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▶ Combining motivational interviewing with compliance enhancement therapy (MI-CET): development and preliminary evaluation of a new, manual-guided psychosocial adjunct to alcohol-dependence pharmacotherapy.

Heffner J.L., Tran G.Q., Johnson C.S. et al.

Journal of Studies on Alcohol and Drugs: 2010, 71, p. 61–70.

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Getting patients to take their medication is a major issue across medicine. This US alcohol treatment study enhanced compliance with treatment through a novel and manageable approach combining brief motivational interviewing with structured clinical counselling involving feedback on the patient's real-time pill-taking record.

Summary Promoting retention in treatment and compliance in taking prescribed medication are major issues in routine practice and in pharmacotherapy trials. Psychosocial approaches involving advice and therapy are one approach. Given the limited availability of therapists in medical settings, such adjuncts should be brief and manual-guided so they can be implemented by clinicians with little psychotherapy training.

To attempt to achieve these goals, for the featured US study researchers combined motivational interviewing with compliance enhancement therapy to create 'motivational interviewing and compliance enhancement therapy' (MI-CET). It formed the psychosocial component in a randomised clinical trial comparing alcohol-dependent patients' responses to the antidepressant citalopram versus a placebo. Patients suffered mild to moderate alcohol dependence and were mainly white and of at least medium income.

Compliance enhancement therapy was added to motivational interviewing because studies have found that the latter's impacts are modest and do not persist. Compliance therapy provides patients with a rationale for their pharmacotherapy and elements common to many types of psychotherapy (empathy, education, convincing rationale, and supportive therapeutic relationship) which are compatible with motivational interviewing. It was designed for a broad range of clinicians (nurses, psychologists, social workers, and counsellors) to work in collaboration with a prescribing physician. However, in the placebo arms of trials involving this approach, medication compliance and treatment completion rates have been as low as 56%, suggesting there is room for improvement. MI-CET attempts to improve this record by adding a single session of motivational interviewing, an intervention intended not just to promote compliance but also directly to tackle alcohol dependence.

In the featured 12-week trial, MI-CET sessions were provided weekly for the first five weeks then every other week. Session one consisted mainly of a motivational interview including feedback to the patient on the severity of their drinking and related problems. It concluded with a review of instructions for taking the medication and problem-solving any anticipated obstacles. Remaining sessions were compliance enhancement therapy. These included reviewing side effects and perceived effectiveness of the medication (which for most was the active drug and a third the placebo) and the patient's record of taking the medication as recorded by a bottle cap which stores the time and date of openings. Therapists drew patients' attention to the links between how diligently they took their medication and their progress in curbing their drinking. No direct advice was given on strategies for change, differentiating MI-CET from other psychosocial interventions also intended to promote compliance with taking medication.

Therapists in the study were chosen to be diverse in terms of background and experience and included a physician, two doctoral-level clinical psychology fellows, pre-doctoral clinical psychology students, and a master's-level counsellor. They had been trained for about eight hours and given opportunities to practice MI-CET through role-plays. During the study they were supervised via audiotapes of their sessions with patients.

Impacts on retention and compliance were assessed by comparing records of the first 121 patients who entered the trial with those of patients in other similar trials. Three such trials had involved alcohol-dependent patients and the same type of antidepressant (though sertraline rather than citalopram) as in the featured trial, and could offer comparable data on retention and compliance. Rather than MI-CET, they had sought to enhance outcomes and compliance through counselling based on AA's 12 steps, cognitive-behavioural therapy, or compliance enhancement therapy.

Main findings

Ratings of recordings of MI-CET sessions with patients indicated that the intervention was delivered as intended and with a high degree of competence.

83% of the 121 patients completed the 12-week treatment phase of the study, including 81% of patients prescribed the active medication. Among patients being prescribed placebos, 88% completed the featured study's treatment, considerably more than the 48% to 78% in the three comparable previous trials. Comparison with the trial which offered compliance enhancement therapy (56%–78% completion over 10 weeks) suggests adding brief motivational interviewing did enhance retention.

Similarly, in the featured study a relatively high proportion of sessions were attended, averaging 90% among patients prescribed citalopram and 93% in the placebo group. These figures are comparable to those achieved in the comparison study which offered cognitive-behavioural therapy and considerably higher than the 54%–61% seen in the study which offered 12-step based therapy.

Compliance in taking medication is harder to assess because studies measured this in different ways. The most comparable trial offered compliance enhancement therapy and used the same bottle cap recording system. In that study 74%–76% of patients took at least eight in ten of their doses of active medication compared to 79% in the featured study; for placebos the corresponding figures were 74%–77% versus 91%, an appreciable difference in favour of motivational interviewing plus compliance enhancement therapy.

The authors' conclusions

The most telling comparisons are with the study which offered compliance enhancement therapy. In the featured study which supplemented this with motivational interviewing, 20%–30% more patients completed treatment and more of the placebo patients took at least 80% of their doses.

These preliminary findings, as well as evidence on the comparative efficacy of behavioural treatments delivered with pharmacotherapy, suggest that MI-CET holds promise as an adjunct to alcohol-dependence pharmacotherapy. Methods like MI-CET based on brief motivational interviewing and clinical management require less training and expertise than fully fledged therapies like cognitive-behavioural therapy. This gives them the potential to be delivered competently by a range of treatment providers across a variety of settings.

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However, the fact that within the featured study there was no comparison group not offered MI-CET limits the strength of the conclusions that can be drawn. Additionally, participants were mainly white and middle-aged, with mid- to upper-level household incomes and low to medium severity of alcohol dependence; results may not generalise to all patients who receive pharmacotherapy for alcohol dependence.

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