

**The ARISE Intervention and Continuum of Care:
Engaging Substance Abusers and their Families In Treatment and Long-Term
Recovery**

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Abstract

Families are an untapped resource in motivating resistant alcohol dependent and drug addicted individuals to enter and complete treatment. This paper outlines A Relational Intervention Sequence for Engagement (the ARISE Intervention), an Evidence-Based, Best-Practice method of Intervention that harnesses the power of the family to achieve individual and family long-term recovery. Contrary to popular belief, families maintain a disproportionately close connectedness with their addicted loved ones. In this article, the author presents the underlying theoretical and functional components of this connectedness, and describes the process called Family Motivation to Change for mobilizing family and friends to motivate a resistant addicted loved one into treatment. Results of several studies show that this ensures not only treatment entry, but also treatment completion, enhancing the likelihood of long-term recovery. The goal of the ARISE Intervention and Continuum of Care is individual and family recovery and healing. ARISE employs Invitational Intervention with the addicted individual being invited by the family to participate. Because the method empowers the family to do a great deal of the work, it has been shown to be time and cost-effective.

Key words

ARISE; treatment engagement; Invitational Intervention; Family Intervention; Intervention; addiction in the family; substance abuse; alcohol-other drug abuse; breaking the intergenerational cycle; family motivation; motivation to change; continuum of care; Concerned Other; living in recovery; family patterns; cost effectiveness in addiction treatment; empower.

Introduction

The prevalence of substance abuse places substantial stress on society. In 1999, conservative estimates of the annual toll of alcohol and drug abuse in the US were \$343 billion and between 65,000 and 99,000 lives (Miller & Hendrie, 2009). In 2003 in Europe, alcohol abuse alone represented a loss of €125 billion (Anderson & Baumberg, 2006). These estimates are based on the “tangible” costs of medical care, premature death, unemployment, criminal justice involvement and addiction treatment. They do not account for more “intangible” costs such as the physical, emotional, and financial toll of addiction on the family members of addicted individuals (many of whom seek frequent medical attention for unidentifiable, stress-related illnesses), the suffering induced by drug and alcohol-related crimes, and the loss of healthy life. In Europe, estimates of the intangible costs of alcohol abuse range from €154 to 764 billion annually (Anderson & Baumberg, 2006).

Several US cost-benefit analysis studies of substance abuse prevention initiatives (specifically certain school-based programs) show a savings of \$18 for every \$1 invested (Miller & Hendrie, 2009; French, Salome, Sindelar, & McLellan, 2002). Investment in effective addiction treatment can save as much as \$23 for every \$1 spent (French et al., 2000). Given that fewer than 10% of substance abusers and addicted individuals ever receive treatment, the need for effective treatment engagement strategies is evident (Frances, Miller & Galanter, 1989; Nathan, 1990, Kessler et al., 1994).

This paper outlines the ARISE Intervention, an Evidence-based, Best-practice method of intervention proven to be effective at achieving treatment entry at a rate of 83% and 61% sobriety at the 1-year mark, with 10% improved (Landau, et al., 2004; Landau, 2010, in press). This method differs from others because, traditionally, interventions stop as soon as an addicted individual enters treatment while ARISE is a Continuum of Care. Merely getting an addicted individual into treatment is not enough to quell the persistent pull of addiction. Addiction recovery is a process involving long-term behavioral and lifestyle change in both the addicted individual and his or her family.

The ARISE Intervention and Continuum of Care is a family motivational approach that mobilizes families and concerned members of the support system to motivate addicted individuals to enter and engage in treatment. This Intervention Network works together for a minimum of a year towards relapse prevention and long-term individual and intergenerational

family recovery and healing. ARISE is invitational, non-confrontational, and transparent. It honors the power of relational connections to facilitate sustainable change. The ARISE process relies on and trusts in the inherent strengths and resilience of families and is designed to respond to the love, fear, worry and guilt of those living with the addiction. It employs a minimum of time, cost, and effort on the part of the Interventionist.

The Importance of Family in Addiction Recovery

Families are powerful motivators for getting alcohol and drug dependent and addicted individuals to get treatment. A study by McCrady (2006) found that 75% of drug addicts and alcoholics credit their families as the major reason for their treatment entry. Despite this finding, the prevailing myth is that substance abusers are “cut-off” from their families so the importance of family involvement in treatment is often overlooked. In fact the opposite is true: In 1979 Purzel and Lamon (1979) found that 64% of heroin users and 51% of polydrug users are in daily phone contact with one or more parents, in contrast to only 9% of non-addicts. These findings were replicated in 1996 (Landau & Garrett, 2008). Worldwide, the percentage of adult drug abusers living with their parents is as high as 67% in Puerto Rico, 80% in England, Italy, and Thailand, and 87% in Mexico (Landau & Garrett, 2008).

Marlatt, Tucker, Donovan, and Vuchinich (1997), demonstrated that families are important to treatment entry and that family involvement significantly increases the likelihood of treatment completion. Regardless of whether or not the addicted individual completes treatment, treatment length of at least two months is strongly correlated to positive, long-term outcomes with respect to relapse, criminal justice contacts, health, and employment stability (Simpson, Joe, Rowan-Szal & Greener, 1995). Therefore, harnessing the power of family towards treatment entry *and* completion is vital to the likelihood of long-term recovery.

In response to the need for a successful method that would capitalize upon the unrivaled power of families towards addiction recovery, Dr. Judith Landau and James Garrett developed Invitational Intervention: The ARISE Model and Continuum of Care. ARISE is a clinical extension of Dr. Landau’s earlier work in the field of Transitional Family Therapy, a preliminary understanding of which is valuable for appreciating the unparalleled success of ARISE.

Theoretical Foundation of ARISE

Fundamental to Transitional Family Therapy is the view of families as inherently healthy, competent and resilient (Landau, 1982; Seaburn, Landau-Stanton & Horwitz, 1995). While

change is a natural part of living, experiencing multiple transitions, typically three or more within a short period of time creates stress in a family and can throw them off track from their normal, healthy functioning. These transitions include normal, predictable life-cycle events such as births or promotions as well as traumatic transitions. Traumas such as premature death, abuse, unpredictable loss, natural or man-made disasters, migration, cultural conflict, and unresolved grief can further disrupt the natural progression of individuals and families through their respective and collective life-cycle stages. The asynchronies created between the differing rates and directions with which individuals adapt to these changes cause Transitional Conflict within the families. Examples of such abound: a son “pulled forwards” through the natural lifecycle to fill in for an absent father as a confidante to the mother; a grandparent “pulled backwards” to a parenting role rather than moving forwards to retirement when called upon to rear a grandchild.

At times of overwhelming grief, families find ways of compensating, driven by their drive for survival. Adaptive behaviors such as addiction develop as a subconscious attempt to protect the family from the pain associated with trauma, loss and unresolved grief. The “symptomatic” family member’s behaviors draw the family’s attention away from the more painful trauma and towards the new problem behaviors. When the addicted individual attempts recovery before the family’s grief is resolved, the pain and grief return, reinforcing the need for the adaptive behavior, and relapse occurs. The addiction cycle is set.

This adaptation is highly successful at assuaging the family’s grief and because of its success is transmitted over time and through generations. This continues long after the adaptive behavior has ceased to serve its protective function. The result is a family pattern that has become dysfunctional despite its original purpose. In families where intervention has not occurred, when the grief is finally resolved (typically after 3-5 generations) someone leads the family into healing and recovery. This intrinsic drive towards health and healing within families, we have called “Family Motivation to Change” (Garrett & Landau, 2007).

Viewing addiction from the perspective that the addictive behavior is a subconscious effort to protect the family from trauma, frees the current generations of their overwhelming sense of guilt, shame, blame and the inevitability of a future locked into addiction. It allows them to see hope for the future rather than despair. The ARISE Continuum of Care acknowledges the deep-rooted origins of addiction and empowers the family to identify and access their inherent strengths and resilience to bring to bear on important life cycle transitions of past, present, and

future. This is the heart of The ARISE Continuum of Care: to relieve the family of blame, guilt and shame and bring a sense of competence and hope so that the addictive behavior is not transmitted further down and across the generations.

Overview of the ARISE Continuum of Care

The ARISE Continuum of Care consists of three phases: Phase A, comprising the actual Invitational Intervention, mobilizes the Intervention Network towards motivating the addicted individual into treatment. Incremental pressure is applied until this is achieved. Phase B is a transitional phase averaging 6 months while the Intervention Network supports the loved one through treatment and into early recovery. The goal is treatment completion, family relational improvement, grief resolution and relapse prevention. Phase C, 6-12 months, aims at the family's becoming a family living in long-term recovery with long-term individual and intergenerational family recovery and healing. It focuses on reinforcing the family's behavioral changes and on healthy behaviors and life style.

Phase A: Invitational Intervention

The ARISE Intervention itself is a graduated, three-level process that can be conducted long-distance via phone, conference call, and videoconferencing if all members of the support system cannot be physically present. The goal is to use the least amount of effort needed to motivate a substance abuser into treatment, stepping up the level of pressure gradually to match the intensity of resistance from the addicted individual. The collaboration between the Interventionist and the family relies on the understanding that while the Interventionist is the expert on the interface between families and addiction, the family is the expert on itself. Throughout the process, the family is encouraged to take into account what they think will work. They are also encouraged to offer a selection of choices to the Addicted Individual so as to reduce the likelihood of a rebellious response. The dual focus of the ARISE Intervention is on engaging the Addicted Individual in treatment *and* supporting the family in healing from the effects of living with addiction for so long. The power of the ARISE process lies in the collective motivation of the Intervention Network to bring about change. As the family's behavior changes the substance abuser inevitably follows suit because as the family system changes, so do the individuals within it. We find typically that if there are additional family members with substance abuse or other behavioral compulsions, they also embark on the recovery process.

Level 1: the First Call. Phase A starts when a Concerned Other contacts a

Certified ARISE Interventionist. The first call or contact is either a brief phone consultation or visit during which the Interventionist coaches and empowers the caller to mobilize the support system as an Intervention Network to invite the addicted individual to a First Meeting. Pivotal to Level 1 is development of the Recovery Message, which explicitly states the understanding of where the addiction started in the family and the intent to keep it from progressing into future generations. The Recovery Message is used to help families understand the addictive pattern across generations, to relieve the guilt, shame and blame, and to bring hope for the future health of the family. It is the central component of the invitation to the Intervention and always draws on the strengths, survival and love in the family.

At the First Meeting, members of the Intervention Network share their concerns and ask the individual to enter treatment. The meeting commences whether or not the addicted individual chooses to attend. A primary focus of Phase A is getting the commitment from the family to enter and commit to the recovery process. At Level 1, 56% of individuals enter treatment.

Level 2: Strength in Numbers. Level 2 begins only if the substance abuser has not entered treatment and the Intervention Network wants to escalate their effort. This typically occurs after 2-5 meetings or 6 months. The addicted individual's participation is continually encouraged, though his or her refusal does not deter the Intervention Network from their work. Strategies evolve over the course of these sessions and the network grows in strength as a group, allowing it to deliver a consistent message to the individual. All decisions are made by the majority of the Intervention Network. This prevents isolation and the vulnerability of any member to the one-on-one manipulation characteristic of addiction. After 2-5 Level 2 meetings 80% have entered treatment.

Level 3: The Formal ARISE Intervention.

Fewer than 2% of families need to proceed to Level 3. At this level, the Intervention Network sets strict limits and consequences for the problem person, expressed in a loving and supportive way. By this time, the substance abuser has been given and refused many opportunities to enter treatment. Since the substance abuser has been invited to every meeting, this final limit-setting approach is a natural consequence and does not come as a surprise. The Intervention Network commits to supporting each other in the implementation of the agreed upon consequences.

Case examples at each of the three levels of Phase 1.¹

Level 1 Case.

The First Caller, Jan, was concerned about the alcohol consumption of her 29-year-old son, Jude. She suspected that he was also using cocaine. Jan had learned earlier in the week from Margaret, her son's wife of four years, that Jude had spent approximately €25,500 of an inheritance over the previous three months and Margaret could not identify anything that had been bought. Both she and Jan were extremely worried about Jude and Margaret's 2-year-old daughter.

Jude's father, Mark, had stopped drinking on his own 15 years before after his intoxication had caused a series of violent domestic episodes. As a result, Jan had divorced him. Mark had not changed any other aspects of his behavior and had not received any treatment, nor attended Alcoholics Anonymous (AA). Mark's father, Ed, also an alcoholic, had passed away approximately 3 months before. Ed had stopped drinking later in life having regularly attended AA meetings. Jude had spent nearly every day with his grandfather for the two months prior to his death and was devastated by the loss, as was his father, Mark.

When Jan was asked who cared enough about Jude to be willing to attend the First Meeting, she constructed the following list: herself, Margaret, Mark, Jude's sister, and Margaret's parents.

The Recovery Message was, "We know you do not want your daughter to grow up scared and insecure like your grandfather and father did. Your grandfather always felt that he wasn't good enough or doing enough for the family after his father died. He was so overwhelmed that he started drinking very young, drawing his mother's attention away from her grief. Your father grew up in an alcoholic home and never felt safe. You don't want your daughter carrying the overwhelming responsibility that your grandfather and your father did. Let's not let these problems carry over into yet another generation."

Jan approached Jude two days before the First Meeting and shared with him her concerns, her contact with the ARISE Interventionist, the date and time

¹ Adapted from Landau & Garrett 2008

for the First Meeting, and who was going to attend. She asked where he would prefer the First Meeting to take place, offering his home, her home or the Interventionist's office. She shared the Recovery Message and invited Jude to the meeting. She informed him that the Intervention Network would be meeting regardless of whether or not he decided to attend.

Jude was 45 minutes late for the First Meeting. The initial time without him was spent discussing the family's intergenerational history of alcoholism, their recent history of violence, and Jan and Mark's courage to be in the same room together for the shared goal of getting their son into treatment and breaking the cycle of alcoholism in the family.

When Jude came into the First Meeting, he sat down, looked at his parents and stated, "I'll bet you thought I wasn't coming. I didn't come on time on purpose. I knew you had things to discuss on your own without me." His parents shared what had been discussed and stated the purpose of the meeting. Jude was asked to listen while each person expressed his or her concerns. Each person shared what s/he knew of his alcohol and drug use and requested that he get help.

After listening, Jude was given an opportunity to respond. He admitted to his addiction and talked about how his use escalated after his grandfather had died, and how he had been having recurrent thoughts of his own death since losing his grandfather. The group supported him, validating how each of them was also having a difficult time with Ed's death. Jude agreed to check into a local hospital detoxification unit the next day and the family agreed to meet again in the detoxification unit to discuss the next level of care needed.

Level 2 Case.

The First Caller was Lisa, whose 15-year-old daughter Angela, was drinking heavily, using marijuana on a daily basis, failing almost every class, playing truant with friends, and running away whenever her parents tried to discipline her. During the previous 3 months, Angela had been involved in 4 car accidents of escalating seriousness. Her parents felt that she was depressed and were reluctant to discipline her too strictly for fear of driving her into becoming depressed or suicidal. They were beside themselves, but felt helpless to change

the situation.

During the Level 1 First Call, Lisa revealed that a 28-year-old man had sexually assaulted Angela when she was 13 years old. He had plied her with drink and taken advantage of her once she was intoxicated. Angela had been through an extremely painful, unsuccessful court case. Her rapist had been found not guilty because the emergency room physician had failed to take the necessary samples at the time of her medical examination.

Angela attended all 3 Level I meetings, along with her parents and 5 siblings, but she refused to consider treatment for her addiction and depression. Whenever action was mentioned, she would explode in fury at her father, Pat, stating, "You're one to talk! You always drink when you're upset! Why don't you go for treatment?" After some intense family conflict, Pat agreed to stop drinking if that would help Angela get into treatment and get better.

Throughout the first several meetings, more family trauma was exposed. Lisa's mother, with whom Angela had been very close, had recently passed away. Both Angela and Lisa were still grieving the loss. Additionally, Lisa had suffered from serious depression since she and Pat lost their first child in a car accident at the age of 3. Angela and her siblings felt that they had been forced to raise themselves because Pat had buried himself in work and drinking while Lisa stayed in bed with the curtains closed and the light off. As soon as these losses were identified, Lisa and Pat's reluctance to discipline Angela was clear: they were terrified of suffering yet another loss.

At this point it became evident that the Intervention Network needed to be expanded, and friends and extended family members were invited to bring their "Strength in Numbers" to Level II. With consequences set for her behavior, and the other members of the Intervention Network not falling for Angela's threats, Lisa and Pat became visibly stronger and were able to insist that she go into a wilderness program for addicted youth. Clear parameters were set for Angela's completing the required program, and she agreed to the conditions with obvious relief that safe boundaries were being set. She did extremely well in the program, and was able to graduate from high school with honors. She attended college did

extremely well academically and socially. She has now been sober for 6 years.

Level 3 Case.

The First Caller, Sara, called regarding her 48-year-old step-granddaughter, Conchetta's alcoholism. Sara was concerned for Conchie's two teenage daughters who were involved with bad company and staying out all hours of the night. Conchie's father Franco was a recovering alcoholic. The participants in the First meeting were: Sara, Franco, Conchie's 16 and 17 year old daughters, and two friends. Sara invited Conchie using the following Recovery Message: "We know how unhappy you have been over the past few years. You have not been the same since your mother died 10 years ago. Your children need their mother, just like you needed yours."

Conchie did come to the First Meeting where she minimized her drinking and refused to enter treatment but did promise to "cut down." The Intervention Network did not think Conchie would be successful at reducing her drinking and decided to continue meeting. They met an additional 3 times over the subsequent 5 weeks and though Conchie was invited to each of these meetings, she only attended the second of the three.

She reported in that meeting how "successful" she had been at cutting down her drinking to one or two drinks a night, even staying sober some nights of the week. Her report was contradicted by one of her friends who noted that Conchie could barely talk the previous weekend, having clearly had more than one or two drinks. Franco shared how he could identify with her minimizing, "Before I went into AA I lied about how much and how often I drank. In the beginning, I even drank before meetings and shared with the AA group how well I was doing not drinking." Conchie still refused to enter treatment.

At the third Level 2 meeting, the Intervention Network agreed to go on to Level 3 where a consequence would be enforced if, by the end of the meeting, Conchie had not agreed to treatment. The Intervention Network prepared for the Level 3 meeting by writing letters to Conchie, to be read in order of increasing impact. She attended the Level 3 meeting and, as in previous meetings, was asked to listen to the concerns of each person before responding at the end. This time,

the group read their letters each of which included expressions of love, concrete examples of her behavior and their concern, the Recovery Message, a request for Conchie to seek treatment and the consequence if she refused.

The group had decided that if Conchie did not enter treatment, her children would be moving in with Franco and Sara until she had entered an alcoholism treatment program. Conchie, shocked by the consequence, tried to single out her daughters to convince them not to leave. She lashed out at the others for threatening to take her children away from her. Conchie's friends calmly explained how the whole group had made the decision during the previous meetings—that she had chosen not to attend—and that their commitment to the consequence was firm and non-negotiable.

Conchie's friends invited her to present her case to a Family Court judge before making her decision. Conchie argued for another 5 minutes. When the group got up to leave, her daughters said, "Mom, we will be in touch from Grandpa's house." Conchie began to cry and asked the group to sit back down because she could not stand to lose her daughters and would enter treatment.

Phase B: Supporting Treatment and Early Recovery

Once the substance abuser enters treatment, or 6 months has elapsed, Phase B begins. The Intervention Network continues meeting on a weekly then biweekly basis to support the recovery process. It is important for the encouragement and support of the family to take place over a period of time and through difficulties and stress that invariably arise during this transitional period. The network collaborates with the addicted individual and their treatment providers to ensure that the group addresses the following topics as they pertain to each member of the network: physical, mental, emotional and spiritual health; relapse prevention and psycho-education about addiction; family, social, and fellowship support, and financial and career vitality.

Phase C: Living In Recovery

Phase C builds on the foundation established in Phase B. The focus is on the individual and family living in recovery. This includes relapse prevention, attendance at self-help meetings, continued family therapy and psychoeducation, and grief resolution. Of primary importance in Phase C is developing awareness of the details of family communication, relationships, patterns,

and activities of daily living, to ensure that difficult issues are discussed openly and without secrecy so that the family can learn to grieve, heal, celebrate, relax and have fun together.

Outcome Data From Studies on ARISE

A clinical study conducted through the National Institute on Drug Abuse (NIDA) on the efficacy of the ARISE Intervention for engaging resistant substance abusers in treatment or self-help showed an 83% success rate (Landau, et al., 2004). Half of those who entered treatment did so within 1 week of the initial call and 83% did so within 3 weeks. On average, professionals spent less than 90 minutes coaching concerned friends and family members to mobilize their networks to motivate addicted subjects to enter treatment.

The engagement rate did not differ across preferred substance of abuse, the level at which engagement occurred, inpatient versus outpatient treatment, demographic variables including age, gender, or race, or level or experience and profession of the Interventionist. There was no significant difference among types of concerned other-addicted individual relationships, however, results improved in cases in which at least one parent was involved as a participant, (Landau et al., 2004). This finding is in line with studies by Meyers, Miller, Hill & Tonigan (1998) and Miller, Meyer & Tonigan (1999) that showed that parents were more likely than spouses to engage addicted individuals in treatment. This also matched the research that addicted individuals are closely involved with one or both of their parents (Meyers Smith and Miller, 1998, Miller et al., 1999, and Szapocznik et al., 1988).

A recent “real world” study on ARISE conducted by Stanley Street Treatment and Resources (SSTAR) replicated the results from the NIDA study with an 80% engagement rate (see Table 1). Their one-year follow-up study demonstrated a 61% sobriety rate with an additional 10% improved (see Table 2) (Landau & Garrett, 2008). SSTAR recently conducted a pilot study wherein the ARISE Intervention was initiated through addicted individuals who had been detoxified a minimum of 3 times with no days in recovery. The goal was to determine the effectiveness of the ARISE Intervention at ensuring that after detoxification these patients engaged in secondary and tertiary care. The study found that 82% went on to a second level of care and of those, 100% went on to a third level of care. Ninety-one percent reported that they were active in NA or AA, and at the time of last contact, 55% had not relapsed. Of those who had relapsed, 80% were back in treatment (P. Emsellem, personal communication, October, 21, 2009).

Conclusion and Practical Clinical Implications

These findings challenge the widespread view that addicted individuals must "hit bottom" and be self-motivated to enter treatment. First Callers in the NIDA study often mentioned the anger they experienced at being labeled "co-dependent," "controlling," a "victim" or an "enabler," and the helplessness they felt at being told that there was nothing they could do until their loved one "hit bottom." They were relieved and felt supported and encouraged by the realization that with the ARISE Intervention they could motivate their loved one into treatment by invitation rather than coercion.

The ARISE Intervention and Continuum of Care has been applied to a number other situations that are as disruptive to individual and family life as substance abuse. These tend to fall into four main categories: (a) other addictions and behavioral compulsions; (b) chronic and/or life-threatening physical or psychiatric disorders; (c) physical or emotional problems that threaten primary relationships, but are not severe enough to warrant psychiatric referral, and (d) co-occurring disorder—a combination of addiction and one of the above.

Hopefully, there will be further studies in the areas mentioned above so that the resources and resilience of families can be brought to bear on many of the problems that currently cause significant and unnecessary mortality, morbidity, and expense.

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