IRMA

Addictions

A Community Reinforcement Approach to Addiction Treatment

Edited by
Robert J. Meyers and
William R. Miller

A COMMUNITY REINFORCEMENT APPROACH TO ADDICTION TREATMENT

The community reinforcement approach (CRA) to treating alcohol and other drug problems is designed to make changes in the client's daily environment, to reduce substance abuse and promote a healthier lifestyle. It is of proven effectiveness, and should be more widely used. This is the first book to present research on the effectiveness of the CRA for a clinical readership. It includes the original study comparing CRA with traditional treatments of alcohol dependence, and summarizes other trials with alcohol, cocaine and heroin users.

The CRA program provides basic guidelines for clinicians, focussing on communication skills, problem solving and drink-refusal strategies, and addresses the needs of the client as part of a social community. Combining practical advice on such matters with a scientific survey of CRA in use, this book offers a new treatment approach to all involved with the support and treatment of those with alcohol and drug problems.

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R.J.M.

To George Hunt and Nathan Azrin, the founding fathers.

W.R.M.

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Preface

The Community Reinforcement Approach (CRA), as originally applied to the treatment of alcohol problems and as later widened in its application to other substances, has always seemed to have common sense to recommend it. We only need a nodding experience with the behavior of children or a modicum of personal insight to find persuasive evidence that reward can alter behavior patterns. So, make stopping drinking tangibly rewarding, and troubled drinkers may be able to stop drinking – a psychological postulate much in accord with common sense and ordinary life.

In fact, in the treatment world, CRA has enjoyed a rather odd status up to now. Most researchers believe that the evidence for its efficacy is strong and reviewers have repeatedly rated this treatment approach as being better supported by controlled assessments than a galaxy of more widely favored practices. CRA seems to have become a succès d'estime only to be left on the shelf.

This immensely authoritative and comprehensive account of the origins of the CRA concept and the research evidence for its therapeutic benefits must surely do much to counter that previous neglect. It is a book which one must hope to see widely read by clinicians and those responsible for the development and provision of services. Researchers will find in its pages stimulating ideas for new applications and testings.

What is also interesting about this book is that beyond its reporting of the research output it raises questions about how research in this kind of field comes to be made – there is a story here within the story. Research on CRA has been carried forward by a relatively small group of people, most of whom have known each other well, and with ideas and traditions fostered within the group and transmitted across a generation of researchers. It is the continuity in the evolution, the incremental nature of the endeavor, the long slog and the idea followed through which form the

deeper story. We need better and more widely to understand how science is made, but meanwhile CRA can provide a case study illustrative of that theme.

The rules for IRMA publications require that all material that has not previously been through peer review will go through external peer review before being accepted, while material which has been previously published in journal form will be scrupulously gone through within the office. We aim at a process which will produce a coherent book rather than at bits put together within covers. The preparation of these monographs is therefore an active process with many demands made on the authors. I am grateful to Robert J. Meyers and William R. Miller and their cast of authors for their courtesy and patience, and believe that the outcome is a statement of landmark significance for its field.

Griffith Edwards
Series Editor

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Developing the Community Reinforcement Approach

ROBERT J. MEYERS AND MARK D. GODLEY

The story of the Community Reinforcement Approach (CRA) begins 30 years ago, when indigent alcohol-dependent individuals in downstate Illinois were routinely admitted to the nearest state mental hospital. For the 27 southernmost counties in Illinois, this institution was Anna State Hospital. Despite the fact that nonmedical detoxification programs were established at the Addiction Research Foundation in Ontario, Canada and other locations in the United States, such programs did not become available in rural Illinois until 1975. So in the early 1970s alcohol-dependent individuals were typically placed on the same ward as the general psychiatric population. Thus, it was not uncommon for them to share a ward with patients suffering from acute psychoses, schizophrenia, bipolar disorder, and severe depression. Not surprisingly, many newly admitted alcohol-dependent patients were frightened and confused upon sobering up and finding themselves in such a place. Fortunately, the majority of them adjusted with time over the course of relatively long stays, and some even developed a sense of humor about it. We remember one recovering alcoholic, years later, showing us a postcard of the state hospital that he had sent to a friend. The inscription read, "Having a great time, wish you were here."

Although at the time it was not a common practice, some state hospitals did have special programs for substance abusers. At Anna State Hospital, alcohol-dependent clients slept on the psychiatric ward but during the day they went to the Alcohol Treatment Program (ATP) in a separate building. Here they spent their hours participating in alcohol education classes, and group and individual therapy. Treatment was based on a disease model and the 12 steps of Alcoholics Anonymous. The unit administrator was a social worker, and most of the staff were stable, caring recovering alcoholics. It was in this ATP unit at Anna State Hospital that CRA was born.

CRA was the brain child of George Hunt, a doctoral student in the Department of Educational Psychology at Southern Illinois University in Carbondale. Hunt also worked as a Research Associate in the Behavior Research Laboratory of Dr Nathan Azrin at Anna State Hospital, which is nestled in the Shawnee National Forest 20 miles south of the city. The 1970s were an incredibly productive time for the Azrin group. Under Azrin's direction the research staff of the Behavior Research Laboratory validated and published reports of behavioral interventions for a variety of nervous habits, marital problems, and unemployment, and developed a host of life and social skills training procedures for the developmentally disabled. Some of these treatments were widely circulated through the popular press (e.g., Azrin & Fox, 1976; *Toilet training in less than a day*).

As inpatient treatment began to lose popularity, outpatient therapy became the logical place to experiment with CRA. In August of 1975, Mark Godley accepted the position of Coordinator of Alcohol Treatment Programs at the Mental Health Services of Franklin and Williamson Counties. This was a community mental health center that operated a halfway house and an outpatient program for individuals suffering from alcohol problems. Godley, a social worker, began a 5-year collaboration with Nathan Azrin when he contacted him in the September of that year, about working together on behavioral alcoholism treatment research. Initially it was George Hunt who trained Mark Godley and his one outreach worker. Hunt, a counterculture icon who did not fit the typical research scientist profile, was killed in a sailing accident in the Gulf of Mexico. This left Nathan Azrin and his colleagues to carry on CRA research, which soon led them to the first outpatient CRA trial.

Mark Godley continued his association with Azrin through John Mallams, another doctoral student and Research Associate from Azrin's lab. Mallams had served as a therapist in the second CRA inpatient trial (Azrin, 1976) and was especially eager to work in a community outpatient setting. After Hunt's untimely death, John Mallams became the coordinator of Azrin's alcohol treatment project. Godley and Mallams were both Texans, and that was about all they needed to forge a friendship. Together they decided to carry out a community-based CRA experiment under Azrin's leadership.

In these pioneering days of community-based outpatient services, enthusiasm for a community-based study was high. However, most alcohol programs still adhered to the 12-step approach with cult-like fervor. The local recovering community, like many, regarded any other approach as

heretical. This made it extremely difficult to introduce changes in treatment regimens, much less conduct behavioral research on alcohol treatment. Another significant event was the emergence of reports that alcoholics might be able to control their drinking if support was found [(Davies, 1962; Heather & Robertson, 1962; Lovibond and Caddy, 1970), the Rand Report (Armour, Polich, & Stanbul, 1976), and work at the Patton State Hospital (Sobell & Sobell, 1973*a*, *b*)]. The Sobells and others encouraged Azrin and Mallams to incorporate such procedures as stimulus control and discrimination training, and to use a controlled drinking goal in the next CRA trial. Godley was familiar with and not unsympathetic to these reports, but he was already struggling to gain acceptance as a young, nonrecovering professional in a field dominated by older recovering alcoholics who were singularly interested in Alcoholics Anonymous. Godley had much negotiating to do even to establish a community-based research study of outpatient alcoholics. In the end he was supported by his administrator, Floyd Cunningham, but in the process agreed that including controlled drinking in a research study – no matter how well-managed – would be unacceptable to the recovering community. The likely consequence would be protests, formal complaints, and protracted debates that could hinder or kill the project. In a meeting with Azrin and John Mallams to discuss the future of the collaboration, Godley stated that incorporating a controlled drinking goal was unacceptable to the community. So in order to collaborate they needed to drop controlled drinking from the design. Azrin smiled and said, "OK, we'll leave controlled drinking to the Sobells. We'll do the abstinence approach." The subject was never discussed again.

The new year ushered in change. In December of 1976, Godley and Mallams had an unexpected resignation and a resulting open counselor position. They were eager to recruit someone who would learn CRA and become a therapist in the next study. The outgoing staff member had come to know a young social work student who was interning at the ATP, and had urged him to apply for the position. With his bachelor's degree still incomplete, the student was hesitant to apply, but he finally agreed to interview for the position. This newcomer to the small CRA group was Robert J. Meyers. Meyers had heard that Godley was easy-going, but nothing could have prepared him for the onslaught of questions that John Mallams had ready for him. But at the conclusion of the interview, both Godley and Mallams knew they had found their CRA therapist for the largest CRA study yet. Meyers joined the staff, with Mallams as the clinical director and his CRA mentor, and Godley as the center's director.

Meyers' intensive training began the moment he walked through the door on his first day of work. Mallams was determined to make sure that Meyers knew every procedure for every possible situation. In the course of training and preparation for the first outpatient trial, Mallams and Meyers modified the inpatient procedures. It was also during this time that they developed the sobriety sampling technique and much of the disulfiram monitoring program. The project was quite progressive for its time, as pilot subject sessions with therapists were taped and reviewed to ensure that all clinical staff were similar in their use of CRA. Several months later, Azrin introduced a new graduate student to the laboratory. Robert W. Sisson underwent similar training and scrutiny by Mallams and Meyers.

The next significant event was Azrin's sabbatical year. Mallams created a great deal of enthusiasm for an evaluation of the social and recreational component of CRA, known as the United Club (UC). The UC was basically a "dry" social club that had been a component of prior CRA studies. It had operated out of locations where Hunt or Mallams had been able to negotiate free or low-cost space. It took place at weekends at the Carbondale Community Recreation Center. Conveniently located on the "main drag", where there were many student bars, the UC operated every Saturday night for nearly two years. Few laboratory situations could parallel this setting for observing and teaching social skills. Godley, Meyers, and Sisson became convinced that when a single recovered male alcoholic asked a woman to dance and completed the dance, he was well on his way to recovery! The Saturday night potluck drew in 80 to 100 recovering people who assembled to hear live country and western music, play poker for cigarettes, shoot pool, and converse. A randomized trial of the UC found that attendance could be primed through a set of encouragement procedures, and that those encouraged to attend had better outcomes in terms of recovery. The UC study became Mallams' doctoral dissertation and was eventually published in the *Quarterly Journal of Alcohol Studies* (Mallams et al., 1982). Even though many Saturday nights were given up to the UC, looking back we particularly appreciate Mallams' tireless work to keep each night at the UC lively, with the help of just a few dedicated therapists, their supportive spouses, and without any grant funds or user fees. It was during this same year that Meyers and Sisson piloted and shaped the outpatient procedures into their final form.

Azrin had been back from his sabbatical for less than a year when Mallams accepted another position, leaving Meyers and Sisson as the heirs

apparent to CRA. During that first year most clients were seen simultaneously by two therapists, with each taking turns as the lead counselor. At the conclusion of a session, one therapist would debrief the other by discussing each procedure used and whether it appeared to be helpful. In addition to practising therapy in tandem and listening to therapy tapes together, much of Meyers' and Sisson's socializing time was spent discussing and arguing about how CRA should be properly done.

As noted, CRA had only been conducted in an inpatient setting before 1976. Both early trials had been completed at Anna State Hospital, where the clients were severely dependent and held by physician or legal commitment. Now it was time to try CRA as an outpatient program. Several years of preparation were required before the 1982 trial could begin. This was a time of great excitement and high energy, but we soon learned that we had been quite naive. Working with outpatient clients presented a new challenge: keeping people in treatment. CRA had only been done with a captive audience up to that point. So before the first outpatient CRA trial began, our team treated literally hundreds of clients as practice cases. Most of the cases were audio-taped and then reviewed. Discussions ensued about the proper way to use a procedure, or, more importantly, about which procedure should have been used in the first place. The process was arduous and critical. Revision on the proper use of each procedure sometimes took months, and during that time clients were already being introduced to the newly revised version. When clients failed to comply with our neatly designed procedures, our group typically concluded that we were not executing the procedures properly. We expected success, and were determined to achieve it. As a result of our work with these less predictable and less compliant outpatients, the CRA procedures multiplied and their order of implementation became more flexible. Importantly, a menu of alternatives from which the therapist could choose emerged. In the course of this process the grave importance of the first few sessions became apparent. Meyers and Sisson came to understand the need to look for ways to "hook" the client into treatment early, to get the client interested and engaged. In retrospect, the term "hooking" seems harsh, and current language focuses more on "motivating". Whatever the process is called, unless clients become motivated, curious, or even excited about the change process, they will never follow through with procedures or stay in treatment. Over time Meyers and Sisson developed a positive clinical style that retained the CRA procedures while also building rapport and trust.