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The "Concerned Other" Call: Using Family Links and Networks to Overcome Resistance to Addiction Treatment

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ABSTRACT

Untreated chemical dependency costs the United States over $ 165 Billion annually. Meanwhile, treatment offsets these costs by a ratio of $7 saved for every. $ 1 spent But the vast majority of chemically dependent people (CDPs) remain uninvolved in either treatment or self-help groups. It is therefore imperative that more effective ways be developed for Therapeutically engaging them. One avenue is to maximize the opportunity presented when a "concerned other" (CO) person-such as a family member, friend, coworker, or clergy member-contacts a treatment agency to get help for a CDP. This paper provides a method for handing such calls. Specific guidelines are presented as to (a) the kind of information to be gathered, (b) procedures to be followed, and (c) options to be offered toward mobilizing the CO and other family/social network members in successfully effecting CDP treatment engagement.

Key words. Treatment engagement; Family; Addiction; Network; ARISE intervention

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INTRODUCTION

Many investigators in the United States have found that a very small percentage of chemically dependent people (CDPs) receive treatment. In fact, in any given year, 90-95% of CDPs do not enter treatment or join self-help groups; for example. Alcoholics Anonymous or Cocaine Anonymous (Frances et al., 1989:

Kessler et al.. 1994; Nathan, 1990). Frances et al. (1989) found that the majority of substance users never get into treatment during the course of their lives. An additional concern is that, despite increasing awareness of the risk of CDPs becoming infected with HIV, less than 50% of chemically dependent HIV-infected individuals have received treatment for their addiction prior to their presenting for medical treatment of their HIV (Sisk et al., 1990).

The annual cost of treated and untreated drug and alcohol "abuse" in the United States is estimated to be more than $165 billion (Brady, 1995: Klaidman et al., 1996; Rice, 1994: Rice et al., 1991). This figure includes the cost of medical care, substance-user treatment, premature death, unemployment, and criminal justice involvement. Meanwhile, the substantial cost benefit of drug- and alcohol-user treatment goes unrealized (Califano, 1995). A 1994 evaluation of recovery services in California (US) estimated that drug and alcohol treatment saved taxpayers $7 for ever $1 spent (Gerstein et al., 1994). In their investigations of the relationship between addictions treatment and general health care cost. Langenbucher (1994) and Berlant et al. (1994), found a similar cost benefit.

From the above, it is clear that improved methods are needed for getting CDPs into treatment and subsequent recovery (Stark et al., 1990). Indeed, Frances and Miller (1991) stated that the addiction field's *"major challenge* is helping substance abusers to *accept* and *continue* treatment" (p. 3; italics added). Further. there is abundant evidence that early intervention results in better treatment outcome (Holder and Blose. 1992; Johnson, 1973,1986; Loneck et al., 1996a, 1996b. 1997; National Council on Alcohol and Drug Dependence, 1989; Pickens et al., 1991; Stark, 1992). Therefore, it is important to motivate the CDPs to enter treatment as early as possible. Involving the family and having a social support system can be highly effective in achieving this goal (Stanton and Shadish, 1997).

By broadening the focus in this way, the issues around treatment dropout and motivational ambivalence characteristic of the beginning phases of addictions treatment are better addressed (Conner et al., 1998). Thus, there is a need to cast the widest possible net for early recognition and engagement in substance user treatment. In order to do this, however, a shift is required in the addiction treatment process which has fiscal and policy implications for health care (Mechanic Et al., 1995, Institute of Medicine, 1990). In addition, it requires a change in the stance of the therapist from doing therapy to guiding a process of change.

The present paper focuses on a commonly encountered nexus for early contact: the first phone call from a "concerned other," calling out of concern for a substance abusing relative, friend, or coworker who refuses to enter treatment. This paper describes a method developed to increase the likelihood of engaging the resistant CDP in treatment.

Although this method can stand alone as an engagement strategy, it is also the first stage of a three-stage intervention--A Relational Interventional Sequence for Engagement (ARISE)--Described elsewhere (Garrett et al.. 1996, 1997, 1998).

In an ongoing study (funded in part by NIDA DA09402), over 100 calls from concerned others (COs) have been taken using the methodology outlined below. Substances used included alcohol, cannabis, cocaine, heroin, and various combinations of these. Subsequent to the first call, over 65% of of CDPs entered treatment or self-help. COs have included parents, partners, siblings, coworkers, employers, and landlords. In combination with the other two stages of the ARISE intervention, approximately 90% of CDPs entered treatment or self-help. The authors have measured success as entering treatment or self-help (Landau and Brinkman-Bull, 1997).

Rationale for Taking Calls from Concerned Others

Partners in the intervention and treatment engagement process are those people who have the closest contact with the CDP (and who are often the ones most negatively affected by the addictive behavior), i.e., the CDP's social network (Galanter, 1993a, 1993b, 1995; Callan et al.. 1975; Liepman, 1993; Liepman **et** al., 1989; Logan, 1983; Speck and Attneave, 1973: Thomas and Ager, 1993; Yates, 1988). Whereas referral procedures between chemical dependency treatment agencies and other systems, such **as** criminal justice and employee assistance programs, are usually well-developed, awareness of a problem and pressure for treatment engagement is even more likely to come from COs such as spouses, parents, siblings, partners, friends, coworkers. or clergy (Belin, 1996; Chafetz et aL, 1970). For example, as Resnick and Resnick (1984) put it,"... the Family can often be the key to forcing the patient to stop denial and avoidance and begin dealing with the (substance abuse) problem" (p. 723). Similarly, changes in the "patient" can often help the family members develop new ways of perceiving and dealing with issues related to mistrust, anger, guilt, shame, and isolation (Barber and Gilbertson, 1996).

Therapists in the chemical dependency field commonly utilize various forms of leverage to get CDPs into treatment, but are often hesitant to use the family itself as a source for such leverage (Stellaio-Kabat et al., 1995). Employee Assistance Programs (CAPS) provide an interesting parallel to the family/CDP interface. The rationale for implementing EAPs was to intervene at an early point in a person's problem and to utilize continued employment as an implement for motivating change. The effectiveness of EAPs in terms of leverage for treatment engagement has been established for a high proportion of working CDPs (Barabander, 1993). The analogy to the family/social network is that the CO functions in a manner similar to that of the supervisor in a-job setting. Like the supervisor, the CO brings attention to the problem and initiates change. A treatment agency functions somewhat like an EAP--both the agency and the EAP are charged with taking rehabilitative action. Figure 1 outlines the similarity of roles and functional interactions among the CDP. Supervisor, CO, EAP, and treatment providers. The process described in this paper utilizes COs to intervene in the destructive cycle of

chemical dependency, regardless of whether the CO is a work supervisor. a family member. or a friend.

EAP ROLE	CO ROLE
1 Problem is documented at work by supervisor	1 Problem behavior is recognized by CO
2. Employee meets with supervisor and agrees to plan for correction	1 CO expresses concern to CDP
3 Warnings at work continue due to monitoring of plan *of* correction by supervisor; EAP is mentioned as part of an informal referral	3. CO admits the problem is more serious than CDP is able to accept-treatment is suggested by CO
4. Job performance improvements promised by employee are not kept	4 Promises from CDP are not kept and CO notices the problem getting worse
5 Deteriorated Job performance results in supervisor formally involving EAP for a Job jeopardy intervention	5 Crisis situation results in CO bringing in more support and making contact with a treatment agency regarding an intervention
6 CDP accepts treatment because of threat of losing Job	6 CDP accepts treatment due to pressure and consequences from the CO network
7 EAP and supervisor coordinate the monitoring *of job* performance and treatment compliance	7 CO network supports CDP in recovery process through regular sessions at the treatment agency
8 EAP monitors as part of relapse prevention	8 CO network support and monitoring is part of relapse prevention

Fig. 1. Parallel referral relationships demonstrating roles in treatment engagement

What happens when a CO calls a treatment program can be all-important in terms of the CDP's successful treatment entry (Belie, 1996; Stark et al., 1990). if this caller is brushed off. or simply told to have the CDP call, the chances for therapeutic engagement drop sign)ficantly. After a11, if the CDP were going to all, he or she would have already done that The fact that a CO has called means hat the best chance for engagement may be to work throughout that CO and the social network(Callan et al.. 1975; Galanta, 1993a, 1993b, 199S).

The addiction field has traditionally viewed the family as an obstacle to successful recovery. Neutral at best and enabling and perpetuating the addiction at worst. Based on our extensive experience with family competence, this approach capitalizes on the love, worry, and concern of those closest to the CDP (Landau Stanton. 1986). Approaching the CDP and the family from this perspective results in increasing the proportion of those entering treatment (Loneck et al., 996a, Stanton and Shadish. 1997). The CO serves as a family link--a link between the CDP and the family and a link between the CDP and the treatment system (ELkin 1984; Galanter.1993a. 1993b; Garrison et al., 1977; Landau,1981; Landau-Stanton 1990). The underlying assumptions for utilizing the CO's call for help are that family members and other COs (a) care more for their members than treaters do. (b) have inherently greater leverage, and (c) provide ready-made continuity of

contact (Steinglass et al., 1977). In addition, COs have experience and knowledge about the history of the CDP, the family, and the process of the disease which arc invaluable to the treatment system (Landau-Stanton et al., 993). They are also in a unique position to recognize early warning signs and to confront denial of them. In other words, treatment programs can take advantage of a powerful opportunity to intervene with a resistant CDP by welcoming he "first call? from a CO. The CDP doesn't want to lose his or her family. The all from the CO allows the treatment agency to capitalize on the loyalty many CDPs have to their families and the built-in accountability the family will expect from the CDP in recovery (George and Tucker, 1996; Garrison et al., 1977; ;Galanter. 1993a, 1993b).

Barriers to Accepting "The First Call" from Concerned Others

Staff in chemical dependency treatment programs vary in their readiness to accept calls "m COs. Barriers to staff taking such calls include (a) countertransference based on experience with addiction ID their own families, (b) agency procedures which require that the addict make the first call to "show motivation," (c) lack of family systems training by addictions counselors, (d) restrictive reimbursement policies, (e) limited charting protocols, and (f) unfamiliarity with moving from a therapy mode to guiding a planned change process (Cunningham et al., 1993; Imhof, 1995; Prochaska and Di Clemente, 1986: Schlesigner and Dorwat, 1992; Stark, 1992).

Commonly, staff believe that CDPs have burned their bridges with family and/or that family contact is bat for them. However, the vast majority of substance users are in regular contact with their parents or other family member. Twenty-six of 28 reports document that, if CDPs don't live with their families, they are at least in touch on a regular basis--usually daily or weekly (see reviews by Cervantes et al., 1988; Stanton, 1982, 1997). In other words. *family* memben are imponaot to substance users, and substance users are important to their families (Nichols. 1988; Shaffer, 1992; Szapoeznik et al., 1988: Stanton. 1997; Steinglass et al., 1987).

Another barrier is concern about breaching confidentiality It is not uncommon for office staff or clinicians to believe that confidentiality laws require them to refuse to take initial phone calls from COs, even when the CDP in question has not vet made any contact with the agency. Given the litigiousness of modern society, such concerns by agency personnel can become pronounced (Rinella and Goldstein.1980). However, one cannot be held accountable for information one does not have. Federal confidentiality rules (42 CFR Part 2) do not apply in this instance. because there has been no actual contact with the CDP. The call recipient has no clinical information about the CDP to give to the caller. Information flows, instead, from a member of the CDP's support system (the CO) to the agency staff, and not vice versa Thus confidentiality is not an issue for these initial calls.

PRACTICAL STEPS: HOW TO TAKE THE FIRST CALL FROM A CONCERNED OTHER

Presented below are instructions for a structured, step-by-step approach to handling the first phone call received from a CO. This call can be taken by a psychiatrist or other mental health worker, primary care provider. substance user counselor, intake worker, clergy, EAP, or even a receptionist who has received some basic training. The same steps can be followed whether the caller is a family member. a friend, or a coworker. The two major goals for the call recipient am I) to obtain relevant background information and ascertain the context of the call; and 2) to determine the next step for the CO to make regarding engaging the CDP in treatment (Stanton and Todd, 1981) Figure 2 presents an overview of the main points in the first call process.

Portions of the text to follow are written in the second person. and in the imperative mood' so the steps can be integrated into operational manuals for practical agency use

Fig. 2. First call process

Call from a CO

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Agency accepts call from CO (not requiring the CDP to call)

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Telephone motivational coaching by training staff

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CO becomes Link Therapist, developing genogram and mobilizing family and social network

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Strategy developed with CO for approaching the CDP to enter treatment

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Appointment set for family, social network and CDP

****

Commitment from the Link Therapist to keep appointment whether the CDP attends or not

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Goal I. Determine Relevant Background and Context

Getting information regarding the background and context of the first call is meant to ensure that the problem identified by the CO matches with the services of the agency. This initial screening determines if chemical dependency is the primary problem.

1. Identify the Crisis

The first few minutes of the phone call are designed to understand the CO's reason for calling, to understand/hypothesize why the CO is calling for help at this time, to determine the appropriateness of this presenting problem for your agency, and to validate that the caller has taken the right step.

a. Join. Identify yourself and your role within your agency. Explain that this phone call will be used to discuss the current problems and options to deal with those problems. Say that you will respect confidentiality by using first names only. (Get more complete information later, when an appointment is set up.) Find out bow the caller bears about your agency and how familiar she or he is with substance use interventions.

b. Address the Caller's Initial Questions before Proceeding. Ask what questions the caller has about your agency, the intake process, the interventions used, and the treatment process.

c. Identify the Presenting Problem. Ask the caller to explain what specific event precipitated this phone call. Determine if there is an appropriate match between your agency's services and the needs of the caller.

d. Validate the Chemical Dependency Problem. Summarize the presenting problems and validate the presence of a significant chemical dependency, problem. Reinforce for the caller the importance of this call and how instrumental he/she is in helping the CDP get into treatment. If there is not a signficant chemical dependecy problem, suggest referral to another community agency.

2. Get Permission to Ask More Personal Questions

Ask the caller for permission to obtain more personal information about the CDP's family, support network, history of substance use, and substance user treatment. This step prepares the caller for the nature of the questions to follow, communicates respect. and provides him/her with control over what is shared in the phone call.

3. Get a Substance Use History

Ask about the CDP's current and past drug and alcohol use, focusing on information about acuteness and chronicity. This information will be used to help determine what level of treatment would be most appropriate.

4. Get a Brief Treatment History

Obtain a history of the CDP's chemical dependency and psychiatric treatment. Include any prior periods of recovery, self-help improvement, use of a sponsor, interest/development of new activities, and perceptions of what made treatment successful.

5. Assess Safety

Obtain information regarding the CDP's risk of harm to self or to others. Ask the caller (a) if the CDP is currently threatening, or has ever threatened, self harm;(b) if the police have ever been called due to episodes of violence; (c) if the CDP has recently been involved in any serious accidents. If the answer is "yes" to any of the above. explore the response in more detail to determine whether a situational crisis exists needing assistance from emergency personnel If there is a risk of imminent danger, advise emergency action. (Examples: bringing in additional family or friends to help, calling police, escorting the CDP to an emergency department, removing weapons, etc.)

6. Identify Past Family Efforts

Find out what previous attempts have been made by the family to engage the CDP in treatment. Acknowledge the love and concern the family has shown in these past efforts and listen for frustration and discouragement. Empathize with discouragement and inform the caller that it is easy to feel helpless and alone when dealing with an addict. Explain that the best way to help the CDP is to assemble the people who care about her or him This network then works together to get the CDP into treatment and to provide ongoing support for recovery.

7. Develop a Three-Generation Genogram

In order to gain a three-generational picture of the CDP's family and broader social network, an initial genogram is helpful (McGoldrick and Gerson, 1985; Stanton, 1992). While completing the genogram, the staff member develops an understanding of who is in the CDP's broader social network. He/she can then draw on this information to help advise the CO who to involve. The genogram therefore provides an opportunity to stress the importance of inviting as many people as possible to the initial session. The more people present for this initial session, the more likely it is the CDP will come to the meeting and follow through by entering treatment (Loneck et al., 1 996a). Since the CO may be an employer or friend and not a family member, it might not be possible to develop a complete genogram. If this is the case, the CO is encouraged to involve as many **members** of the social network possible.

Goal II. Plan the Next Step toward Treatment Engagement

After gathering the above data, the next step is to plan specific action for treatment engagement. The person taking the call should explain to the CO that the following options exist for taking action.

Option I

The caller convinces and supports the CDP to come in alone for an evaluation. The risk of this option is that there is no accountability to family and the network if the CDP's motivation to keep the appointment and and/or enter treatment subsequently decreases. Discuss with the caller this downside and get the caller's commitment both to talk further with you or your agency, and to come in as support for the CDP in future sessions.

This option is often successful if the CDP has already approached the caller asking for help, or is perhaps physically present while the call is being made (see "Three Special Cases," below).

Option 2

The caller convinces the CDP to come in for an evaluation and supports the CDP by accompanying him or her. Explain to the caller that he/she should keep the appointment regardless of whether the CDP comes in. This agreement initiates the momentum to influence the CDP, regardless of who comes to the first session.

This option is often successful if the caller believes he/she has the necessary leverage to bring the CDP for the evaluation.

Option 3

The caller invites others to accompany the CDP to the initial session. The caller identifies other people to invite (from the genogram) and plans a strategy to get their cooperation. The CDP is also invited to the meeting.

This option is most useful if the caller believes the CDP will be resistant to entering treatment. The CDP is told that the network is asking for cooperation and a commitment to come for one session. The network agrees to attend regardless of whether or not the CDP comes.

Option 4

An informational appointment is set up with the caller and the network with*out inviting the CDP.* This option is used if the caller wants *to* discuss options with the larger group before agreeing to an action plan. This type of meeting involves discussion and education about chemical dependency, the intervention process, and a review of the options. The goal of this meeting is to empower the network to design a strategy for engaging the CDP in treatment.

Option 5

The ARISE graduated intervenrional sequence may be used for working with the caller and network until the CDP engages in treatment (Garrett et al., 1997).

This method involves one or more meetings with the network to develop strategies and cement solidarity toward accomplishing the goal of treatment engagement. Several stages are defined culminating in a formal ARISE Intervention. If that becomes necessary.

This option is best performed by trained ARISE interventionists (Garrett et al., 1996).

Goal III. Decide Which Option to Take

Closure to the first call is usually a quick negotiation and pro/con discussion of the above options. The intent is to help the caller choose an option, at least for the present. While this pan of the procedure is usually shoe, it gives a wealth of information to the call recipient about the degree of invasiveness of the chemical dependency within the system. and what may be needed to empower the system to change (Stanton and Todd. 1981: Wallace, 1981; Treadway, 1989).

Most callers are ready to take action and follow through with an appointment. However, some callers are ambivalent on the phone, but are ready to be convinced to take action

High ambivalence usually indicates the degree to which the chemical dependency process dominates the system, and the resultant fear and shame in the network. Expanding the network at this point provides support to the caller and allows the fear and shame to be more adequately addressed (Berenson, 1976).

Feedback to acknowledge f:ear and shame issues is often helpful for ambivalent callers because it brines up topics which have been avoided in the past. This type of discussion is a powerful statement to the caller that the chemical dependency does not have to remain in control any longer. The caller often is ready to set up an appointment after such a discussion (Elkin, 1984).

Even if the caller decides to do nothing at this time, remain optimistic. Ask the caller to think about these options and to call back in a week or two to discuss them. If that is refused. Invite a future call "if things get worse," acknowledging that untreated chemical dependency always results ID serious future consequences. Predicting this deterioration in functioning gives the caller confidence in your skills and gives the caller greater courage to mobilize an intervention in the future (Stanton and Todd. 1981; Loneck a al., 1996b; Wright and Wright, 1990).

Three Special Cases

In some treatment settings. those who answer the telephones may not be skilled in handling the interaction described here, while there may be other staff members who do possess such skills. These instances can be dealt with by transferring the call to the specialist. or providing a phone number ant time when the specialist is available. At such points, a response to the caller such as, "Wait a minute . . . I've got just the person (program) for you to talk to," may be appropriate

Another special circumstance alluded to earlier is when the CDP is actually present in the room or home while the CO is making the call. The call recipient may sense that this is so, or may discern it by inquiry or happenstance. If the CDP is indeed present, it is usually a good idea to request that he or she also get on the phone. Under this circumstance, however, it is best not to lose contact with the CO. The wise option is to have a closing conversation with the CO in order to finalize a commitment to proceed to the next step.

On some occasions, the CO may walk into the treatment agency rather than telephoning. In this instance, the "first contact" is handled by the same process as "the first call."

Implementation

Change needs to occur at the levels of the CDP, the family, and the treatment agency. A culture shift is required for treatment agencies as they prepare to receive calls from COs rather than insisting that the CDP call. Treatment and ongoing supervision at all levels of

the clinic will be needed, from the office staff who answer the phones to the therapists who must learn to think in terms of mobilizing an intervention network for preengagement and motivation on the telephone. Administrators need to develop policies to support the shift, including necessary changes in billing procedures and funding requirements.

CONCLUSION

The model presented in this paper provides a logical method for utilizing family and network links as leverage for both earlier identification of chemical dependency problems and successful treatment engagement. This model can be readily adapted for use in a variety of settings. Including psychiatric practices, primary care offices, chemical dependency treatment programs, information/referral services, employee assistance programs, family and children's agencies, and religious institutions. Subsequent papers will elaborate the detailed steps for actual hands-on work with networks convened to get a substance user into treatment.

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RESUMEN

Dependencia quimica sui tratamiento tiene un costo para los Estados Unidos de Norte America de 165 billones de dolares por aflo. Mientras que el tratamiento de la misma disminuye en 7 dolares per cada dolare que se gasta. Pero lo gran mayoria de las personas con depcndencia quimica (PCDQ) permaneceu no envueltas en tratamiento o grupos de un mismo interes. Es por lo tanto imperative de desarrollar maneras mas efectivas para atraerlos en forma terapcutica. Una avenida es de utilizar al maximo la oportuidad prcsentada cuando una "persona interesada" (PI) - como un miembro familiar, un amigo, un miembro del lugar de trabajo, un miembrc de la inelesia se pone en conlacto con un agencia de tratamiento para obtener ayuda para personas con depcndencia quunica (PCDQ). Este manuscrito provee un meiodo parp manipular estos llamados. Una gia especifica es prescntada a) para obtener la informacion necesaria, b) proccdimientos a seguir, c) opciones ofrecidas para mobilizar la "persona intercsada" (PI) o miembros de la familia/red social satisfactoriamcnie para engranar en tratamiento efectivo a la persona con dependencia quimica (PCDQ).

RÉSUMÉ

Aux Elats-Unis, Ie coflt de la toxicodependance non-traitee s'cleve a plus de 165 milliards de dollars par an. Pour Ie moment, la traitement compcnse ce cout: pour 1 dollar de depense, c'est en fail 7 dollars d'cconomise. Mais la majeure partie des toxicomanes ne participent ni au traitement ni aux groupcs d'cntre-aidc. c'est done utgent dc developper des moyens plus efficaces pour les intercsser a la thcrapic. Une solution serait d'exploiter au maximum les contacts, comme par cxemple lorsqu'un "autre concerne" • membrc de famille, d'cglise, ami ou collcgue de travail-contacte Ie centre de traitement pour aider un toxicomane. En ce sens, 1'article explique comment s'y prendre dans de tels cas et offire des indications specifiqucs quant aux (a) informations a recueillir (b) options a offrir pour mobiliser l'"autre conccmc" vers un succes du traitement de la toxicomanie.

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