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A key challenge for motivational interviewing: training in clinical practice

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Abstract

Motivational interviewing (MI) has a strong evidence base supporting its clinical efficacy, yet provider fidelity is difficult to maintain over time, may be costly, and the effects of proficiency on client outcomes remain unknown. These issues need further research and may pose significant challenges to MI implementation in health care.

Keywords

Fidelity; implementation; motivational interviewing; SBIRT; training

As the authors describe, motivational interviewing (MI) is well established as an evidence-based method of treating alcohol problems; its use is based on research conducted around the world. It rises above many other interventions, because its procedures are clearly specified and measurable with fidelity monitoring systems. Training has been disseminated widely (the authors point out that more than 15 million people in 38 countries have received MI treatment). Yet even as MI is embraced, its effectiveness hinges on adequate provider training to ensure that MI is delivered proficiently over time. This review [1] addressed the pressing question: what do we know about training outcomes and client outcomes as they are affected by training proficiency?

It is striking how little research has focused on the effectiveness of training in MI skills and their stability in practice. The authors screened more than 400 studies; they could assess training proficiency at follow-up for only 15, and only two found 75% proficiency following initial training. Even with ongoing training, supervision and follow-up, proficiency levels never exceeded beginning proficiency. We note that a study published on MI training (in emergency services) after this review was completed had similar results [2].

Maintaining fidelity in other evidence-based treatments, e.g. cognitive behavioral therapy (CBT) [3], has faced similar challenges and studies show the importance of ongoing supervision and coaching [4]. The authors discuss why psychosocial interventions in general

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are difficult to implement. They include ‘system’ factors which have received insufficient attention, but are crucial in implementing and monitoring in health care.

MI is a prominent underpinning of screening, brief intervention and referral to treatment (SBIRT) for substance use in primary care, which has huge implications for training. While MI provides the opportunity to motivate large numbers of people to reduce their drinking or other drug use, primary care clinicians have little time to devote to it. Research has focused on volunteer trainees, but health-care organizations train health professionals of all types in large numbers, and MI interventions must be incorporated into overall medical care rather than in dedicated treatment sessions.

Even fewer studies (two reported) have addressed client outcomes related to training, and they were not promising. Could this partially explain why some studies of SBIRT for drugs have weak results? In busy health-care settings with one-session, brief MI interventions, should SU outcomes or outcomes of raising motivation from one readiness level to another be measured? Why should a brief intervention be responsible for changing SU outcomes when its focus is to address ‘where the patient is’ and increase motivation to change? This it might accomplish, with reducing alcohol and drug use levels regardless of motivation level, a more challenging goal [5,6]. Future studies of training effectiveness might explore increased readiness to change in addition to (or instead of) substance use outcomes.

The authors comment that, overall, measuring the impact of intervention fidelity on patient outcomes is important, and has often been overlooked. The authors lacked sufficient data according to their review. Other relevant studies could include the impact of Twelve-Step facilitation (TSF) fidelity on patient outcomes [7]. However, their findings mirror what is known about the need for consistent training follow-up, and TSF would be more relevant to those with severe problems in specialty treatment than in primary care.

The review raises an obvious question: should MI be so broadly disseminated if it is difficult (and costly) to learn to do well? It discusses training costs, which is important, but should perhaps be framed in terms of specific treatment setting, e.g. perhaps MI is best suited to specialty SU and mental health settings [8], or other settings in which ongoing training support is available. Even when training is available, staff turnover in front-line settings [9] also creates logistical and cost challenges for sustained implementation.

The costs of training and maintaining fidelity are probably higher than is typically anticipated. However, while MI may not be less costly than other interventions over time, it may remain the most promising model for primary care settings, especially in treating individuals whose problems are less severe. The authors challenge us to continue research on the questions they raise: how much training is necessary to sustain MI fidelity over time in real-world clinical settings, how should it be accomplished and how can the cost justify the expense without evidence of a benefit to patients? They have begun an important dialogue.

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