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National Dissemination of Motivation Enhancement Therapy in the Veterans Health Administration: Training Program Design and Initial Outcomes

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ABSTRACT

Motivational enhancement therapy (MET) can be defined most simply as the "….combination of Motivational Interviewing (MI) with assessment feedback…." (Miller & Rollnick, 2013, p. 250). MET has a clear evidence-base promoting its use especially for treatment of substance use disorders (SUDs). Despite its efficacy and utility, MET is not widely used in clinical settings. In 2012, to facilitate the dissemination of MET, the Veterans Health Administration [VHA; the health care component of the U.S. Department of Veterans Affairs (VA)] launched a national training program that provided competency-based training in MET to VA staff working in SUD specialty care clinics. All VA facilities are required to implement EBPs for SUDs, such as MET, and ensure that they are available to veterans. This paper describes the VA MET training program and examines the impact of the MET training program on participants' knowledge of MET and self-reported MET skills. We review the components of the training and consultation and discuss adaptations made from the Project MATCH MET model to a real-world clinical setting. Of the 264 training participants we trained 2012–2013, 213 (81%) successfully completed all requirements of the training program, including requirements for demonstrating competency and attending at least 75% of scheduled consultation calls. After completion of the training program, approximately 85% of the clinicians reported implementing MET often (either 1–3 times per week or daily). Furthermore, we saw significant increases in MI knowledge from pretraining assessment to post-workshop and from pretraining to post-consultations. Additional training program details and revisions are discussed.

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1. Background

Motivational enhancement therapy (MET) can be defined most simply as the "….combination of Motivational Interviewing (MI) with assessment feedback…." (Miller & Rollnick, 2013, p. 250). Central to the method is the presentation of findings from a clinical assessment of some problem area (for example, alcohol or other drug use) in a non-confrontational manner. The clinician presents those findings and then uses strategic reflections and open questions to evoke the client's own thoughts about the topic of feedback. Miller and Rollnick (2013) note that using MI with assessment feedback "is a Socratic way of presenting information in order to help clients reach their own conclusions and motivations for change" (p. 152).

MET has been applied to a range of health behaviors, including alcohol and substance use disorders, smoking, HIV risk reduction, diet, and exercise (Burke, Arkowitz, & Dunn, 2002). Miller and Rollnick (2013) have most recently noted the development of MET protocols for marijuana use, recovery management, marital and family interactions, and domestic violence (p. 152). Perhaps of most importance, meta-analyses of the now burgeoning research literature on MI indicate larger standard effects (compared to control conditions) for MET (d = 0.32, 50 studies) compared to MI alone (d = 0.19, 33 studies; Lundhal & Burke, 2009).

Perhaps some of the strongest research evidence for the effectiveness of MET came quite early, and indirectly, via Project MATCH (1997, 1998). This large multisite trial was not designed as a direct evaluation of MET, rather it was designed to test if subgroups of clients with alcohol problems (e.g., different levels of alcohol dependence severity, sociopathy, etc.) would respond differently to three different types of psychotherapy: cognitive–behavioral therapy (CBT), 12-step facilitation therapy (TSF), or MET. Both CBT and TSF prescribed 12 weekly individual therapy sessions and homework exercises over 12 weeks. MET, as developed for Project MATCH, consisted of only four individual therapy sessions spaced over 12 weeks (weeks 1, 2, 6, and 12). The first two sessions were fairly prescribed: participants completed a thorough assessment of drinking patterns and problems in the first session, and were provided assessment feedback (from information gathered both during

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that first session and from a pretreatment baseline interview, usually completed by a research assistant) using MI techniques in the second session. Consistent with the tenants of MI, participants were encouraged to devise a plan for changing alcohol use that would respond to their own concerns and make use of their own skills and experience. Two additional MET sessions followed, again using MI techniques, to support motivation to change and follow-up on progress with a self-developed (or collaboratively developed) plan for change.

Project MATCH is noteworthy for its methodology: therapists were selected and trained to produce high quality treatment and fidelity to each treatment protocol was carefully monitored. Also, participants completed an extensive baseline assessment. The results of Project MATCH have been widely reported (see Longabaugh & Wirtz, 2001). Of the initial hypotheses for matching subgroups of clients to treatments, very little was found. Secondary analyses showed that clients with higher ratings of anger at baseline did better in MET compared to other treatments (Waldron, Miller, & Tonigan, 2001). Yet drinking rates and problems assessed as long as 3 years post baseline were essentially similar between MET and the other two individual treatments (Project MATCH, 1998). All three treatments produced robust and enduring declines in rates of alcohol use and alcohol-related consequences, however; the 4-session MET appeared to be more efficient than the other 12-session treatments.

MET has a clear evidence-base promoting its use in clinical settings. In fact, it is has a readiness for dissemination rating of 3.5 out of a possible 4 in SAMHSA's National Registry of Evidence-based Programs and Practices (SAMHSA, 2014). Despite its efficacy and utility MET is not widely used in clinical settings. Furthermore, MET is rarely differentiated from MI despite key differences in clinical practice between the two approaches.

To promote the availability of MET for veterans with substance use disorders, in 2011 the Veterans Health Administration [VHA; the health care component of the U.S. Department of Veterans Affairs (VA)], implemented an initiative to nationally disseminate MET as part of its efforts to broadly disseminate and implement evidence-based psychotherapies (EBPs; Karlin & Cross, 2014). To facilitate the dissemination of MET, VHA launched a national training program that provided competency-based training in MET to VA SUD staff. All VA facilities are required to implement EBPs for substance use disorders, such as MET, and ensure that they are available to veterans. This paper describes the VA MET training program and examines the impact of the MET training program on participants' knowledge of MET and self-reported MET skills.

2. Method

2.1. Training Program Description

The VA MET Training Program is a competency-based training model, similar to other VA evidence-based psychotherapy training programs (Karlin & Cross, 2014). Training consists of participation in a 3.5-day experientially-oriented training workshop followed by 6 months of consultation with a training consultant (TC; both components described below). We combined the VA model with training and supervisory practices based on research in the training of MI (e.g., Miller, Yahne, Moyers, Martinez, & Pirritano, 2004; Moyers et al., 2008) to enhance implementation and fidelity.

2.2. Participants

Eligible SUD specialty care clinicians from the 107 VA medical centers were nominated via the 21 Veteran's Integrated Service Networks (VISNs) that are distributed geographically throughout the country. Each VISN was allocated a number of "seats" that was proportional to the number of SUD specialty staff in that VISN. VISN and facility leadership collaborated to nominate clinicians for the training.

To be eligible, a participant needed to meet the following criteria: be a permanent VHA staff member who delivers psychotherapy as a formal part of his/her job responsibilities and functions as one of the following mental health professionals in VHA: psychiatrist, psychologist, social worker, mental health nurse, licensed professional mental health counselor, marriage and family therapist, or addictions counselor; deliver individual psychotherapy or counseling services to veterans on a regular basis and spends at least 50% time treating veterans with SUDs; works in settings where SUDs are a common presenting issue and where SUD-focused treatment can be implemented; be fully committed to uninterrupted participation in the 3.5-day, in-person training workshop and the required 6-month, weekly consultation; be able to recruit therapy cases for the consultation process, ideally before the in-person workshop; be motivated and wanting to learn and implement MET; and have pre-approval from local leadership to participate in the training workshop and the 6-month consultation period. Individuals still in training (e.g., interns) were not eligible. In general, participants had no prior training in MET.

2.3. VA MET Protocol

The ultimate goal of the VA MET Training Program is to treat veterans; therefore, materials (e.g., therapist manual, supporting documents, etc.) were adapted to the specific needs of this population. We also made the materials accessible (e.g., materials are uploaded to an internal SharePoint site). In addition, we ensured that all materials referred to the patient or client as "Veteran." The manual was adapted from existing MET open-source manuals and included a 4-session structure. One key adaptation was to include in-session time for the clinician and veteran to complete the assessment (described below). In prior studies, parts of this were completed outside the therapy dyad (usually a clerk or research assistant) in advance of treatment initiation. To make the protocol more amendable to VA outpatient practice, the assessment was included in session 1 of our adapted MET manual.

For the assessment feedback component, we utilized a web-based VA-developed program called the Assessment and Feedback Tool (AFT), which is available for VA clinician use. The AFT is a standardized, comprehensive assessment of the veteran's alcohol and substance use, as well as related risk factors (e.g., family history, comorbid conditions, etc.) and consequences (e.g., health and financial consequences, etc.). Veteran responses to the AFT are used to generate a printable personalized feedback report (PFR). This report is used to structure the second MET session when the clinician and veteran review the results. In essence, the PFR serves as a stimulus for an MI-consistent discussion of alcohol/substance use and the consequences of use. All participants utilized the AFT as part of the training program.

2.4. Participant Training

To successfully complete the MET training program, participants were required to attend the workshop training, participate in 75% of all individual and group consultation calls (call schedule outlined below), submit at least six audio recordings of MET sessions, and meet Motivational Interviewing Treatment Integrity 3.1 (MITI) coding system's competency criteria (Moyers, Martin, Manuel, Hendrickson, & Miller, 2005) on at least two of the six sessions submitted. The MITI is described below. Finally, at least two of the six recordings had to be a demonstration of session 2 of our MET manual, the "Feedback" session when the clinician and veteran reviewed the PFR.

2.5. Workshop Training

All participants attended a 3.5 day in-person MET workshop that consisted of didactics, demonstrations, and skill practice led by MET experts (members of the Motivational Interviewing Network of Trainers; MINT) and MET training consultants (TC). Each workshop included