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SCIENCE DIRECT
Drug and Alcohol Dependence 82 (2006) 269–275
DRUG and ALCOHOL DEPENDENCE
www.elsevier.com/locate/drugalcdep

Effects of motivational interviewing training on mental health therapist behavior

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Received 2 June 2005; received in revised form 5 October 2005; accepted 6 October 2005

Abstract

This study examined the effectiveness of training community mental health therapists in motivational interviewing (MI) adapted to treat clients with co-occurring disorders. Ten therapists with high caseloads of culturally diverse clients in two different community mental health settings fulfilled all study requirements. MI training consisted of a two-day didactic and experiential workshop followed by eight biweekly small group supervision (coaching) sessions. Using an interrupted time series design, 156 randomly selected therapy sessions involving 28 clients were coded for assessment of therapist fidelity to MI at multiple points in time, both pre- and post-training. Employing hierarchical linear modeling analysis, significant improvement in MI skill was observed after training on five of six key therapist ratings, and on the sole client rating (client change talk) that was examined. Importantly, the present study demonstrates training-related proficiency in motivational interviewing using: (a) a representative sample of mental health therapists from the community; (b) a protocol emphasizing adherence to a mental health treatment regimen as well as management of substance use behavior for clients with co-occurring disorders; (c) repeated random observations of therapy sessions; (d) measurement of training-related changes in clinician skills and self motivational statements by clients. Findings of this effectiveness study compared favorably with efficacy literature on MI training.

Keywords: Motivational interviewing; Training; Co-occurring mental health and substance use disorders

1. Introduction

People with co-occurring mental health and substance use disorder (COD) manifest more severe psychiatric morbidity, poorer psycho-social adjustment and ability to manage their lives, lower compliance with clinical recommendations, greater utilization of social and health care services, and more frequent hospitalization compared to those with only one of the conditions. Because CODs are complex, it has been suggested that integrated treatment approaches would be most effective, and studies of such protocols have been encouraging (Hellerstein et al., 1995; Herman et al., 1997; Jerrell, 1996; Jerrell and Ridgely, 1995a, 1995b; Mueser et al., 1996). In addition, recent studies have found Motivational Interviewing (MI) promising for COD populations (Bellack and Gearon, 1998; Carey et al., 2002; Caroll, 2004; Daley et al., 1998; Graeber et al., 2003; Martino et al., 2000, 2002; Swanson et al., 1999). Taken together, these reports offer persuasive evidence that integrated MI treatment can improve general functioning and increase abstinence rates of COD clients. However, dissemination of motivationally based integrated treatment for people with COD is daunting because few therapists today are prepared to deliver such care. Indeed, the ability of active practitioners to achieve proficiency in such therapy using a conventional model of continuing education is unknown at this time. The present effort is informed by the efficacy studies of Miller et al. (2004) and Baer et al. (2004). Miller et al. (2004) conducted a randomized trial comparing a conventional two-day workshop alone with the addition of feedback, coaching (supervision) and combinations thereof on MI-skills of their trainees. They noted that only those in the enhanced conditions (feedback and/or coaching) exceeded the 95% proficiency standard for MI-consistent behavior at four month follow-up.

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doi:10.1016/j.drugalcdep.2005.10.003

This finding underscores the value of supervision to achieve skill proficiency.

Baer et al. (2004) also evaluated the impact of a two-day MI workshop and retention of MI skills over two months by 22 local therapists; however, they employed "standardized patients" rather than real clients for skill assessment. They found that less than half of their trainees achieved and sustained the proficiency standards recommended by Miller (2000). Indeed, almost the same number came to the study with prior knowledge and/or training in MI as reflected in their high baseline skill levels. There was no ongoing supervision in this study and MI proficiency declined from post-workshop assessment to follow-up.

The purpose of the present study was to determine if practicing therapists at community mental health clinics could demonstrate proficiency in MI modified for clients with co-occurring disorders following a two-day workshop and regular supervision (coaching).

2. Methods

2.1. Participants

Fifteen therapists at three mental health clinics in urban and suburban middle class communities originally enrolled in this study along with 35 of their eligible clients. Of those 15 therapists and 35 clients, ultimately 10 therapists and 28 clients at two clinics completed all requirements of the study. Of the five therapists lost to the study, one terminated employment early on and four others were unable to enroll a sufficient number of eligible client-participants. Clients were included in the analysis only if they had at least one pre- and one post-session, and a minimum of four sessions overall. This requirement reduced the analytical data set from 28 clients to 17 clients. To determine if the clients who dropped out of treatment were similar to those who remained in treatment, we compared baseline data of the 17 clients who were included with the 18 clients who were not. Chi-square analyses were conducted on gender, race/ethnicity, age, marital status, diagnosis (mood disorder, thought disorder, and anxiety disorder) and substance abuse/dependence diagnosis (alcohol, cocaine, marijuana, and opiate). No differences were found between groups on any of these variables. In addition, *t*-tests comparing those included versus those who were excluded on age and years of education revealed no differences.

Clients were eligible to participate in the study if they were adults (aged 18–65 years) who met diagnostic criteria for current substance abuse and/or dependence plus another Axis I disorder as confirmed using the Structured Clinical Interview based on the DSM IV (SCID-IV). They were not considered for participation if they were experiencing major medical problems (e.g., carcinoma, cardiovascular disease) or cognitive impairment that would limit their involvement. Acutely psychotic, suicidal, or homicidal clients were not considered for participation either. A majority of the client-participants who completed the study ($N = 17$) and were included in the analysis were female (70%). African-Americans accounted for 58.8% of this sample, 35.3% were Caucasian, and 5.6% were Hispanic. Clients typically manifested two or more Axis I psychiatric diagnoses with 58.8% meeting criteria for a major mood disorder and 41.2% for thought disorder. Eighty-eight percent of the sample reported using alcohol, 47.1% cocaine, 17.6% opiates (primarily heroin), and 17.6% cannabis. Their mean age was 39.4 years, most were unemployed (88.2%), and they had completed 12.1 years of education on average, with a range of 10–14 years.

All therapists on staff at the cooperating CMH clinics were invited to participate in the study. Those who refused did so because they did not have any eligible clients or because their time was too limited. The therapists who enrolled and fulfilled all study requirements included 7 women and 3 men; 7 of the 10 were full time employees and three of them worked part time. Eight of the 10 therapists were Caucasian, while 2 were African-American. Seven had Master's degrees in Social Work and one a Bachelor's degree in the same field. One of the male therapists had a Master's in Nursing, and another had a doctorate in Clinical Psychology. Experience in practice ranged from 1 to 34 years (mean = 15.4 years). None of the participating clinicians had speciality training in motivational interviewing or held certification for alcohol and drug abuse treatment. All of them reported large, diverse caseloads and numerous demands on their time.

2.2. Procedures

All research activities were reviewed and approved prior to implementation by the Institutional Review Board of Wayne State University. Clinician and client-participants were enrolled in this study following procedures to establish eligibility and ensure informed consent. When clinical intake staff suspected that a new client would meet inclusion criteria, the client was informed that they might be eligible to participate in a treatment study. A member of the research team contacted each client who indicated interest and scheduled an assessment appointment. If eligibility was confirmed, the client was asked to review the Informed Consent and HIPPA forms with a member of the research team. Thus, clients learned about the purposes and procedures of the study, as well as their rights to refuse to participate or withdraw from the study at any time without affecting their treatment.

An extensive structured assessment of clients confirmed their eligibility and characterized their baseline condition. A subset of the baseline assessment instruments was administered after each individual treatment session before and after therapist training. Clients were compensated (US$ 25) for the baseline, and received a small gift certificate (US$ 5) for completing each post-session questionnaire.

All individual sessions of participating therapists and clients were audiotape recorded, and randomly selected tapes were sent to the University of New Mexico for analysis of MI techniques using the Motivational Interviewing Skill Code (MISC; Moyers et al., 2003). The MISC was designed specifically to capture elements of the therapeutic process that are central to the MI model. In all, 156 tapes were submitted for analysis by trained raters as described by Baer et al. (2004). From the pool of 10