Voiceover: Welcome to the VA HSR&D Investigator Insights podcast series. In this episode, QUERI Dissemination Coordinator, Diane Hanks, speaks with HSR&D Investigator, Dr. Karen Seal. Dr. Seal is Chief of Integrative Health Services as the San Francisco VA Healthcare System. They’re discussing her recent randomized controlled trial, which looks at engaging rural-dwelling veterans in VA mental healthcare treatment.

Diane Hanks: Can you describe your randomized controlled trial to determine the effectiveness of motivational coaching?

Karen Seal: Motivational coaching is an adaptive version of an actual psychotherapeutic technique that has a very, very large evidence based called “motivational interviewing.” And motivational interviewing is essentially when you work with somebody in a way that supports positive behavioral change by supporting their confidence, their self-efficacy, and being able to change their behavior, not being judgmental. If they’re resistant to behavioral change, you roll with it. You don’t get into conflicts with them.

And you try to get them to think about the behavior. Let’s say smoking. You try to actually get them for just a little bit of time to say what they like about smoking, anything that’s positive about smoking. You don’t want to give too much air time to what’s positive about it.

And then, you also, with them, you want to assess their overall values and goals for their life. You say, “Well, on the one hand, you say that you like to smoke because you get nervous and it’s the one thing that calms you down. But you also say how much you really love your family and you want to be there for your kids and you want to be able to keep up with your grandchildren who are running around. And you told me earlier that you’re having a little trouble with your breathing, that you’re getting short of breath.

So, on the one hand, you like it. But on the other hand, there are all these life goals that you have and it doesn’t seem like continuing to smoke is really going to serve your overall mission, aspiration, and purpose in life.”

It’s a lot about listening and reflecting back what you’re hearing and trying not to do so much talking, counseling, and judging.

Motivational coaching is really an adaptive version of that. In the current study that we designed, we designed it with peer veteran coaches in mind. And so, we didn’t want to have them have to learn this manualized motivational interviewing technique that’s often used, frankly, by psychologists.

So, what we did was we adapted it for use by a veteran peer coach. And we did do some very loose fidelity monitoring to make sure that they were using principles and techniques that are consistent with motivational interviewing, but did not hold them to such a high standard that, for instance, a psychiatrist might be held to.

Diane Hanks: Can you briefly discuss the types of mental illness the veterans in your cohort had been diagnosed with, and whether they indicated reasons for not seeking treatment that went beyond logistics?

Karen Seal: First of all, we had a total of 272 research participants in our study and they had to – in order to be eligible for the study, they had to screen positive on one of several mental health conditions; for instance, PTSD, depression, anxiety, and substance use disorder. Of course, most veterans and most people have more than one mental health condition so, most of our participants actually had two of those mental health conditions. And they also needed to not be in treatment for the 60 days prior to study enrollment in order to be eligible.

So, a lot of these veterans had never been in treatment. Some had been in treatment the year before but had dropped out and were no longer in treatment.

Reasons for either not seeking treatment or dropping out of treatment are myriad; there are a variety of different reasons for that. We were working in this study with rural veterans. So, a lot of the reasons …

Diane Hanks: It was travel.

Karen Seal: … for barriers to care were due to travel; difficulties actually getting to the VA community-based outpatient clinic. Not even the medical center but even the CBOC was hard to access for many.

And there were also a lot of, among the rural veterans, I think we heard a lot about – especially among those who had never accessed mental health treatment – a lot of about self-sufficiency, wanting to just suck it up, take care of their problems themselves. Their families would be helpful, churches, community groups would be more helpful. They didn’t need to see a mental health professional.

A lot of cultural barriers were relevant for the rural veterans.

Diane Hanks: I'm curious; do you see a difference in gender with acceptance of psychotherapy?

Karen Seal: Well, in our study, our study was conducted exclusively in VA and as you know, VA has mostly male veterans as patients.

So, while we did try to oversample women in this study, we only had – I think we had, at best, in each arm is 20% women. So, we weren’t actually statistically powered to see differences between men and women in terms of their engagement in mental health treatment related to whether they received motivational coaching or not.

But in other studies that are out there, I think women have a higher likelihood of engaging in mental health treatment.

Diane Hanks: What are the findings that you have from your study that you can share at this point?

Karen Seal: Well, this was a randomized controlled trial where we compared veterans receiving mental health assessment and a personalized mental health referral from a veteran peer coach. And then, three additional motivational coaching sessions geared around helping them to engage in some sort of mental healthcare for their mental health problem that wasn’t being addressed versus mental health assessment and a personalized mental health referral but no motivational coaching in the control arm.

And what we found was that our primary outcome was engagement in mental health services that were directed by a clinician. So, you know, going to a VA CBOC – Community-Based Outpatient Clinic – and seeing a psychologist or a social worker or a psychiatrist or going out in the community and seeing a mental health provider.

We saw that there was no difference – no statistically significant difference – between our intervention that had motivation coaching versus our control.

But background rates, you know, before we did the study, we certainly looked at the literature. And background rates of mental health treatment engagement among rural veterans is quite low; it’s around in the low 20s. So, of people who have diagnosed mental health conditions, about 20% will engage in some form of treatment.

In our study, even though there was no difference between the two arms, what we found was that we had over 50% engagement in both of the arms.

So, at a very minimum, each arm had a veteran peer coach conducting a mental health assessment and doing a personalized mental health referral, at a bare minimum.

So, somehow, even just having the peer coach ask the questions about mental health symptoms and then, make the referral, seemed to make a big difference.

What we found was that there were also very high rates of engagement in what we call “self-care activities” in both arms. So, veterans reported that they were doing various activities to mitigate their mental health symptoms like yoga or gardening or woodworking or going to church, for instance, were all interesting self-care activities.

The study was multisite; it was done in Northern California at four CBOCs there and three CBOCs in rural Louisiana. And what we found is self-care activities in Northern California are actually very different from the self-care activities …

Diane Hanks: I would imagine.

Karen Seal: … in Louisiana. In Louisiana, we got a lot of going to church, getting together for a barbecue, going fishing, going hunting. In Northern California, we got going hiking, going biking, gardening.

Diane Hanks: I'm curious. The motivational coach here; how long was the relationship with the veteran for that veteran to feel comfortable in that person being an advocate?

Karen Seal: That’s a really great question. So, it actually wasn’t that long. The intervention with the motivational coach was they had their initial coaching session at baseline so, time zero. Then, two weeks later, at four weeks, and then, at eight weeks.

So, it was a two-month-long intervention with only four contacts [interruption] …

Diane Hanks: Four contacts.

Karen Seal: Yes.

Diane Hanks: Wow. Veterans who participate in the research [sound out] asked to be informed about the results and what they might mean to policy, changes in policy, changes in practice? Or do they not ask about that? And do you think it would make a difference?

Karen Seal: That’s a really interesting question. I think throughout the entire study, only one veteran asked to be informed of the results.

Diane Hanks: Wow.

Karen Seal: So, we really didn’t get a lot of requests for that. We developed an implementation toolkit that we shared with our operational partner, The Office of Prevention & Rural Health. We published three papers on our pre-implementation phase because a lot of pilot qualitative interviewing went into this to try to really understand the barriers to engagement [interruption] among rural veterans and what mental health resources we could curate, essentially, to put on a list so that our peer coaches could give them that information that they might find particularly useful.

So, obviously, these weren’t peer specialists, per se, but obviously, the whole idea of peer coaching with regard to assessment in mental health symptoms and making a mental health referral, may actually – if we had compared it to just a mental health assessment or nothing – we might find – or some neutral intervention, we might’ve found that that was significantly greater than doing nothing, you know?

Because what we did hear from our veterans who did exit interviews who had participated in the motivational coaching intervention was they said that the veteran peer coach cared about them, they provided good resources, they were a trusted person, that they were less judgment than the mental health clinician, that they appreciate that the – one thing we didn’t talk about; this intervention was delivered all by telephone so, they really appreciated the convenience of using the telephone and not having to drive long distances for care.

So, veterans who received the intervention seemed to really like it. And what we did find in terms of our results is our primary outcome, you know, there was really no difference between the motivational coaching group and those who didn’t receive motivational coaching.

But what we did find was that those who received motivational coaching had decreases in three different mental health domains; PTSD symptoms decreased, depression symptoms decreased; and use of cannabis decreased, significantly more than the control arm. We had four quality of life indicators that also decreased; physical functioning, environmental quality of life, social, and mental health or emotional quality of life. All of those actually improved in the intervention or the motivational coaching arm compared to the control. And those were both significant in both the improvement in mental health symptoms and improvement in quality of life indicators in the telephone motivational coaching arm by peer coaches.

And so, sort of what we’re left with, that, coupled with the qualitative information we got about how wonderful or how nice it was, really, to speak to a veteran peer on the phone, I think what we may be seeing is that the rural veterans may have felt like they got their needs taken care of actually by the veteran peer coach. Which means that they wouldn’t necessarily have a need to engage in treatment.

So, in some ways, our results were paradoxical. We actually designed an intervention that somewhat undercut itself. Because I think the coaches might’ve made the veterans feel very comfortable and at ease and symptoms decreased over the course of their contact on the phone and, therefore, why should they get mental health services?

Diane Hanks: Right. And some of them may have just needed someone to say, “I care, you’re important.”

How important is it to work directly with veterans when conducting research? And what kinds of benefits and challenges come with doing research in VA?

Karen Seal: There are two different kinds of research that a health services researcher can conduct. I'm sure there are more than that, but two main categories. One is conducting secondary data analyses on data that’s already been rolled up in our very large VA national administrative databases. So, you can just apply, get IRB approval to receive large data sets, and you can ask and answer questions using already rolled-up electronic medical record data.

Or you can do what I often do, which is a lot more work but I also think, in many ways, a lot more rewarding, which is to conduct pragmatic randomized controlled trials with veteran participants. There’s just nothing more satisfying in a way than being able to offer veterans a vehicle for being able to help other veterans and to compensate them for their time and effort in doing that, and to really go a little deeper and learn more than we really can just using …

Diane Hanks: Data, yes.

Karen Seal: … medical record data. So, I think it’s really important to preserve this kind of research. It is more expensive, it is more time-consuming, it is potentially a burden on veteran participants.

But I think in the end, most participants feel that their participation in a trial hopefully is worth it because it is helping other veterans, if not directly helping them themselves.

Voiceover: The views and opinions expressed in the preceding podcast are concerned with the scope of recently concluded or ongoing VA HSR&D-funded research and do not necessarily reflect current or to-be-implemented VA policy.

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