

COVER
STORY

Use structured interventions to speed clients into care

STRUCTURED FAMILY AND WORKPLACE INTERVENTIONS ARE A POWERFUL CATALYST FOR CHANGE, RAISING A TROUBLED PERSON'S 'ROCK BOTTOM' TO THE HERE AND NOW WITHOUT THE DANGERS OF A PROGRESSIVELY-WORSENING ADDICTIVE LIFE. DEIRDRE BOYD STUDIED CUTTING-EDGE GUIDELINES FROM BOBBY BONDS AND SZABI ISHTAI-ZEE



Bobby Bonds MHS has, since 1983, been responsible for designing and implementing the US railroad company Amtrak's substance-abuse programmes. His Operation RedBlock is the railroad industry's model programme for drug and alcohol interventions and prevention: in the 18 years since this started, Bonds trained over 15,000 volunteers to deal with workplace interventions. He also regularly leads coordinated efforts with agencies to implement integrated peer-based models for families dealing with a drug or alcohol problem. Bonds earned a Master Degree in Human Service and was recognised by the US government on a national level for his innovative work.

Dr Szabi Ishtai-Zee PhD is professor and director of Human Services at Lincoln University. He is on the faculty of the Educational Leadership & Change programme at Fielding Graduate University.

Deirdre Boyd is editor of *Addiction Today* and CEO of the Addiction Recovery Foundation, which she joined in 1993 after training in BACP-accredited integrative psychotherapy and facilitating women's groups at the Drug & Alcohol Foundation. This year, she gained a certificate in proactive structured interventions.



If we cannot help someone with alcohol or drug problems until they want help, what will it take to get them to that point? This question changes most seemingly-hopeless scenarios: we do not have to wait for personal tragedy such as divorce, job loss, financial ruin, prison, cirrhosis or death – indeed, we can avoid the worst of these. Modern intervention techniques have had four decades to be refined and expanded since they were first developed by Vernon Johnson and the staff of St Mary's Hospital in the 1960s.

William Bennett, author and former White House drug czar, said that "Success is often a function of time in treatment. And time in treatment is often a function of coercion – being forced into treatment by a loved one, an employer or, as is often the case, the legal system". The more we understand about the nature of addiction/dependency, the faster we can get people into treatment, and the better we can all do our jobs.

EARLY WARNING SIGNS. The following signs are not a formal diagnosis but their existence can signal the need to reduce the risk of substance-abuse problems. Have you (or the family member, employer or colleague who contacted you for help) noticed any of the following in someone close?

- missed days at work
- frequent sick days
- traffic tickets, traffic accidents
- penalty points on driver's licence
- more family arguments
- taking things out on your children
- inefficiency ratings at work
- blackouts
- using alcohol or drugs to get through the day, or to sleep.

COMMITMENT. Structured intervention requires a commitment to a great deal of work, and is not be undertaken lightly. Hours – even days – of preparation are needed with all the participants in the "intervention event". These can include union officials, union members, colleagues, managers, friends and family who had previously tried unsuccessfully to get the user to change. As well as this group of concerned and caring people, structured

COVER STORY

“WE CAN USE OUR EXISTING SKILLS TO SWITCH FROM A FACILITATIVE STRATEGY, TO A RE-EDUCATIONAL STRATEGY, PERSUASIVE STRATEGY OR POWER-COERCIVE STRATEGY AS THE SITUATION DICTATES. OUR APPROACH MATTERS... IT CAUSES A REVERSAL IN THE USER’S ABILITY TO MAINTAIN THE HARMFUL *STATUS QUO*”

intervention requires at the minimum:

- specific dates, times and places of the user’s behaviour, accompanied by observations, feelings and message of care
- that anger, hurt and pain be set aside so that the concern is evident
- a suggested treatment plan for the user; cost, availability, timeliness and other factors – right down to how household bills will be paid while in treatment – go into this researched plan which covers the entire treatment range from inpatient to outpatient to self-help groups... there is something for everyone
- consideration of the consequences if things do not change; threats are common but specific and honest consequences must be discussed and pre-planned.

The earlier an intervention takes place, the more likely the relationships can use consequences – such as loss of job or withdrawal of financial support – as leverage. Later, it can be hard to find consequences. The main job of the interventionist is to teach and trail all the parties involved.

STRATEGIES. Each intervention is “situationally based” depending on the user’s circumstances but we can build a systems approach for our foundations. We can use our existing skills to switch from a facilitative strategy, to a re-educational strategy, persuasive strategy or power-coercive strategy as the situation dictates. Our approach matters: using strategies of behavioural knowledge of change on identified areas of resistance causes a reversal in the user’s ability to maintain the harmful *status quo*. We will see a paradigm shift in relationships and the environment in which they exist. In many cases, the need for change is clear. How to go about that change needs to be understood and accepted. We can start with a force field analysis.

List all the forces for change in one column, and all the forces against change in another column. Assign a score to each force, from a weak 1 to a strong 5. Draw a diagram showing the forces for and against change, with the strength of each force as a number beside it. An interventionist utilising the help of both family and employer might draw up a force-field analysis like that below. If you then had to implement the plan, the analysis would suggest the following changes:

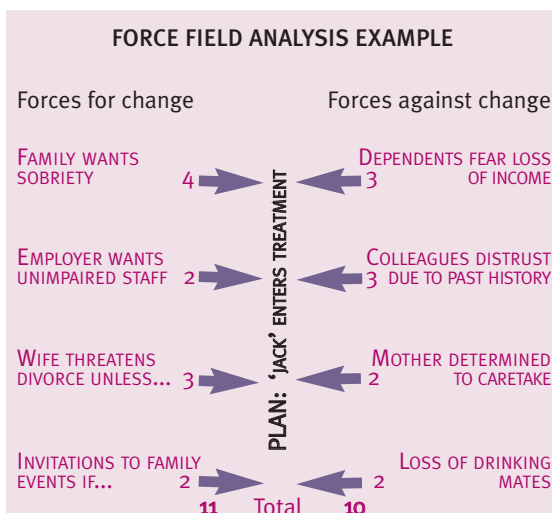
- by training staff (increase cost by 1) you reduce risk of recovery sabotage for this and future employees (reduce by 2)
- it would be useful to show the mother that change is necessary for long-term gain (in favour, +2)
- family members financially dependent on Jack need support in exploring the short- and medium-term effect of treatment.

Already we can see that changes swing the balance from an ambivalent 11:10 to a likely 13:7. And we can identify a re-educational strategy for the workforce, probably the whole set of strategies to get the mother on side.

PREPARATION, PREPARATION, PREPARATION. The cornerstone to any intervention is assessment. Collecting and analysing information about the exact nature of the situation is vital. Here, we can use the Intervention Readiness Scale, a 25-item questionnaire rating severity from 1 to 5 of such things as the current crisis, worklife, co-workers, family life and important relationships, stressors, previous attempts to change, scope of the problem and who else is affected, general knowledge about addiction/dependency, obstacles to recovery and the impact of the addiction. The scale will help us identify people and resources who could facilitate the intervention, and to determine their role.

To gather the information for both the Intervention Readiness Scale and the force-field analysis, it is important to contact, either face to face or by telephone, everyone concerned. Involve as many family members as possible, and to learn from them who else is influential in the user’s life and could also help. If there is a particularly negative influencer, the best course of action might not be to omit them from the intervention as they could sabotage recovery later down the line, but to use a re-educational or other strategy to convert them into a positive force.

The Intervention Readiness Scale first looks at history of use: demographics, drug/alcohol history, prior treatments and the like. The second section looks at leverage points: what losses does the addict fear which in turn could be used as motivation to seek help. What positive factors or people exist in the addict’s life? Ask open, leading questions as an interview and rate from 0 for not applicable to 1 for mild/unlikely, 2 for little, 3 for



“THE FINAL STEP BEFORE THE INTERVENTION IS A REHEARSAL. BY THIS STAGE, YOU WILL HAVE SHORTLISTED APPROPRIATE TREATMENT FACILITIES AND ALERTED THEM OF A PENDING ARRIVAL... YOU WILL ALSO HAVE REHEARSED WHAT WILL HAPPEN IF THE ADDICT REFUSES TREATMENT – THERE ARE ALWAYS OTHERS IN THAT ROOM WHO NEED HELP”

moderate, 4 for often and 5 for severe/often. Then ask the following.

- 1 What is the pending crisis which brought this situation to a head? How severe is it? Does it concern legal, family, work, health, financial or other factors? How often has this crisis occurred in the past? How was it dealt with?
- 2 What is going on at work? What is the potential motivation for an intervention?
- 3 Have there been any past negative job consequences due to addiction? How many actions have taken place?
- 4 Is there any formal or informal threat/job jeopardy? Is the user concerned about losing his/her job?
- 5 What is the user's relationship with co-workers?
- 6 Are those co-workers a positive or negative force?
- 7 What resources exist at the job? What quality are they and how accessible? Is the client willing to use them?
- 8 How long has the person been working in their current position?
- 9 How stimulating/important is the job to their life?
- 10 What is going on with the family? Who are the important relationships? What is important about the relationship? List these in priority. How many important relationships are there?
- 11 What strains have been placed on the important relationships? List.
- 12 What past attempts have been made to correct the strains on the relationships? How many attempts?
- 13 Who and what are the more difficult or negative relationships in the addict's life? What makes them difficult?
- 14 What is the difference between the two (difficult vs important) relationships?
- 15 What previous attempts have been made to change the difficult relationships, by either party? How many?
- 16 What is going on with the family? What are the family members doing to help perpetuate the problem or to positively manage the situation? Who are the principal caregivers in the addict's life?
- 17 When is the caregiving successful?
- 18 What is it not successful?
- 19 Describe how you (the person being interviewed) control the problem.
- 20 Describe how you try to manage the situation.
- 21 Describe how you contribute to the way the situation is now.
- 22 Scope of the problem: who and what are affected besides the addict? Identify all the principal players and situations adversely affecting any positive progression of change in the addict's world. What do they know



AS WELL AS INDIVIDUAL MEETINGS, THE INTERVENTIONIST SHOULD FACILITATE AT LEAST ONE GROUP MEETING OF ALL POTENTIAL PARTICIPANTS TO GET THE MOST SUCCESSFUL RESULTS

about addiction (personal philosophy)?

- 23 What obstacles besides the addict's behaviours/use of drugs or alcohol prevent the situation from changing?
- 24 What personal impact does the dependency have on the interviewee's life (loss of sleep, worry for the addict or self, monetary, fear)? List these.
- 25 What changes have been made to alleviate the suffering caused by the addicted person's behaviour?

The scores are totalled under two headings: motivational factors and influence factors. Priorities are then ascertained, so you can decide where to focus your efforts. The development of the intervention strategy begins with the interventionist's interpretation of the principal leverage and dynamics found in this scale. Often, the family/institution will not recognise their repetitive reaction to similar situations: enablers tend to overlook, rationalise and justify behaviours which trigger automatic, counterproductive responses. These often inhibit change and the development of healthy relationships. Discovering these triggers becomes an important factor in facilitating the plan.

AND MORE PREPARATION... As well as individual meetings, the interventionist should facilitate at least one group meeting of all potential participants. If some people cannot attend, invite them to write a letter to the addict which can be read aloud. As a general rule, do not lie to the addict about a facilitation taking place – but the decision about whether to reveal this must be made on a case-by-case basis. The final step before the intervention is a rehearsal. By this stage, you will have shortlisted appropriate treatment facilities and alerted them of a pending arrival, packed the suitcase, and agreed with all participants what the ground rules are about physically restraining the addict.

You will also have rehearsed what will happen if the addict refuses treatment – there are always others in that room who need help themselves. And remember: 85% of addicts accept help the day of the intervention.