intervention network (typically, 1 week later) to report on progress. The network then continues to meet with the substance abuser (typically, once or twice a month) until treatment entry. This process may unfold over 2 or 3 months, for a total of two to five sessions. The atmosphere is supportive throughout, even though confrontation and limit setting are used as needed. A formal network contract is negotiated and signed, specifying the responsibilities of both the substance abuser and the intervention network (see Ref. 39).

If the substance abuser is not present, the session is conducted in a similar manner, with each person describing the problem. The whole intervention network plans the steps to engage the substance abuser in treatment. If the substance abuser has refused initially to participate, the network mobilizes its strength to persuade him or her to enter treatment. Whether the substance abuser engages in treatment or not, the support network may continue to meet biweekly or monthly as noted above. It might seem surprising that families would continue as long as 2 or 3 months without the substance abuser entering treatment. But, it is our experience that they tend to continue because of their investment in the outcome and because of the positive changes they themselves are making in their communication and relationships. Their discouragement and despondency is replaced by hope. If the substance abuser continues to avoid engaging in treatment, the intervention network members must decide whether or not to undertake a more formal intervention, of either the ARISE or Johnson type (38).

For the purpose of clarity, the procedures outlined below appear in numbered sequence, but the process itself is not necessarily sequential. Were this an intake for therapy or addiction treatment, rather than an engagement session, it would include the standard tasks of (a) finding out about the substance abuser's insurance and (b) assessing the severity of the addiction and the substances used and their consequences since these are routine in any addiction intake and treatment process. However, even though this is an engagement process only, it is still necessary to determine these important facts to guide decisions about level of care and appropriate referral. In this paper, we have concentrated on those aspects that are unique, or specific, to the ARISE process.

The ARISE interventionist pays particular attention to the critical incidents that have occurred and how they might have affected the substance abuser and otha network members. The interventionist assures the network of his or her plan to be supportive, offering to be available between sessions (usually by telephone only). The interventionist also explains that sessions will be safe, positive, and goal directed, informing the network of his or her experience in dealing with difficult situations. Seating arrangements and other use of physical space can be employed to produce a feeling of welcome and security. The interventionist also stresses that the network sessions will be held regardless of whether the substance abuser attends.

1. "Joining" each member of the network. We have found that it is easiest to start by greeting the concerned other (the person who has done all the work to ensure that everybody came to the session) and to have the concerned other introduce the interventionist to the others, ensuring that he or she gets to meet and greet everyone present. It is also important to have members of the network meet and greet each other. Even if they are family members, they may not have seen each other for a while. Such a process also helps people relax and realize that they are all present because they care about the substance abuser. We find this important because we consider families to be the natural change agents (i.e., partners in the process). In the same way, we are most comfortable if the substance abuser is involved from the start so that the abuser can be awarded the same level of respect that other members of the network receive. This also allows the substance abuser to be included in the information sharing since this network approach is based on openness rather than secrecy. One of the earliest tasks is to help the network understand the importance of being open with the substance abuser to avoid secrecy and coalitions.

2. Eliciting family strengths. Families dealing with substance abuse have typically been "through the mill" by the time they present to the ARISE interventionist. They feel guilty, ashamed, and blamed_ both by themselves and others_ for the substance abuse in their families. We believe that there is a circular causality in families with addicted members; that is, the family is affected by the chemical dependency, and the family affects the course of the chemical dependency. We also believe that, for change to happen, the family needs to believe in its own potential for change. Even though families living with addiction are involved in dysfunctional patterns, they are, like all other families, intrinsically healthy and competent. When stress hits a family, members develop ways of coping that **may** be adaptive at the time, but become redundant and even destructive as

future generations act them out automatically (26, 73). The case vignette below illustrates the eliciting of family strengths:

Case 1: *Malcolm*

Malcolm dropped out of treatment after his 12th hospital-based detoxification from alcohol, cocaine, and whatever other street drugs were available. His exwife was called by a hotel manager to say that he'd been found unconscious in a full bathtub—hotel staff had been alerted by a complaint of water leaking into the room below and had rushed him to the hospital, where it was touch-and-go for several days. Malcolm was found to have overdosed on an amalgam of alcohol, sedatives, and street drugs.

Malcolm's ex-wife called an ARISE interventionist and was coached to invite as many members of his network as she could to discuss getting Malcolm into treatment because she feared he would die. The first ARISE session was attended by his ex-wife, mother, father (a long-term active alcoholic), great-uncle, siblings, children, and employer. During the session, it was difficult for the network to consider that there were any family strengths. They were overwhelmed with the magnitude of the problem in light of the "horrible history" of multiple catastrophic deaths in the family. The imminent threat of Malcolm's death or longterm permanent paralysis and vegetative state from serious brain damage had immobilized and terrified them. They were only able to think in terms of crisis, deficits, and dysfunction. Clearly, the family had not resolved their grief over earlier catastrophic losses. Listing those losses during the construction of a genogram (see paragraph 3 below) enabled them to see that no family could have emerged unharmed from so many catastrophes and to realize that Malcolm's current crisis was not the only cause of their immobilization and terror.

During the second intervention session, the realization that they were not to blame, and that there was hope for the future, allowed the members to start thinking about positive action. It was only after having them consider how they might proceed toward engagement and what family strengths they would like to see handed down to future generations that they were able to think in terms of "strengths and resources." Their list included family loyalty and protectiveness, a "hard-work" ethic, a pioneering spirit, a love of music, and many others. With the interventionist's guidance, the network was able to plan for Malcolm's return should he ever regain consciousness. After the network had met for four sessions, they heard that Malcolm had turned the corner, regaining consciousness and mobility. Some weeks later, when Malcolm was discharged, the family was able to put their strategies for his engagement into practice, and he reentered treatment.

In an ARISE intervention network session, this exploration and focus is often accomplished by an early exercise of having the network make a list of family strengths on a flip chart that the family can draw on for the engagement process. The interventionist helps to eliminate the "we/they" dichotomy by explaining how all families go through times of hardship and testing as well as good times—people and

environments are constantly in transition and are vulnerable during those times. In this process of identifying strengths, the interventionist can also point to the courage of the family in addressing the painful issue of addiction and the strength of the concerned other in initiating the process. This sets the stage for a base of achievement and praise rather than blame, shame, and guilt. It thus allows the family to accept and exercise its own competence.

3. Constructing a genogram. After listing family strengths, the ARISE interventionist works with the network to construct a genogram (81). This accomplishes several things: (a) It allows those present to think more broadly about potentially important players; (b) it helps them think about enlarging and mobilizing the extended support system; (c) it enables access to additional competence across the system; and (d) it prevents members from getting caught in their own perspectives, old alliances, and triangles. The genogram also allows family members to explore losses and "cutoffs" that may have resulted in some members being out of touch with others whose competencies might have been helpful through difficult times. The genogram provides a visual chart of the potential support network that can be mobilized to help get the substance abuser into treatment. This "reconnection" is often highly effective in its own right. Substance abusers are often part of a cutoff pattern, and it is helpful for the family, so they can plan what to do next, to review why it has been difficult to get the substance abuser into treatment.

4. Review previous efforts to engage the substance abuser. The substance abuser may or may not be present for the session and may or may not have been involved in previous efforts to engage him or her in treatment. The intervention network invariably learns that most prior attempts at engagement were one-on-one confrontations with the substance abuser, and that this network meeting is the first attempt at a partnership or teamwork. This underscores the realization that dealing with the substance abuser on a one-on-one basis is bound to fail. The network is capable of restoring the power that the individual change agent (usually the concerned other) has lost during these futile attempts. No matter how tough and disconnected the substance abuser appears to be, the abuser still cares about his or her family. This caring (even if hidden) provides the network with leverage to motivate toward change. The effect of this bond of mutual caring gives the network the capacity to proceed with or without the substance abuser's permission. This, in turn, removes the power of the substance abuser to control the process and allows the network the power to act regardless of the level of denial or resistance of the substance abuser.

5. Eliciting statements of concern about the substance abuse. During this phase of the intervention session, the major element is mutual respect, especially when the substance abuser is present. This is achieved by asking each member of the network to describe his or her concerns, ensuring that a balance is maintained between the need of the network to act and the substance abuser's need for autonomy and control. This openness and balance counteracts the possibility that the substance abuser might feel coerced into treatment, either during the session or after. If present, the substance abuser is likely to feel relieved to be able to discuss things with everyone, cutting through secrecy. The interventionist's observation of the network during the telling of individual perspectives on the problem

allows identification of patterns of alliance and potential healing. If the substance abuser is not present, the session proceeds in a similar manner, with the statements of concern evolving into motivational strategies for change and engagement.

6. Determining patterns of alliance. The interventionist expands on his or her observation, identifying natural leaders and potential allies of the concerned other. The interventionist looks for the network's ongoing patterns of alliance, their subgroups and hidden coalitions. The interventionist particularly notes (a) which network members take strong positions about issues; (b) who, if anyone, takes a leadership role; and (c) when differences of opinion arise, who might act as mediator. Sometimes it is difficult for the interventionist to remember that the coalitions and apparent battles_the family's intergenerational dynamics_are usually based on loyalty and protectiveness, although they present as power struggles with confused hierarchies, poor boundaries, and miscommunication. These observations of patterns of alliance create an opportunity for building or rebuilding positive alliances.

Case 2: *Harry*

Harry and Carol had been married for 25 years, during most of which Harry had been an active alcoholic. Carol was an extremely competent woman who "held things together" at the office that she managed. Harry was on the brink of losing his long-term job because his employer (and close friend) could no longer protect him. A long-term member of Alcoholics Anonymous (AA), Harry had never been sober for longer than a couple of months, despite many attempts at treatment. Carol's competence and control, so evident at the office, failed her in the home. Her two adolescent children were constantly in trouble at school, and both her brother and sister had grown tired of discussing her problems since she didn't follow up on their advice. She felt that she had nowhere to turn and called an ARISE interventionist for advice.

She was asked to invite all the members of her network to an ARISE intervention session. Her brother and sister refused to attend, but the rest came. Carol's growing isolation and inability to feel supported had caused her children to align with their father, saying that they understood why he drank and couldn't wait to get out of the house. They blamed their mother for all the problems. A plan was made for the interventionist to invite the brother and sister to the next session, telling them that if Harry were fired, it would result in their sister being out on the street. They came to the session. For the first time, as Carol started to weep, Harry's employer and Carol's brother and sister started to realize the depth of her hopelessness. What they had experienced previously as nagging was clearly based on the fear that she had always covered up by apparent control and bossiness. Harry had advanced liver disease, peripheral neuritis, and early cognitive loss. The intervention network decided that Carol needed more support in setting limits and establishing constructive consequences for his continued drinking. At the fourth session, they informed Harry that he would lose his job, his wife, and his children if he refused to go into treatment. Harry went to the hospital that day.

The network sessions were supportive, loving, and goal oriented. At no point were there secrets or surprises. Harry was included and kept informed of the process throughout, even when he did not attend sessions. When limits were set, he was involved in the negotiations. The setting of limits and Carol's support from her siblings marked a shift from Carol's isolation to her feeling supported and becoming effective. The new alliance got Harry into treatment.

7. Developing strategies for engagement when the substance abuser does not attend. The interventionist assists the network to identify a range of options for engagement. These options, based on the family's strengths and previous experience, will lead to natural strategies. The development of strategies keeps the interventionist focused on the single goal of engagement and avoids turning the session into treatment. The strategies are designed to match the level of resistance and denial shown by the substance abuser. A component of these strategies always includes inviting the substance abuser to the next session. The network benefits from the engagement process regardless of its outcome (i.e., whether the substance abuser enters treatment) since it results in improved communication, an airing of prior difficulties, a forging of new collaborative relationships, and a belief in their competence as change agents.

8. Negotiating with the substance abuser and network to make a contract. A key aspect of the ARISE process is helping the network negotiate with the substance abuser to make a formal contract. This typically involves two key decisions: (a) level of care and (b) when treatment will start. Conventional wisdom in working with a substance abuser discourages any negotiation. This belief results from the experience of many failed negotiations. However, these are invariably one on one, feeding into the desperate attempts of the substance abuser to bargain his or her way out of changing. The ARISE process of negotiation includes the intervention network, and there is always someone to do a reality check and to hold the substance abuser accountable for any commitments made. The network then designs appropriate consequences for any lapses and decides how to (and who will) enforce them. Substance abusers frequently enter treatment at this stage, and the engagement process is complete.

9. Monitoring the process. If the substance abuser has not yet entered treatment (whether he/she has agreed to do so), the network implements its strategies for motivation of the substance abuser. A component of most motivational strategies is monitoring the behavior in order to act the minute an alcohol- or drugrelated problem occurs.

Case 3: Joan

Peggy, aged 32, had observed her sister Joan, aged 42, drinking and driving despite her two prior convictions for driving while intoxicated. When Peggy consulted with her parents and other family members, she was told about "interventions." They agreed that Peggy should make inquiries on behalf of the family, and that she and five other family members would be involved whether or not Joan agreed to participate. They had been concerned about putting too much pressure on Joan because, "She is going through a

divorce from a compulsive gambler and gets depressed easily. We don't want to add to her problems." But, they were concerned that she'd continue to drink and blame her problems on other things. The family agreed to meet to discuss the dilemma without Joan.

Three sessions into the ARISE process, the network presented Joan with a contract, and she agreed to attend AA meetings and to stop drinking. The next session opened with the following report: The sister-in-law and her husband (Joan's older brother) were concerned that Joan was still drinking. They agreed that her brother would follow Joan home from an AA meeting. He observed her stopping at the liquor store and drinking in the store parking lot before driving home. The family agreed that if anyone learned that Joan was drinking and driving again, they would report her to the police unless she agreed to treatment. This pressure brought her to the next session, at which she agreed to start treatment. With the engagement process successfully ended, the network agreed to continue meeting regularly on their own to support Joan's early recovery and to hold her accountable for any further drinking or lapses in treatment.

This case illustrates the combination of both caring and firmness. Had the family not decided to set clear boundaries, Joan inevitably would have continued her drinking and might have died as a result of it. Through the ARISE process, Joan was able to hear her family's concerns, as well as recognize that she could no longer fend her parents off with stories and evasions because everybody was together, and there was no way out.

PRACTICAL CONSIDERATIONS

Our experience with the ARISE model in real-life clinical settings (e.g., private practice, treatment settings under managed care, health maintenance organizations, hospital clinics, and free-standing outpatient services) highlight two frequent concerns: confidentiality and payment.

The question arises as to how federal regulations and professional ethics concerning confidentiality apply to the ARISE model. Because ARISE is a pretreatment intervention, and the substance abuser has not yet presented for treatment, the ARISE interventionist is not sharing any clinical information gleaned from the substance abuser. Rather, the information flow is the other way, with the intervention network sharing their information with the ARISE interventionist. Normative practices regarding confidentiality of what is shared within a meeting, even if it still pretreatment and in the ARISE intervention format, are followed.

Since this is pretreatment, third-party payers vary in regard to reimbursement. In our experience, some require a member of the intervention network to have a diagnosis. Others do not require that and are comfortable reimbursing for a method that leads to treatment of the substance abuser. When no reimbursement is available, the intervention network members are generally very comfortable sharing the expense.

CONCLUSION

For over 30 years, the substance abuse field has been developing methods for engaging resistant substance abusers in treatment. An intervention philosophy has evolved: "It's never too early to intervene," and "substance abusers do not have to hit bottom" to start the recovery process. Many studies have now shown that utilizing family and concerned others can be very effective in motivating substance abusers to enter treatment. ARISE is the only staged method for engagement intervention and is also alone in its use of members of the extended family and support system to work as family links between the network and the ARISE interventionist, allowing for a reduction in burden on the professional. The family does a great deal of the work. ARISE's concentration on relieving shame, blame, and guilt and its emphasis on family strengths also make it more inviting to many families than some of the more onerous and confrontational methods.

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