ARTICLE

Introducing the Community Reinforcement Approach (CRA) as an effective evidence-based treatment modality in a traditional addiction treatment unit

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Abstract

This study aimed to introduce an evidence-based treatment programme known as the Community Reinforcement Approach (CRA) into an addiction treatment unit and to convince the counsellors who are devoted to the existing practices to become open to new and better validated treatment modalities. CRA follows the typical cycle of Action Research, 'unfreeze'-'moving' - 'refreeze'. A qualitative research methodology approach, including a triangulation of interview and focus group methods, was used for the gathering of data. This Action Research was undertaken in the Addiction Treatment Unit, Department of Psychiatry, County Hospital, Roscommon, where four counsellors (core agents) working in the Addiction Unit were recruited. The data were transcribed, tabulated and analysed using the 'method of framework' and a 'member check validity' approach was adopted. The findings suggest that the core agents embraced the idea of an evidence-based approach in the form of CRA, implemented CRA, and found it useful and effective. However, a subtle resistance was found during these cycles in the form of 'dodging'.

Introduction

Alcohol consumption in Ireland has increased dramatically in the recent times (Strategic Task Force on Alcohol, 2002), which brings an enormous cost to Irish society in the form of medical, psychological and social harm. It is evident that alcohol disorders continue to be a major cause of admission to psychiatric hospitals and alcohol-related disorders were ranked as the third most common reason for admission to Irish psychiatric hospitals in 2000 (Daly & Walsh, 2003). Furthermore, alcohol is often found to be a contributing factor in death by suicide (Russell et al., 2004), car accidents, drowning, falls and burns. In fact, it affects every part of Irish society. Therefore, it is vital to deal with this menace immediately and effectively. It is a complex problem, requiring multi-faceted strategies in order to combat it.

Treatment approaches make up one important aspect of the multidimensional strategies to deal with this problem. In the Irish context, the disease model has dominated in terms of treatment programmes since 1945, and it has continued to influence the Irish health system until the more recent influence of the Minnesota model (Butler, 2002). The treatment programmes which are currently in practice lack empirical evidence to support their validity. Edwards (2000) suggests that innovation is required for new treatments to replace remedies of unproven worth. Therefore, it is essential in the Irish health setting to review the current alcohol treatment policy and to look for an evidence-based treatment programme in line with the recommendations of the Strategic Task Force on Alcohol (2002).

In general, the majority of treatment programmes overlook the environmental determinants, which are an equally important part of the pain and suffering associated with alcohol abuse. The cultural patterns of alcohol use are very important and of course a 'favourable' environment consequently contributes to alcohol abuse (Vaillant, 1995). Meyers and Miller (2001) revealed that relapse upon discharge to the normal environment is often reported following inpatient and residential treatment. Furthermore, Meyers and Wolfe (2004) found that programmes that emphasise the effectiveness of the individual and environmental determinants, and involve the drinker's loved ones in the effort to change, are now seen as best practice. In this regard, the Community Reinforcement Approach (CRA), an evidence-based treatment approach, was identified as having a proven record of efficacy. This programme stands on the principle that environmental contingencies can play a significant role in encouraging or discouraging drinking. It utilises social, recreational, familial, and vocational reinforcements to help clients in the healing process. Its effectiveness has been demonstrated in both inpatient and outpatient settings and with individuals and couples. It has been shown to be effective with mild to severe problems and its efficacy has been documented in treatment formats varying from 50 hours of therapy to as little as five hours spanning over 30 years (Meyers & Miller, 2001). In addition, in a large number of studies CRA treatment has produced significantly better outcomes or yielded efficacy similar to the treatment in common practice (Meyers & Wolfe, 2004; Miller et al., 1999; Azrin et al., 1982).

As already mentioned, alcohol dependence is a complex and widespread human problem which needs multifaceted strategies to combat it effectively. Nevertheless,

treatment approaches play a significant role in the amelioration of this problem. However there can be an evangelical and stubborn commitment to treatment modalities which are ineffective. This study aims to examine how difficult it is to introduce a well-validated modality, CRA, to a team of counsellors already committed to traditional treatment systems, through Action Research. Action Research is a methodology that aims both to take action and to generate knowledge about that action.

Method

Participants

Four addiction counselors (core agents) were recruited for the present study. They are full-time addiction counsellors working in the Addiction Treatment Unit in Roscommon. They all are qualified in this field, having a number of years' experience (between 3 and 10 years) working as addiction counsellors.

Research Instruments

A triangulation (Denzin, 1989) of two techniques was adopted. Both 'interview' and 'focus group' methods are required for good qualitative research (Greenhalgh & Taylor, 1997).

Procedure

A summary of the research proposal was submitted to the Clinical Director, Mental Health Services, Roscommon, and was approved. Copies of this proposal were also sent to the consultant psychiatrists in charge of each sector.

Firstly, the participants' consent and willingness to participate were obtained and the purpose of this research was explained to them. All interviews took place in the Addiction Treatment Unit (ATU), Mental Health Services, Roscommon. Each participant was interviewed individually and the responses were recorded with the help of audiotape; interviews took between 45 minutes and an hour and were later transcribed.

The next stage was the 'moving' stage; the author/researcher attended a workshop on CRA, which was delivered by the founder members of CRA (Meyers & Smith, 2003). The author then organised the same workshop on CRA in the ATU and delivered a presentation about CRA to the participants (core agents) in group form, which was called the 'focus group'. In this presentation, the author built an understanding of the CRA approach and proposed a model to incorporate it into the current treatment policy as an effective treatment modality to involve the participants in the change process. The presentation and discussion lasted for four hours. The group's responses were recorded and later on the author asked some questions himself about the focus group discussion, which were answered.

The third stage, which is called 'refreezing', which aims to ensure the change is maintained and works. The progress of the change was monitored and refined as necessary in order that the changed state becomes normative and central to the new way of life. The new way of delivering the service was rewarded by organising social evenings and small successes were celebrated. The participants were re-interviewed individually and their responses were recorded via tape recorder. This took from 45 minutes to about an hour.

Results

In this study open-ended but specific questions were asked within a limited time scale; therefore, a 'framework' analysis approach was adopted (Richie & Spencer, 1994). All the interviews conducted during the study were transcribed and were analysed using the method of 'framework' analysis where the data were closely examined or sifted, charted and sorted according to key issues and themes. The summarised key information about each index was recorded and is summarised in Tables 1, 2 and 3. A 'member checks validity' (Douglas 1976) approach was adopted, where the core agents were asked for validation of the researcher's analysis. They judged the adequacy of the researcher's analysis, and confirmed if they recognised, understood and accepted the description. They were doubtful about one or two points, but, overall they commented that it was 'excellent', 'carefully done' and 'very interesting'. The three versions of the thematic framework produced for this study as a result of the Action Research are extracted in the tables.

Table 1: Unfreezing

Quote
Qualification and experience
No definite treatment policy
A range of approaches based on Rogerian principles
Minnesota is the popular model
No vigorous evaluation
Less options
We cannot stay with the traditional treatment for the sake of it
Review of the current policy, more specialist services, revolving doors overlooking the environmental issues
Dissatisfied with the current policy
No guidelines working in conjunction with psychiatrists
Lack of professional people
Stigma is still attached
Relapse rate is high
Long-term rehab with medical cover
Family involvement
A need for practical or proven treatment programme

Table 2: Moving (Taking Action)

Quote
Menu of options
Set goals
Treatment plan
Environmental determinants
Assessment tools
Involvement of significant others
Sobriety sampling
Inpatients and out-patients
AntAbuse (disulfiram)
Research based
Addresses life issues
We are already using some part of it
CRA should be a part of a treatment policy
Technical know how

Table 3: Refreezing

Quote
Implemented CRA, bits and pieces
Useful
Different tools
Explores and reinforces clients needs
AntAbuse (disulfiram)
Social skills, emotional life, recreational, marital therapy
Quality of life
Significant others
Social club
Continuous journey
CRA works particularly in rural areas
Improved relationship
Guidelines for counsellors
Slightly lower IQ
A common sense approach
Environmental Factors
Current issues
No need of labelling
Some elements work
Formulation
Enjoyed
Relapses
Systematic approach
Solution focused
Drink refusal training
I don't like the discipline of it because I have been working for several years the way I work
Own instinct
Team effort
Scientific model
Stimulating
Research based
Disable club
Trainings
Part of treatment policy
Add to the existing policy

Discussion and Conclusion

This section offers a discussion on the actions taken in this study, which are presented in the above tables. At the end, this discussion leads to a conclusion based on the findings of this study and answers the questions generated in the 'unfreezing' stage. To bring about organizational change, especially in the context of a health care organization, the introduction of a new regime into an existing system needs to 'unfreeze' that very system. No change will occur unless the system is unfrozen (Rashford & Coughlin, 1994).

In order to unfreeze the existing system, and to identify dissatisfaction or doubts about the existing system, and also to acknowledge a need for change to make a baseline for 'moving' (taking action), the data of the first interviews were analysed (Table 1), which facilitated the action of 'unfreezing'. It was pointed out that the present policy based on the Traditional Model was not compatible with present circumstances. It was based on the model which only focuses on the individual and overlooks other environmental determinants which are equally important in the treatment of alcohol abuse in patients. The present policy was like a 'revolving door'. It was not explicit. It was narrow, and rigid, with no menu of options and no vigorous evaluation and research to monitor its effectiveness. The relapse rate was high, which has put pressure on the unit and increased demand for long-term rehabilitation and community detoxification. It was also suggested that there was a need for the involvement of family in the treatment process. This action created anxiety with the realisation of dissatisfaction and disconfirmation of the existing treatment policy and acknowledged a need for change, which created a baseline for the further stage of moving (taking action).

To bring about this change, the researcher provided enough support, direction and help so that the core agents felt confident and competent to become active problem solvers, and to build their commitment as a team. Confrontation was avoided and the concept of changing competency rather challenging it was put forward. This action motivated the change agents to look for a new solution in the form of CRA, which addresses both individual and environmental issues with attainable goals. This lessened the learning anxiety aroused as a corollary of action in the 'unfreezing' stage. On implementation of this approach, the learning anxiety that emerged during the first phase of this action research was dissipated. As mentioned earlier in the procedure, the second stage of action research involved 'focus group' discussion, which provided a non-threatening environment for the core agents. In these, they expressed their opinions, feelings and attitudes about CRA. This also provided an opportunity for agents to gain insight and generate ideas in order to pursue CRA in greater depth, to keep the services going on and changing at the same time. This 'focus group' discussion resulted in action. The core agents decided to take action and to implement CRA in a transition period of six months, and developed a 'shared direction'.

The findings of Table 2 indicate that all the core agents who took part during the discussion asked relevant questions and showed a keen interest and understanding regarding this approach. They were impressed and excited and showed motivation to move on to the desired future state. They were fully prepared and were planning to start CRA with new clients as well as with the clients already receiving a traditional treatment approach. They considered it to be a move forward, and one which would improve the quality of life of the clients and could rebuild their emotional and social life. They saw it as a life-enhancing journey. They also requested technical help. A clinical guide to alcohol treatment (Meyers & Smith, 1995) was provided and printed materials

about CRA were made available

The researcher noticed two states of 'dodging' during the implementation stage and focused on their resolution to prevent the 'bogging down' of the change processes. The first 'dodging' state began with the accumulation of evidence from the 'unfreezing' stage where the core agents did not deny the importance of evidence- based practice but they were reluctant to bring change in their own way of providing services. They gave emphasis to community detoxification and long-term rehabilitation programme to minimise relapse. They wanted changes in other parts of the system but were resistant to modify their own way of delivering services. They wanted to remain peripheral to the change. The researcher, in formal and informal discussion, tried to resolve this issue and brought them around in a subtle way. The researcher avoided confrontation and asked amicably that this evidence-based approach be added to the present regime rather than replacing the old modality.

The second 'dodging' was articulated as 'we are already using some parts of it'. Again the participants did not deny the importance and effectiveness of CRA but were reluctant to accept the regime in its full form. It is worth noting that the 'dodging' was not because of any malevolence on their part, but because the idea of radical change was new to them and they had not been exposed to such changes since they started their work in this field. The researcher adopted the approach to work with resistance rather than to overcome it, and this approach was found to be successful. Subsequently the following measures were adopted in this regard. A trusting and friendly climate was developed, a rapport was established, and accurate, complete information and technical know-how were provided. An opportunity was provided for the change agents to speak their mind, adequately motivated by making explicit benefits to all; their participation was encouraged and the approach adopted was solution-oriented rather than problem-oriented. It was also suggested to the change agents that the change as a result of action would not threaten or challenge their competency rather it would enhance it.

The researcher also acknowledged that the core agents were using some parts of CRA specifically in the form of counselling techniques. However, if they could use CRA step by step according to the clinical guide, and also focus on work, family, recreational and social components, sobriety sampling and involving significant others, then it would make a difference and they would find CRA more effective. They embraced this idea with the passage of time and tried to implement CRA in its full form to achieve the desired goals. The progress in the transition stage was continuously reinforced, keeping in mind the vision of the desired future, and encouraging implementation. Problems were identified and available resolutions were sought. After the transition period a move was made to the 'refreezing' stage to consolidate and sustain the change. As is frequently described, no change will last unless the system is refrozen sufficiently (Rashford & Coughlin, 1994). However, there is little stability in the present world and the only constant thing is change itself. Change is not an event, it is a process. So, unfreezing, moving and refreezing can overlap in the sporadic change following Lewin's stages of unfreezing-moving-refreezing. Immediately after implementation the progress of change was monitored, assessed and refined as necessary in order that the changed state becomes normative and central to the new way of life. The delivering of this evidence-based approach was rewarded; social evenings were organized for the core agents and small successes made during this action were celebrated.

In summary, in the third refreezing action (Table 3), all the core agents have implemented CRA, (although some of them use it partially). They all engaged in applying this approach. They found it scientific, evidence-based with menus of options and involving significant others (a need was felt in the "unfreezing" stage for family involvement). Nevertheless, the dodging element has been found in this action, where the core agents again expressed the idea that they were already using some parts of it. They did not like the discipline of it because they have been working for a considerable number of years with previous work methods. However, to "refreeze" this stage, this action provided an opportunity for the core agents to implement an evidence-based approach in the form of CRA. To conclude, CRA was added as an effective treatment modality to the existing treatment policy. However, a continuous slight resistance was found throughout these stages.

Lessons Learned

Change is not an incident; it is a course of many cycles to contribute distinctive knowledge. It is hard to triumph over resistance rather to work with it. Change is almost never easy, but change for improvement is always worth the effort.

Acknowledgements

The author would like to acknowledge the support of Health Services Executive (West) Galway, Frank Murphy (General Manager), Dr Mary McGuire (Clinical Director) and Dr Charles Byrne (Consultant Psychiatrist) for their encouragement and support. Special thanks goes to Dr Sean Butler (supervisor) for his valuable guidance and moral support.

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