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General Hospital Psychiatry 34 (2012) 450–459

General Hospital Psychiatry

A randomized controlled trial of telephone motivational interviewing to enhance mental health treatment engagement in Iraq and Afghanistan veterans☆,☆☆,★,★★

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Received 19 February 2012; revised 12 April 2012; accepted 17 April 2012

Abstract

Objective: To test the efficacy of telephone-administered motivational interviewing (MI) to enhance treatment engagement in Iraq and Afghanistan veterans with mental health (MH) problems.
Method: Between April 23, 2008, and February 25, 2011, 73 Iraq and Afghanistan veterans who screened positive for ≥1 MH problem(s) on telephone-administered psychometric assessment, but were not engaged in treatment, were randomized to either personalized referral for MH services and four sessions of telephone MI or standard referral and four neutral telephone check-in sessions (control) at baseline, 2, 4 and 8 weeks. Blinded assessment occurred at 8 and 16 weeks.
Results: In intent-to-treat analyses, 62% assigned to telephone MI engaged in MH treatment compared to 26% of controls [relative risk (RR)=2.41, 95% confidence interval (CI)=1.33–4.37, P=.004], which represented a large effect size (Cohen's h=0.74). Participants in the MI group also demonstrated significantly greater retention in MH treatment than controls [MI mean visits (S.D.)=1.68 (2.73) and control mean visits (S.D.)=0.38 (0.81), incidence rate ratio (IRR)=4.36, 95% CI=1.96–9.68, P<.001], as well as significant reductions in stigma and marijuana use at 8 weeks (P<.05).
Conclusions: Telephone MI enhances MH treatment engagement in Iraq and Afghanistan veterans with MH problems.
Published by Elsevier Inc.

Keywords: War veterans; Treatment engagement; Trial; Posttraumatic stress disorder; Motivational interviewing

☆ Prior presentation: Some of the data contained in this article were previously presented at the Society of General Internal Medicine 33rd Annual Meeting, Minneapolis, MN, April 28–May 1, 2010, and at the VA HSR&D 28th National Meeting, National Harbor, MD, February 16–18, 2011.

☆☆ Funding support: This work was funded by a grant from the Department of Veterans Affairs (VA), Clinical Sciences Research and Development (award no. MN078889-01) and by the VA Health Services Research and Development (HSR&D) Research Enhancement Award Program at the San Francisco VA Medical Center.

★ Role of the sponsor: The sponsor had no role in the design and conduct of the study; in the collection, analysis and interpretation of the data; or in the preparation, review or approval of the manuscript or the decision to submit. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

★★ ClinicalTrials.gov Identifier: NCT00419029. http://clinicaltrials.gov/ct2/show/NCT00419029.

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0163-8343/$ – see front matter. Published by Elsevier Inc.
doi:10.1016/j.genhosppsych.2012.04.007

1. Introduction

After a decade of war, over 52% of Iraq (Operation Iraqi Freedom, OIF) and Afghanistan (Operation Enduring Freedom, OEF) veterans in Department of Veterans Affairs (VA) healthcare have received one or more mental health diagnoses; 28% have received diagnoses of posttraumatic stress disorder (PTSD) [1]. There is strong evidence to support the efficacy of specific psychotherapies (e.g., prolonged exposure for PTSD), and the VA mandates that all veterans have access to these evidence-based therapies [2]. Despite the large burden of combat-related mental health problems and the availability of effective treatments, the majority of OEF/OIF veterans have not received an adequate course of mental health treatment, as found in a nationally representative sample of veterans [3], veterans enrolled in VA healthcare [4,5] and active duty military service populations [6]. Overall, it is estimated that over half of veterans in need of mental health treatment do not receive it [3].

Poor engagement in mental health treatment is not unique to veterans [7]. Nevertheless, this problem may have particular salience for newly returning veterans who fail to engage in mental health treatment due to negative beliefs about mental health treatment and stigma [8–10]; symptoms of the disorders themselves, such as PTSD-related avoidance; and the perception that skills honed in the war zone, such as hypervigilence and emotional numbing, are not "symptoms" that require treatment [11]. Tragically, for a minority, failing to engage in mental health treatment can be lethal; suicide rates may be higher in this generation of war veterans than in prior eras [12]. For others, failing to engage in mental health treatment may result in chronic mental illness and social and occupational dysfunction with high costs to individuals, families and society [13–15].

There have been a limited number of published studies of interventions to enhance mental health treatment engagement in veterans [16–18]. In the only study of younger OEF/OIF veterans, using a pre–post quasi-experimental design, Stecker et al. [16] showed that among 26 National Guard and Reserve veterans, one session of telephone-administered cognitive behavioral therapy significantly increased veterans' self-reported intention to engage in treatment, but did not result in actual increases in mental health treatment initiation.

One candidate treatment engagement intervention, motivational interviewing (MI), is a client-centered counseling style for enhancing intrinsic motivation for change [19]. The primary goals for MI counselors are (1) expressing empathy, (2) developing discrepancy between clients' values and current behavior, (3) "rolling with resistance" or avoiding confrontation, and (4) supporting self-efficacy [19]. Multiple studies have demonstrated the efficacy of MI in increasing mental health treatment engagement in civilian and veterans patients [20,21], and in individuals with co-occurring disorders, including substance abuse [22]. Moreover, MI may be delivered effectively over the telephone [18], which may appeal to younger OEF/OIF veterans who are accustomed to using mobile phones to access information and services.

To date, no study has evaluated the efficacy of MI to improve mental health treatment engagement in Iraq and Afghanistan veterans. The main aim of this randomized controlled trial was to test the efficacy of telephone MI to enhance mental health treatment initiation in OEF/OIF veterans with mental health problems. Secondarily, we investigated the efficacy of telephone MI to improve mental health treatment retention, reduce mental health symptoms and barriers to care, and to increase readiness and intention to engage in mental health treatment. We hypothesized that a greater proportion of veterans randomized to telephone MI would engage in mental health treatment compared to the control condition.

2. Methods

2.1. Participants

2.1.1. Recruitment and enrollment

VA administrative databases were used to identify OEF/OIF veterans who had enrolled in two VA Medical Centers in Northern California within the past 2 years. In addition, study recruitment flyers were posted in VA facilities (including Vet Centers) and other community locations (e.g., local colleges). Veterans identified through administrative databases and those requesting study information were sent letters with opt-out post cards. Study staff contacted veterans who did not return postcards within 14 days to assess their eligibility, and those who were eligible and interested in study participation underwent informed consent prior to enrollment. Participants were enrolled from April 23, 2008, through February 25, 2011 (Fig. 1). The study protocol was approved by the institutional review boards of the University of California, San Francisco, Stanford University Medical Center, and the San Francisco and Palo Alto VA Medical Centers.

2.1.2. Eligibility criteria

Inclusion criteria included being (1) a veteran of OEF and/or OIF military service, over age 18 with a service separation date after October 1, 2001; (2) a resident of Northern or Central California with no plans to relocate; (3) positive for ≥ 1 of the following disorders on study baseline assessment (see below): PTSD, depression, anxiety, high-risk drinking and/or illicit substance use. Exclusion criteria included being (1) engaged in VA or non-VA mental health treatment currently or within the past 60 days, including current use of psychiatric medications; (2) hearing-impaired; or (3) without a working telephone.

2.1.3. Baseline assessment

After study enrollment, trained study staff administered a 45-min baseline assessment by telephone to collect information about sociodemographics, military service, level of