Competencies for High Quality SBIRT

(Screening, Brief Intervention, and Referral to Treatment)

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We wonder precisely what competencies make a practitioner particularly good at sizing someone up with an interview-style screening and brief intervention assessment.

Before puzzling over that question, allow us to share some thoughts about the screening and a brief interviewing assessment process. *"It's not the screw, rather the hand that turns the screw."* that makes the difference when it comes to a quality screening and assessment. There is a tremendous amount of variance between practitioners regarding quality of screening, the brief interviewing assessments, and rarely can it be attributed to variance in screening, assessment tools. So called fourth generation screening and assessment tools in substance use, misuse and mental health, nearly all linear and comparable in itemization and scaling, may vary in price and automation slickness, and *don't* differ that much regarding predictive validity.

What does vary, that is frequently under-considered, is the initial training for practitioners; their preparation, their accountability and positive reinforcement during the early stages of their work with SBIRT. This preparation makes a big difference in the validity of the screening, brief intervention assessments. There is significant variance across agencies and within agencies in the areas of:

- Active empathic listening, compassion, and building the working alliance with the person we serve and its fidelity. What evidence do we have for the practice we do to people?
- Ability to interpret and use the reliable screening, assessment results in conversation to recognize and strengthen "change theory/talk"

We realize that the reliance on the "right" screening, assessment tool is the problem in our "clinical" work. Practitioner engagement and alliance-building are no doubt the most important and given the least accountability. Invalid assessments tools and their reliably can lead to inappropriate use of resources, and a disconnect with the person we serve as well as a *poor* brief interview.

The WHAT of this paper is simple, though I'm not sure it is obvious because this topic was on my mind and resurfaced in many of the conversation I have had with others while training people in SBIRT. Does the screening, assessment tool encourage the people we serve to "lie" or misrepresent their use, their emotional health in an effort to protect themselves from *shame*? Posing the question in these discussions about what the most critical tools and/or skills for conducting *high* quality screenings, brief intervention assessments might be, a pattern of answers often emerge from trainees and they fall into two general categories: People either emphasize

empathy and/or Motivational Interviewing, or intangible, experienced-based competencies like street smarts and a good BS detector, not the tools. These conversations yielded the current opinion, belief, and evidence which for us is that radical acceptance and compassion (empathy) and amplifying the ambivalence are of crucial importance when it comes to an effective screening, brief intervention and referral to treatment (SBIRT). Furthermore, these two competencies do not always play well with screening, assessment tools.

Empathy

"Empathy is about finding the echoes of another person in yourself"

Across all definitions we could find, empathy is described as an ability to vicariously experience the feelings, thoughts, and attitudes of another person, as if you were that other person. Not surprisingly, this ability correlates with emotional intelligence and the core of what is Motivational Interviewing Spirit. Moreover, a search quickly reveals that empathy has been extolled by leaders in the arts, sciences, and religion as one of the *most* valuable human characteristics since the earliest records of civilization. Empathy, and the need for it is a part of our human nature, and its only requirement appears to be the willingness to pay undivided attention, to listen deeply to another person's pain and suffering. Empathy is vital if we are to minimize the "lie" or underrepresentation of a person's alcohol and other drug and/or their emotional health in our brief intervention.

This understanding precedes compassion, defined as the desire or response to our ability to demonstrate empathy repetitively. It is our ability to *sit* with the suffering. In other words, compassion goes beyond empathy, bringing an active desire to act in the interest of the other person. However, in addition to building a path of compassion, empathy alone can produce the positive effective of siphoning away the defensive energy of the other person simply because he or she feels *heard and believed*.

Thus, in the context of screening and brief intervention assessment, tapping into *our* empathy for another is likely to assist our listener, the person we serve in several ways:

- Creates deeper understanding regarding the person's frame of reference and inner feelings, thoughts.
- Aids in reducing some of the natural defensiveness of the person we serve.
- Establishes a foundation for an interactive and more egalitarian relationship (power with, not power over).
- Sets the stage for *change theory/talk* as a possibility in the ongoing working alliance.

None of the above are minor when struggling to screen, interview, and assess another person at a

deeper level. And grouped together, they lead to a clear and clean gathering of balanced information within an screening and assessment session or two.

Amplifying the Ambivalence

Ambivalence is the state of having simultaneous contradictory feelings or ideas about alcohol and other drug use, misuse and one's own emotional well-being. The discrepancy between the person's present behaviors and their hopes and dreams. Recognizing this ambivalence honors the duality of the person's suffering and their self determination towards physical and emotional health. What is the internal struggle?

Exploration of ambivalence is an ability as well as a skill to see both the present behavior and the dream of the person we serve; some folks are naturally endowed with more *hope* than others. We have found it vital for practitioners to see the internal conflict, the divided self that the person we serve is going through without judgement, to see the depth of the individual's struggles with values and core needs. We believe that this is one of the competencies that workers learn to take pride in through our conversations, to find the accurate ambivalence.

Given the definition of this ability, it follows that workers who can apply the exploration of the ambivalence as they screen, interview, and assess are apt to draw more accurate conclusions and achieve higher inter-rater reliability of the screening, assessment tools. If one could control or account for the level of empathy and compassion workers have, we believe we could prove that the exploration of ambivalence has a great influence on screening and assessment validity.

Conclusions

Workers with *high* empathy and the ability to see the innate struggles (ambivalence) have the unique ability to engage and help their clients, the people we serve settle down their defensive self-protective patterns in the screening, brief assessment interview and the careful, fragile transition of referral treatment.

So, the remaining question is how do we develop both competencies when working in organizational cultures that tend to reward the focus on the tools? Does the local culture lean more towards empathy or toward doing the task? And if it does, how can space be made to generate excitement and accountability about these competencies of empathy and of amplifying the ambivalence simultaneously and alongside the valid screening and assessment tools?

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