

# Brief Intervention: Process and Techniques

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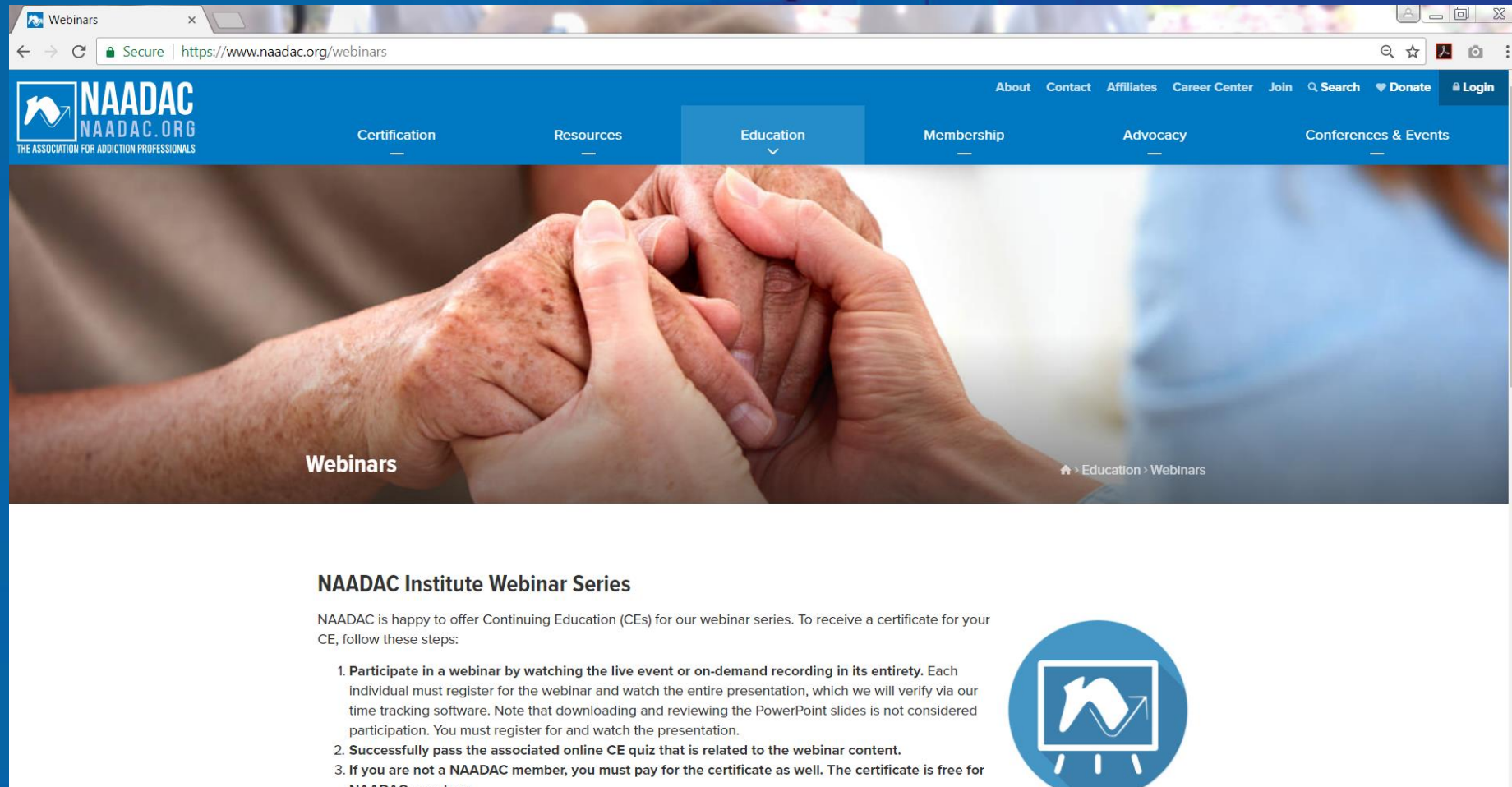
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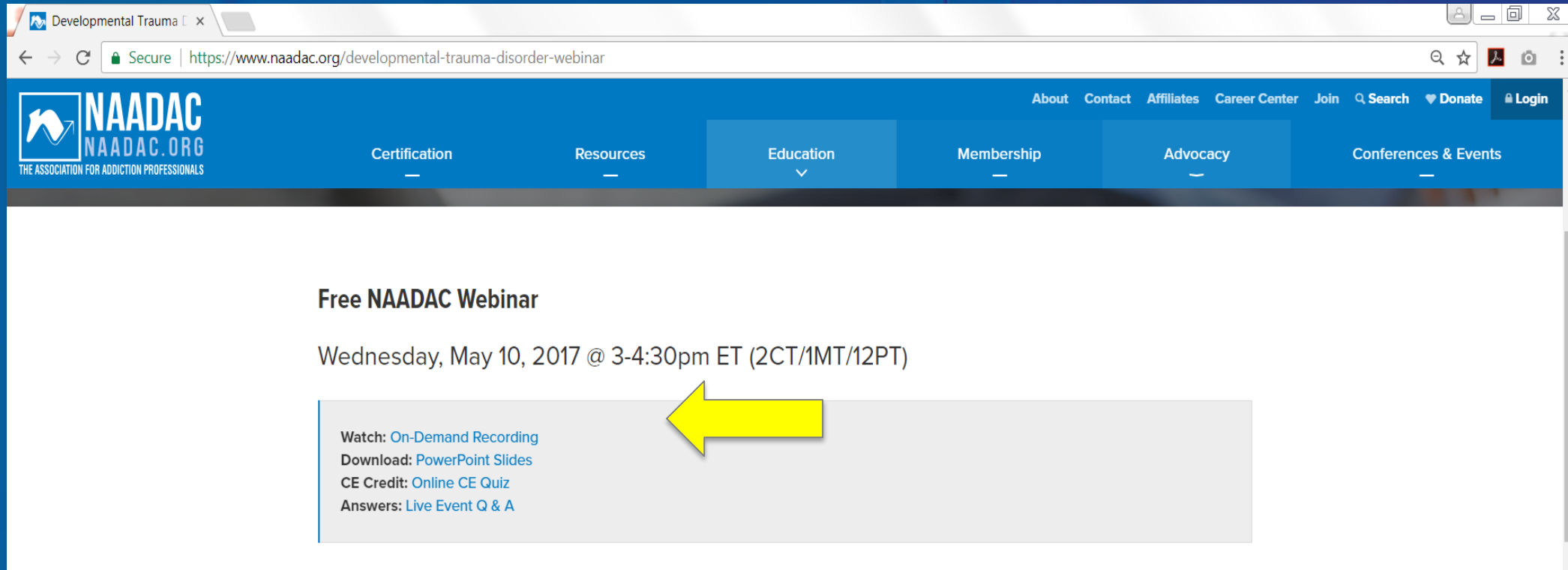
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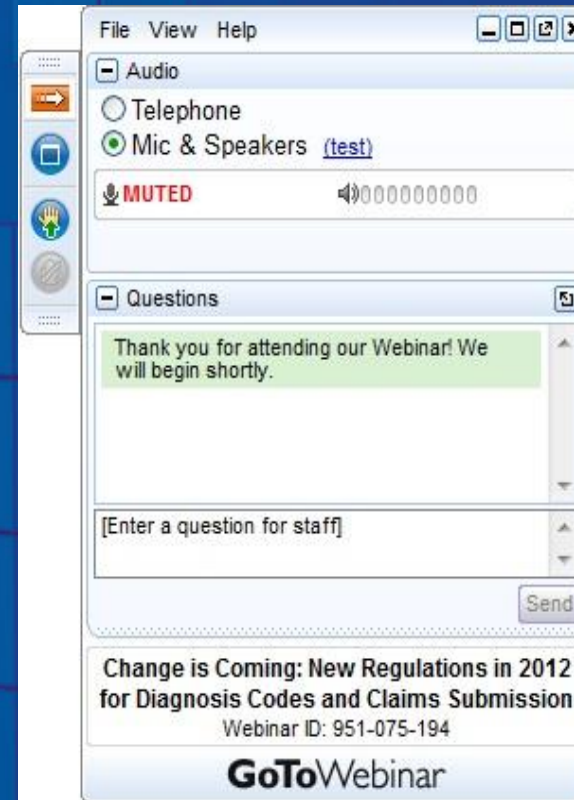
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- Control Panel
- Asking Questions
  - Audio (phone preferred)
  - Polling Questions





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# Webinar Learning Objectives

1

Learning Objective #1  
Attendees will apply the 7  
steps in the brief  
intervention process

2

Learning Objective #2  
Attendees will  
comprehend 3 roadblocks  
to success in the brief  
intervention process

3

Learning Objective #3  
Attendees will identify 6  
elements of Brief Interventions



## Polling Question #1

Have you worked in any capacity conducting interventions in the substance use disorder field?

Yes or No

# Overview of Webinar Agenda

1. Discussion of brief vs. full intervention
2. Steps of conducting Brief Intervention
3. Team Building/Assessing the Intervention Team Readiness
4. Roadblocks to Successful Intervention
5. Discussion of Family Roles and how they affect the Team dynamics
6. How to address crisis management if needed
7. Informed Consent and Disclaimer review
8. Discussion of Pros and Cons of Brief Intervention



## Polling Question #2



Have you had previous training in intervention or brief intervention?

Yes or No

# What Is a Full Intervention?

Full intervention usually requires much more planning and preparation time and thorough care is taken on each detail and step involved in getting a client to treatment

In Full Intervention, usually more tasks of intervention are handled by the interventionist.

Follow-up care time is usually longer in full intervention.



# What is Brief Intervention?

Brief Intervention utilizes the primary process of intervention inside of an abbreviated time frame. It uses the power of the group in a face-to-face meeting to motivate an IP to get appropriate help

# **“Soft” Intervention vs. Brief Intervention**

- Definition of soft intervention**
- Places to use soft intervention**
- Tools for soft intervention**

# Some Reasons to Conduct Brief vs. Full Intervention

- 1. Limited finances of family to spend on intervention.**
- 2. IP is incarcerated or in hospital and transfer to treatment needs to be expedited.**
- 3. Size of intervention team is very small and usual team preparation time is less**
- 4. IP is already very motivated for treatment and group intervention is not necessary.**



# Limitations of Brief Intervention vs. Full Intervention

- Agenda of the family/team gets addressed as primary agenda vs. agenda of Interventionist.**
  - **Most families call for an intervention when they are in partial or full crisis mode and want immediate intervention.**
  - **Interventionist joins with family in expediting the process which may lessen the desired outcomes for family system change through extra team building and facilitation of change for the family system.**
- Time for attention to detail is limited.**
- Time for support of individual team members is limited.**
- Time for picking best possible resource for treatment may be limited.**

# Steps in Brief Intervention

1. Initial call usually from concerned family member or friend
  - Establish rapport by listening to their concerns for about 5 minutes by allowing them to vent)
  - Start to complete questions on the Intake/Screening Form
2. Schedule Conference Call with potential Intervention Team asap
3. During call debrief team on steps/structure of intervention process
4. Discuss roadblocks to successful intervention/educate about disease
5. Help them write/edit the love letters, plan transport, pick treatment center, manage insurance benefits
6. Be available during the intervention for phone support
7. Be available for contingency planning phase if needed

<b>I. Initial Call from Client/Caller:</b> <b>II. Identified Pt. Name and DOB:</b> <b>III. Phone Number of Caller:</b>	<b>Time/Date of Call:</b>  <b>Amount of Time Caller wants to talk on this call (15 minutes pre-interview needed):</b>	<b>Location of Caller:</b>  <b>Location of IP:</b>
<b>DOC:</b> <b>Detox Need: YES NO</b>	<b>Currently Using: YES NO</b>	



# Tips for Working with the Initial Caller

- Know that this person is often the most aware of the problem
- Know that this person can often be the most controlling of what kind of help is needed and may not be on target
- Know that this person can think that they have the situation fully assessed when actually major points have not been factored in
- Know that this person is overwhelmed often and needs centering
- Know that this person may want interventionist to take over but can't let go of the control
- Minimize extensive discussion of all aspects and history of the addiction of IP



# Tips for Written Contract

- It is best to have a written contract outlining duties of interventionist and expectations of the team in order to increase understanding of the process.
- Email to client and ask for signature. Use of programs like Doc-U-Sign can help reduce time involvement when clients are in a hurry
- Don't skip this step
- Disclaimer concerns

# Steps for Team Guided Intervention

- Appoint a Team Lead person who transmits information to all team members and is the interventionist primary point of contact for communication
- Plan time, date, location of intervention
- Appoint appropriate person to address insurance/payment issues and make intake plans with treatment center (can be team lead but may be spouse or other person)(can be interventionist as well)
- Contingency plans for the 72 hours following Intervention with IP if IP refuses to go



# Choosing the Treatment Center

- ❑ In full intervention, the interventionist usually makes the recommendations for best fit after doing investigation of level of care needed, financial resources and other logistical issues.
- ❑ In brief intervention, picking the treatment center may become the job of the team lead or other team member in order to save time.
  - This presents a risk in that the treatment center has not perhaps been adequately vetted by interventionist.
  - This vetting role, again, may be passed to team members if they are able.
  - Disclaimer needs to be applied in this situation.



# Level of Care Placement

- Assess as much as possible what level of care seems appropriate utilizing information from the team knowing that ultimately the treatment center will make that call
- Choose treatment centers for each level of care, ideally both levels inside of one treatment center in order to reduce complications if higher level of placement is needed
- Be aware that clients will minimize use and cannot be used as a reliable source of information



# Assessing IP Willingness

- ❑ Initially assessed by the opinion/viewpoint of the caller
- ❑ Continue to assess by speaking with the team during phone conference
- ❑ Speak to client and use motivational interviewing if using an intervention model that supports this

# Assessing Chief Enabler Willingness

- Team needs to clearly understand that chief enabler getting on board with intervention 100% is key
- Key enabler needs consistency in action and word with the team and with the IP
- Education about disease of addiction using additional reading materials provided to team and enabler about disease of addiction

# Address Roadblocks to Successful Intervention with the Team

Biggest roadblock is allowing the power of the group to get off track via:

- Allowing too much discussion with the IP in the intervention meeting
- Arguing/getting into family fight with IP
- Not following the monologue letter reading format
- Not re-directing other manipulations from IP or any other team member



# Other types of Roadblocks

- Inadequate appropriate treatment resources
- Financial and treatment funding issues
- Trying to go too fast and not allow time for roadblocks to be worked out
- Shifting commitment of any team member to be involved in the intervention
- Suicidal ideation or other mental health issue with IP not being appropriate for chosen treatment



# Linking family to Additional Resources

- 12 STEP and Al Anon referrals are always recommended. Use Al-Anon website to provide locations
- Referrals to supportive counseling for team members as needed
- Legal and/or financial resources as needed
- Additional reading resources

# Co-Occurring Disorders

Co-occurring disorders can become a roadblock to intervention success as they arise and must be dealt with in order to insure appropriate placement of IP. If mental health issues are previously identified/diagnosed/treated, some of the Intervention Team and almost always the IP will want to make the mental health problem the primary focus vs. addiction as a primary problem.



## Co-Occurring Disorders Con't.

In Brief Intervention, any discussion of medication maintenance or recommendations for anything that would be considered a treatment issue or not within the scope of practice of Intervention needs to be minimized and re-directed as it cannot become a focus of the intervention. Assure family that the issue will be dealt with by treatment staff in the facility that IP will be attending.



# Disclaimer to Intervention Team

It is best practice to gather emails from each team member and send a disclaimer about the Elements of Successful Intervention and a Disclaimer Statement/Hold Harmless statement if Intervention does not lead to IP going to treatment or any other outcome that might be deemed “negative”, “unintended” or “less desirable outcome”





# Amount of Time to Conduct Brief Intervention

- Brief intervention can be conducted ideally in a 3-4 hour time commitment if no major roadblocks surface or are identified
- Additional time can be added by contract with Team
- Interventionist needs to estimate based on family dynamics after
- Initial Conference Call how much time will be needed to get through all steps

(Family dynamics may slow down getting to Intervention Day and may need to be addressed as an issue prior to organizing the actual intervention.)



# Codependent Family Dynamics as a Roadblock

- ❑ Interventionist needs to understand that he/she is entering into the family system and needs to work from the standpoint that all members are operating from a codependent stance no matter what the role of each person looks like, i.e. hero child vs. scapegoat.
- ❑ Family Dynamics may start to derail the process and cause Brief Intervention to move toward Full Intervention need.
- ❑ Contract with team as needed if process derails and add more time.

# Family System Roles

- 1. Hero Child – Is often the initial caller – most insightful/objective**
- 2. Chief Enabler – May be the initial caller/less objective but sounds at initial call as if there is more objectivity/ recovery than there actually is**
- 3. Scapegoat or Lost Child - often is the IP**
- 4. Mother/Father's Surrogate - may be the IP**
- 5. Mascot/Cheerleader**
- 6. Member may have more than one role**

# Use of Motivational Interviewing and Coaching to Prepare the Team

- ❑ Since less time is spent with team building in Brief Intervention, it is important to provide the Team with additional support reading after the Initial Conference Call. Working with the family/team dynamics needs to emphasize keeping the focus on love and concern for IP's welfare and suffering vs. just getting into an argument or negative derailment.
- ❑ Provide points for keeping a positive focus via the use of the love letters and a list of pitfalls to avoid during the intervention is very helpful.



# Elements of Brief Intervention

(Excerpt from Brief Intervention by Ken Winters quoting Miller and Sanchez' FRAMES)

## FRAMES

- 1. Feedback on personal risk**
- 2. Responsibility for Changes Originates with the Client**
- 3. Advice to Change (suggestion to change)**
- 4. Menu of Change Options**
- 5. Empathy**
- 6. Self-Efficacy and Optimism**



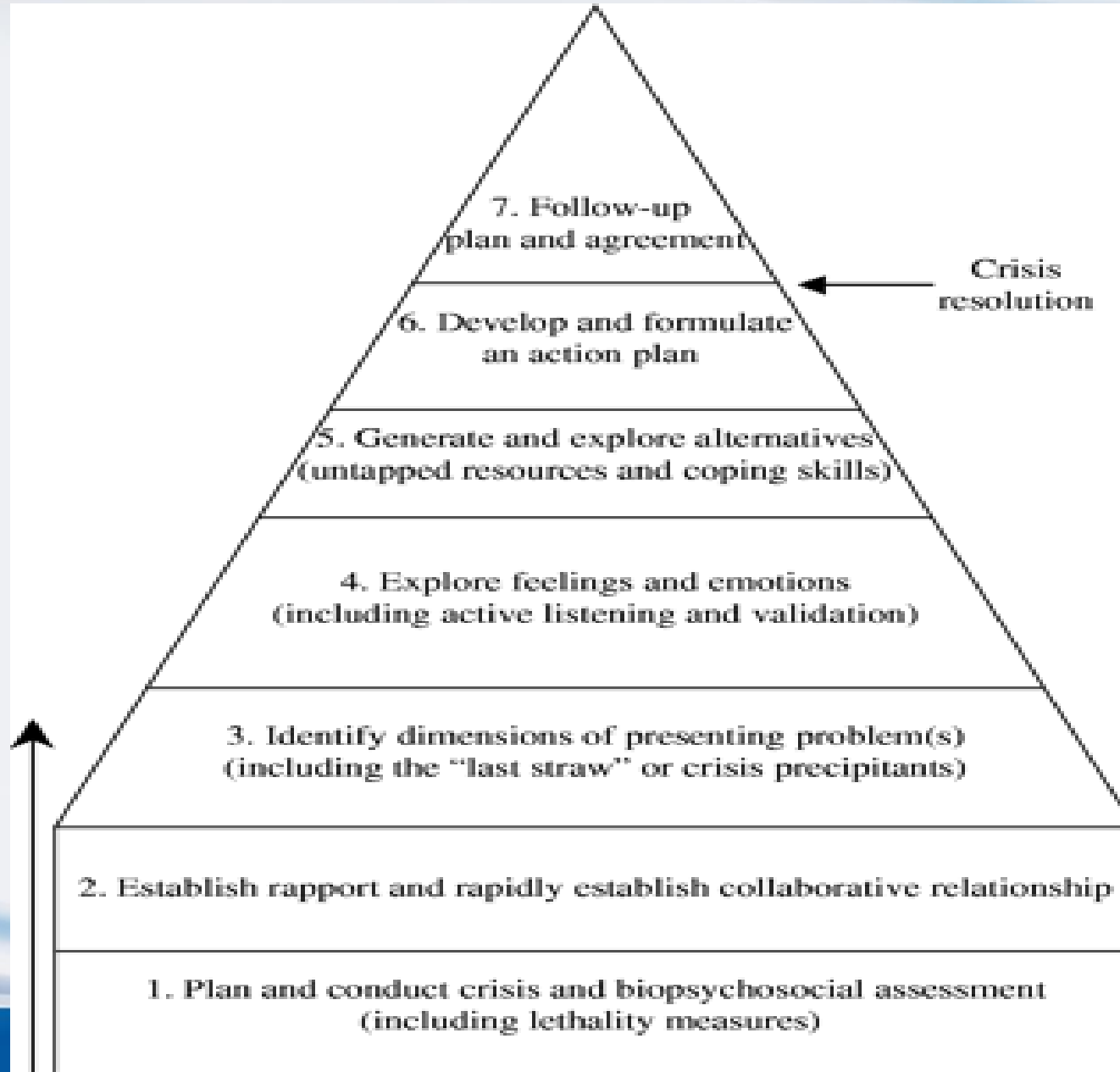
# **The Difference Between Brief Intervention and Early Intervention (according to FRAMES)**

- 1. Less feedback about negative aspects of substance use with brief intervention**
- 2. Menu of change options are not offered in early intervention**
- 3. All other elements are the same**

# Working with Client Resistance

- ❑ After coaching the team/family and using additional resources to provide psychoeducation to them, the interventionist may still need to provide “live-time” coaching by phone during the intervention if IP provides resistance.
- ❑ IP will very frequently try to negotiate for counseling or seeing a psychiatrist vs. going to treatment for addiction. Provide instruction on how to “hold the line” when resistance arises.

# Crisis Contingency Planning





# Accessing Emergency Services

If the IP becomes suicidal at any point, be prepared with resources for local emergency management phone numbers, etc. The team lead person can be the one to gather these for the geographic area for where the intervention will be held



# Case Study Example

Use of case of “Stewart” to discuss how brief intervention case was handled using points of discussion from webinar.



# What is the Measure of Success of the Intervention?

- Is it solely measured by the outcome of the IP going to treatment?
- Can it be measured by the success of the ceasing of enabling?
- Can it be measured by the growth and change of team members?
- Harm reduction as a measure of success

# Following Up with the Team/Family

- At two and four week points after the last contact
- Necessary to address need for further intervention
- Used to reinforce team members seeking their own help for coping with the disease of addiction and family issues
- Follow-up should be addressed in the initial conference to insure team understanding about how long it can take to get an IP into treatment and dispel magical thinking



# Thank You!

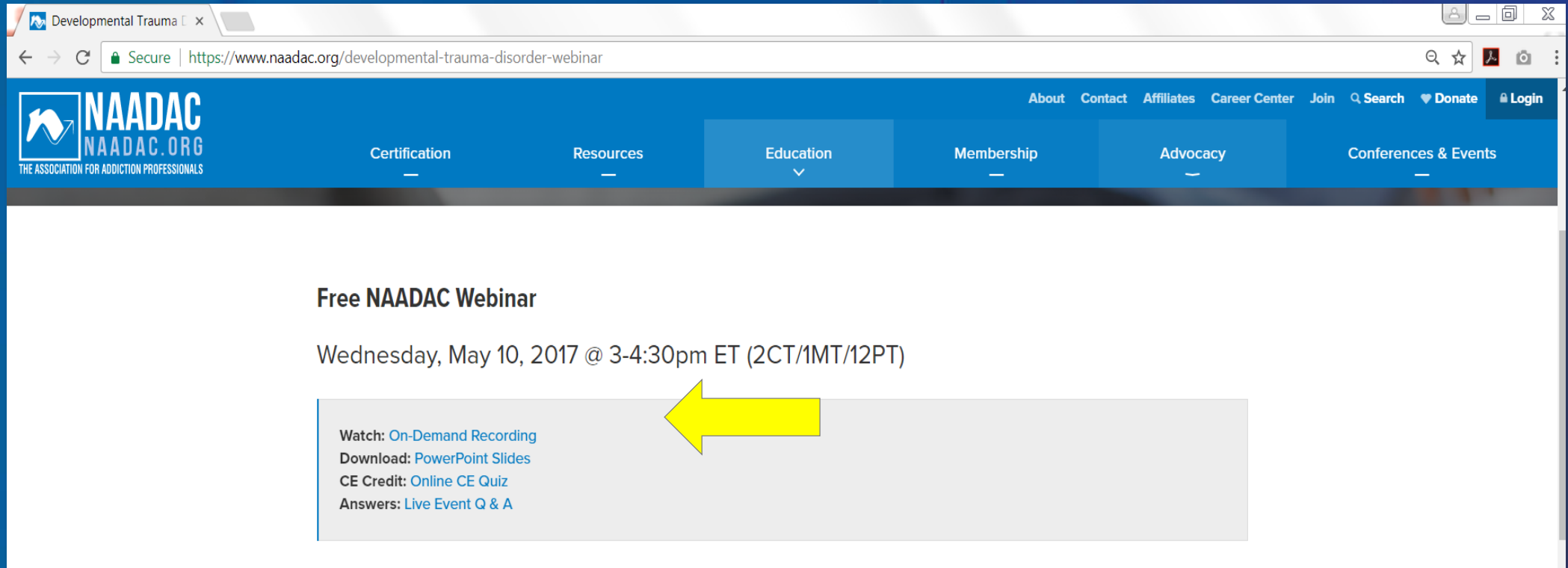
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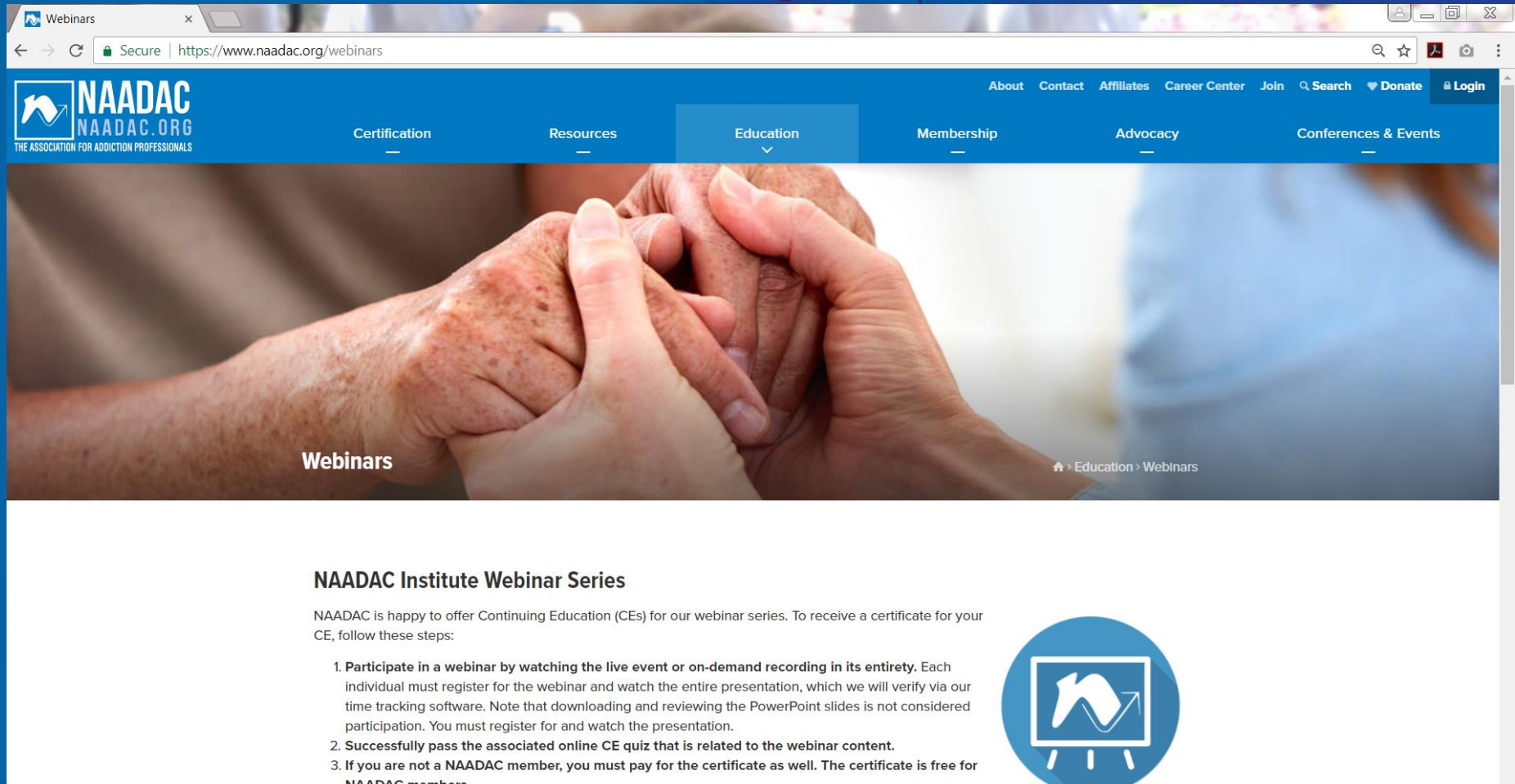
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