

CRA and CRAFT: Behavioral Approaches to Treating Substance-Abusing Individuals

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The Community Reinforcement Approach (CRA) and Community Reinforcement and Family Training (CRAFT) are behavioral treatments for substance abuse problems that have received widespread empirical support. CRA, a treatment intended for the drinker him- or herself, was introduced 30 years ago (Hunt & Azrin, 1973). It is based on the belief that a drinker's "community" (e.g., family, social and job environment) plays a critical role in supporting or discouraging drinking behavior. Consequently this environment needs to be restructured such that a sober lifestyle is more rewarding than a drinking lifestyle. CRAFT, an outgrowth of CRA, is a highly successful method for working with concerned family members in order to get a treatment-refusing substance abuser to enter treatment (Meyers & Wolfe, 2004; Sisson & Azrin, 1986). The components of both CRA and CRAFT are outlined in this paper, and the scientific support is summarized.

Keywords: Community Reinforcement Approach (CRA); Community Reinforcement and Family Training (CRAFT); alcohol treatment; behavioral treatment

The Community Reinforcement Approach (CRA), a comprehensive operant program that was started in the 1970s (Hunt & Azrin, 1973), is one of the most highly effective treatments for alcohol use disorders to date. Its companion program, CRAFT (Community Reinforcement and Family Training), grew out of the recognized need for a method of working through motivated family members of treatment-refusing substance abusers. Both treatments are based on the belief that an individual's environment plays a critical role in recovery. This environment, or "community", is comprised of family, friends, work, social activities, and sometimes spiritual affiliations that reinforce drinking or non-drinking behaviors. The goal of CRA is to influence various aspects of a person's environment such that a sober lifestyle becomes more rewarding than one involving alcohol. And although ultimately CRAFT shares the same goal, the major purpose of CRAFT is to get a treatment-resistant drinker or drug user to enter treatment. Both CRA and CRAFT rely on behavioral principles and motivational procedures instead of confrontation.

How efficacious are CRA and CRAFT? Given that CRAFT does not work directly with the drinker, it has not been included in meta-analytic reviews of controlled alcohol treatment studies. Nevertheless, individual studies have found it to be highly effective at engaging resistant alcohol and drug abusers into treatment (see "Scientific Support" section for CRAFT). CRA, on the other hand, is intended for the drinker him- or herself, and it consistently has been ranked among the best alcohol treatments. In the two most recent reviews, CRA was rated as the top program in a cost-effectiveness analysis (Finney & Monahan, 1996), and it tied for fourth place among 48 different treatment modalities in a review by Miller and colleagues (Miller, Wilbourne, & Hettema, 2003). Although CRA also has been used in combination with contingency management programs to treat illicit drug use (Higgins & Abbott, 2001), this paper focuses only on the "pure" CRA program for alcohol use disorders.

CRA Procedures

A description of the components of CRA follows (see Meyers & Smith, 1995 for a more detailed

account). It should become apparent that several aspects of the CRA program are similar to the behavioral clinical approach called Positive Behavioral Support (PBS), which is appearing increasingly in the literature. PBS is rooted in behavioral analysis, and is defined by its person-centered approach to planning, reliance on a functional assessment of the problem, and multifaceted and environmentally-focused treatment strategies (Carr & Sidener, 2002). As shown below, CRA has been applying these principles to problem drinkers for over 30 years.

CRA Functional Analyses

A recent paper reviewed 277 studies that utilized functional analyses for problem assessment and treatment prescription. It reported that problem behaviors (of many different types) were usually maintained by differential reinforcement, largely including positive and negative social reinforcement (Hanley, Iwata, & McCord, 2003). The CRA program relies heavily on functional analyses, as it outlines the context in which the drinking behavior occurs. The antecedents, or triggers, to drinking are identified first, so that the establishing operations are apparent. Internal triggers are individuals' thoughts and feelings that set the stage for the drinking. Oftentimes it becomes apparent that a person uses alcohol because it is positively reinforcing (Type P drinking). Perhaps it is associated with feeling happy and sociable, or with relaxing. But drinking is also frequently experienced as negatively reinforcing (Type N drinking), as it allows individuals to temporarily avoid dealing with unpleasant emotions, such as anger, sadness, and anxiety (Wulfurt, Greenway, & Dougher, 1996). Although the CRA therapist accepts the client's drinking-associated thoughts and feelings as valid, the treatment entails helping the client find healthier ways to achieve these same objectives. External triggers include the people, places, and times linked with the start of drinking episodes. These high-risk situations that supply cues strongly associated with drinking are highlighted and addressed later in treatment. The drinking behavior itself is next identified, including the specifics regarding the type of beverage as well as the amount. The short-term positive consequences of the drinking are explored fully, since they represent the factors that are maintaining the problem behavior. Preliminary ideas are generated for new behavioral repertoires that might satisfactorily replace the drinking. Finally, the long-term negative consequences of the behavior, or the "cost" of the drinking in terms of reinforcers lost, are examined. In general, as the client and therapist both become aware of how drinking fits into the larger system of reinforcement in the client's environment, this information is used to explore alternative sources of reinforcement.

Antecedents and consequences of *non*-drinking, pleasurable behaviors may also be explored using the CRA functional analysis, since it is assumed that these, too, are being maintained by contingencies of reinforcement. Most clients already participate in at least some enjoyable activities that do not involve alcohol, and the objective is to increase the frequency of these behaviors so that they can compete with and eventually replace the drinking activities as the primary reinforcer in the client's environment. The client chooses one of these already existing desirable behaviors to use in the functional analysis. The triggers and consequences of the behavior are again identified, but this time the negative consequences are labeled as short-term obstacles and they are contrasted with positive (healthy) long-term consequences. The client is taught to recognize and respond positively to the triggers for these behaviors more readily.

Sobriety Sampling

The concept of "sampling" sobriety stands in stark contrast to the philosophies of most traditional alcohol programs, which use abstinence as the sole criterion of success. Rather than impose rigid and overwhelming expectations, CRA asks clients to experiment with a time-limited period of abstinence.

Understandably, clients are more receptive to this type of approach, especially those who initially wish to simply moderate their drinking. In introducing sobriety sampling, it is useful to point out the many advantages. For instance, a period of sobriety is often viewed extremely favorably by family members, which in turn results in their support. Thus, an increase in the density of reinforcement often is associated with this period of sobriety, and client motivation to remain abstinent is enhanced.

A negotiation process characterizes the selection of the length of the period of sobriety. Typically the therapist suggests an overly ambitious goal, such as 90 days, understanding fully that most clients will not agree to it. Through discussion and negotiation, a reasonable period of time of abstinence is chosen. Depending on the client, this could range from two days to two months. Information is gleaned from the functional analysis to devise strategies to reach the client's abstinence goal. Triggers and risky situations are highlighted, and problem-solving is used to help the client avoid these stimuli or respond to them with healthier behaviors. When approaching the end of the planned period of sobriety, the therapist reviews the benefits experienced by the client during that time, and suggests extending the period further.

Monitored Disulfiram

Disulfiram (Antabuse) is sometimes used in the early phases of CRA as an adjunct to treatment, particularly if a client is repeatedly failing to achieve even short periods of abstinence. Disulfiram acts as an effective punisher if an individual imbibes alcohol while taking it, because it causes an aversive illness in the client that can range from feeling mildly sick, to requiring immediate medical attention. Use of this medication must be medically cleared and carefully followed. There are multiple advantages to the use of *monitored* disulfiram, such as improving treatment retention and compliance, and relapse prevention (Brewer, Meyers & Johnsen, 2000). But having a monitor is critical. A monitor is usually a family member who is trained to administer the disulfiram daily in a supportive, reinforcing manner. In general, clients only remain on disulfiram for a few months. During this time they receive positive reinforcement supportive of their sobriety from family and friends, and they acquire the necessary skills to remain abstinent.

CRA Treatment Plan

Two instruments, the Happiness Scale and the Goals of Counseling, form the basis of the CRA treatment plan. The Happiness scale is a brief questionnaire that asks clients about their happiness in 10 areas (e.g., drinking, job/educational progress, social life, marriage/family relationships). It provides a baseline measure of problem areas that can be evaluated throughout treatment, and it demonstrates CRA's commitment to address other areas of life; not just substance use. After problem areas are identified, the Goals of Counseling form provides a framework for developing specific behavioral goals and strategies to achieve them. Ultimately, the client's satisfaction in other areas of life should grow and diminish the role of alcohol in achieving a rewarding life.

Behavioral Skills Training

In examining both the functional analysis and the Goals of Counseling, behavioral skills deficits that would interfere with the client's participation in healthier behaviors are identified. For instance, if a client drinks as a means of social reinforcement, the therapist would assess whether he or she has the communication skills necessary to acquire socially rewarding non-drinking relationships. The communication skills training entails the therapist educating the client about the components of a good conversation (see Meyers & Smith, 1995, Chapter 6), and rehearsing the behavior through role-plays.

Some clients are socially skilled, and yet they find it difficult to seek new social outlets. In such cases, the therapist uses problem-solving procedures instead. Clients commonly use alcohol as a maladaptive coping strategy to deal with daily struggles. CRA teaches new coping strategies, and provides a structured framework for problem-solving in general. Based on D’Zurilla and Goldfried’s (1971) approach, clients are instructed to define the problem, generate alternatives, decide on a solution, anticipate and address obstacles, and evaluate the outcome.

Since a client’s unassertiveness could place him or her at risk in situations involving alcohol, a therapist would introduce the third component of CRA’s behavioral skills package; drink-refusal training. First, the client enlists the support of family members and friends in providing a reinforcing environment for non-drinking behavior. High-risk situations are then identified and the client rehearses appropriate responses, that are drawn, in part, from the social skills work of Monti and colleagues (Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002).

Job Skills

The job environment is a significant part of a person’s “community”, with valuable potential for providing reinforcement (e.g., money, social interactions). A steady, satisfying job competes with drinking in many ways, such as by providing structure to the day and requiring the physical and mental skills that are disrupted by alcohol. To help clients find gainful employment, the CRA approach to job-training addresses areas such as completing job applications, generating job leads, and telephone and interview skills rehearsal. If responses on the Happiness Scale indicate that a client who already has a job is dissatisfied with it, problem-solving is undertaken. A full description of the job club procedures are in Meyers and Smith (1995) and in Azrin and Besalel’s *Job Club Counselor’s Manual* (1980).

Social/Recreational Counseling

By the time individuals seek treatment, the majority of their friendships and recreational activities revolve around the use of alcohol. Since the ultimate goal of CRA is to replace drinking with other pleasurable, non-drinking activities, substantial attention must be paid to individuals’ social reinforcement. In the beginning, clients may require considerable assistance in determining how to manage their free time in a healthy, rewarding manner. Functional analyses for non-drinking behavior may be employed for this purpose, along with problem-solving. Still, clients may be hesitant to experiment with new activities. To address this, CRA offers Systematic Encouragement; a technique that increases the likelihood of sampling a new activity by enlisting the help of a contact person for the activity, addressing potential attendance problems, and subsequently reviewing the activity’s reinforcement value. If CRA is offered to a number of clients, a Social Club may be formed in which participants engage in scheduled non-drinking social activities together weekly during high-risk times (Mallams et al., 1982; Smith et al., 1998). The “club” provides a safe, supportive environment where clients can experience enjoyable, healthy activities (e.g., bowling, dinner).

CRA’s Relationship Therapy

CRA therapists typically invite clients’ partners to participate in several sessions in order to enlist their support for the drinker, and to introduce efforts to make the relationship more reinforcing for both individuals. CRA’s behavioral couples therapy views most relationship problems as arising from unrealistic expectations, poor communication and problem-solving skills, and attempts to control the partner’s behavior through aversive means. In addition to skills training, this segment of CRA utilizes

three instruments to assist in other problem areas the couple might be experiencing. Potential sources of conflict (e.g., household responsibilities, raising the children) are identified by the Marriage Happiness Scale, and the Perfect Relationship form (much like the Goals of Counseling form) identifies specific behaviors that each individual would like to see changed. The Daily Reminder to Be Nice is introduced to increase the occurrence of pleasing behaviors. Through these techniques, it is believed that a strained relationship can be transformed into one that is rewarding and supports a non-drinking lifestyle.

Scientific Support

CRA was first tested with alcohol-dependent inpatients in two studies about 30 years ago (Azrin, 1976; Hunt & Azrin, 1973). The results of these early, small-sample studies were very promising, as clients in the CRA conditions experienced significantly greater decreases in drinking than the 12-step comparison group at 6 month follow-ups. CRA participants showed significantly more improvement in employment status than the comparison condition as well. Impressive results were also demonstrated for CRA participants in outpatient trials that tested the addition of the disulfiram and the Social Club components (Azrin, Sisson, Meyers, & Godley, 1982; Mallams, Godley, Hall, & Meyers, 1982). Somewhat less robust results were found when CRA was contrasted with traditional 12-step treatment that also used disulfiram monitors (Miller, Meyers, Tonigan, & Grant, 2001). Significant group differences that favored CRA were detected in terms of lower dropout rates and significantly better drinking outcomes – but only for earlier follow-up periods. Conceivably the disulfiram monitoring (a CRA procedure) contributed markedly to the success of the traditional treatment. Most recently, CRA has been tested with one of the most severe and vulnerable populations of substance users, the homeless (Smith, Meyers, & Delaney, 1998). Participants lived in grant-supported housing for three months while primarily receiving group CRA therapy. The CRA condition significantly outperformed the standard treatment in alcohol consumption. Currently, a modified version of this study is being conducted by Smith and colleagues to address the special needs of homeless women. Interestingly, a study with a similar population found that “life skills training”, which resembles CRA’s behavioral skills training and functional assessment, enhanced the standard cognitive-behavioral protocol in the most severely alcohol dependent women (Connors & Walitzer, 2001).

Community Reinforcement and Family Training (CRAFT)

It is an unfortunate reality within the substance abuse field that many individuals who clearly need professional help are adamantly opposed to seeking treatment. Addiction centers regularly receive phone calls from the desperate family members of these treatment-refusing substance abusers. Until recently, there were few options to offer these Concerned Significant Others (CSOs). The traditional response was to send them to Al-Anon meetings, which advocate loving detachment from the drinker or drug user (Al-Anon Family Groups, 1984). Alternatively, some CSOs were trained in the Johnson Institute Intervention (Johnson, 1986); the “surprise party” confrontation of the substance abuser (identified patient; IP) by a group of loved ones. Perhaps understandably, many CSOs were not satisfied with these options, either because they were unwilling to follow Al-Anon’s directive to step aside and do nothing for their IP, or because they were uncomfortable with the highly confrontational style of the Johnson Institute Intervention. Unilateral family therapy, a relatively recent, non-traditional treatment for CSOs, is based on the belief that loving family members can play an active role in influencing a resistant individual to begin treatment. The various unilateral programs differ somewhat in terms of the use of confrontational techniques and the specific skills training offered. Although evaluations of the efficacy of programs have been hampered by methodological problems (Thomas, Santa, Bronson, & Oyserman, 1987) and the fact that participants are not necessarily outright treatment refusers (Landau et al., 2000),

none of these programs (e.g., Barber & Crisp, 1995) can match CRAFT's success at engaging resistant individuals into treatment.

As noted, CRAFT is an outgrowth of CRA. Early CRA researchers recognized that the spouses of drinkers could play a critical role in getting resistant drinkers into treatment. Within the CRA program, spouses had already proven to be reliable and supportive disulfiram monitors or marital therapy partners (Azrin, 1976; Azrin et al., 1982). Furthermore, reluctant drinkers' spouses were highly invested in supporting positive change, and in fact, they were often the ones to contact the treatment facility. Importantly, since family members tended to have extensive contact with their IPs (Stanton & Heath, 1997), CRA researchers were convinced that CSOs were in an ideal position to exert considerable influence over the drinking behavior (Sisson & Azrin, 1986). In support of these convictions were the reports of innumerable substance abusing individuals that they eventually pursued treatment in response to pressure from family and friends (Cunningham, Sobell, Sobell & Kapur, 1995; Room, 1987). The final impetus for deciding to work with CSOs was the CRA researchers' concern for CSOs' psychological well-being. Living with a substance-abusing individual is considered a chronic stressor. The specific stressors often take the form of violence, constant arguments, financial problems, and disrupted relationships with the children (Jacob, Krahn, & Leonard, 1991; Velleman et al., 1993). Given that a natural CSO response to these stressors is depression, anxiety, and low self-esteem, it is conceivable that CSOs would benefit from psychotherapy themselves (Brown, Kokin, Seraganian, & Shields, 1995; Spear & Mason, 1991).

Similar to the CRA program already described, CRAFT relies on behavioral reinforcement strategies. However, since the substance-abusing individual refuses to enter treatment, the *CSO is the client* in CRAFT. Thus, CSOs are taught how to rearrange contingencies in the *IP's* environment in order to support clean/sober IP behavior and effectively discourage drinking/drug use. Behavioral skills training is conducted with CSOs to provide them with the necessary tools to successfully influence their IP to enter treatment, and to enhance the overall happiness in their own lives (Meyers & Wolfe, 2004; Sisson & Azrin, 1986; Smith & Meyers, 2004). An overview of the CRAFT procedures follows.

Motivational Strategies

Although CSOs tend to be invested in seeing change in their IP's behavior, they are sometimes taken aback upon learning that they are expected to play a major facilitative role. In an effort to "hook" them into the treatment process and appropriately increase their expectations for a positive outcome, CSOs are informed about the success rates for CRAFT; namely, that seven out of 10 CSOs are able to get their resistant IP to enter treatment. They are also told that treatment entry typically occurs within five CSO sessions, and that neither the type of IP drug (e.g., alcohol, cocaine) nor the type of CSO-IP relationship (e.g., spouses, parent-adult child) seems to be a factor. Finally, CSOs are told that regardless of the IP outcome, they are likely to feel better themselves (Meyers, Miller, Hill, & Tonigan, 1999; Meyers, Miller, Smith, & Tonigan, 2002; Miller, Meyers, & Tonigan, 1999). Importantly, the firm message is given that CSOs are not responsible for the IP's drinking or drug use.

CRAFT Functional Analysis of the IP's Substance-Using Behavior

The objective of the CRAFT functional analysis is the same as that of the CRA Functional Analysis; to outline the antecedents and consequences of the substance-using behavior. However, since the problem drinker/drug user is not in treatment, the *CSO* completes the functional analysis (for the IP) as part of CRAFT. This information then serves as a springboard for determining how the CSO should change her or his behavior toward the IP during high-risk periods, and also at times when the CSO's

behavior might unwittingly be serving to support the use.

Domestic Violence Precautions

There is a strong association between substance abuse and domestic violence (White & Chen, 2002). The assessment of the potential for domestic violence is an essential part of the CRAFT program, given that CSOs are trained to interact in ways that are intentionally meant to be experienced by the IPs as undesirable. While considering the alternatives, the therapist must decide whether it is even safe to train a CSO in CRAFT. The predictability of violent episodes, as well as the magnitude of the aggression, may be evaluated through a functional analysis. If it appears reasonable to proceed, both a violence prevention and protection plan must be developed (see Smith & Meyers, 2004).

Communication Skills

Communication problems are commonly found in relationships involving a substance abuser, and thus are a standard focus of behavioral couples therapy with such a population (Epstein & McCrady, 1998; O'Farrell & Fals-Stewart, 2003). In CRAFT, only half of the "couple" is present, but communication training is deemed crucial, nevertheless. Not only is positive communication more effective at helping CSOs actually obtain what they want from the IP (or from others), but it forms the foundation for other CRAFT procedures. For instance, CSOs are taught to present verbal explanations as to why their behavior has changed toward the IP, including why they are offering small rewards for sober behavior and withdrawing rewards when the IP is using. The demonstration of strong communication skills is also required prior to a CSO inviting the IP to sample treatment (see Meyers & Smith, 1995, Chapter 6 for training details).

Positive Reinforcement of Clean and Sober IP Behavior

A cornerstone of CRAFT is the behavioral principle that states that individuals will repeat behaviors that are "rewarded". The behavior of interest in CRAFT is an IP's *non*-drinking, *non*-using behavior, and the rewards typically are inexpensive or free activities/ behaviors offered by the CSO. These may include, for example, spending enjoyable time with or complimenting the IP, or preparing a special meal for the IP – but only when the IP is sober. When the notion of positively reinforcing an IP's sober behavior is explained initially, CSOs frequently confuse the practice with "enabling". So the fact that CRAFT's positive reinforcement is only linked with *sober* behavior must be stressed. Once this concept is understood and appreciated, a list of reasonable reinforcers is generated (see "Guidelines for Reinforcers", Chapter 6, Smith & Meyers, 2004) and a set of IP behaviors suitable for positive reinforcement is selected. CSOs are also taught how to anticipate possible negative repercussions for delivering contingent rewards, how to recognize whether the IP is under the influence of drugs prior to administering a reward, and how to verbally link rewards with sober behavior.

The Use of Negative Consequences

CRAFT also entails teaching CSOs to pair negative consequences with IP drinking or illicit drug use. The first of these negative consequences procedures, a time-out from positive reinforcement, involves withdrawing a reward from the IP during a substance-using episode. This technique tends to make sense to CSOs, as it is contrasted with the positive reinforcement of sober behavior. Nevertheless,

selecting an IP reinforcer to withdraw and planning its implementation requires practice. As an example, a CSO may decide to stop playing cards with her IP on the evenings that he is drinking. In many cases the CSO would use therapy time to rehearse giving the IP an explanation for this new behavior, and the CRA problem-solving procedure would be employed to address anticipated obstacles. The second negative consequences procedure involves CSOs allowing for the “natural consequences” of the IP’s substance use to occur. In other words, CSOs are taught to refrain from intervening in a way that would solve a problem created by the drinking/drug use. For instance, a CSO might decide to let her 21 year-old son (the IP) oversleep the morning after he has used marijuana, instead of repeatedly trying to get him up so that he can attend an art lesson that he thoroughly enjoys. In most cases the CSO informs the IP in advance about the planned change in behavior. Regardless of which of the two negative consequences procedure is discussed, the notion of the CSO inadvertently making it easier for the IP to continue using is addressed gently but directly, and without blaming the CSO for the IP’s decision to use.

Helping CSOs Enrich Their Own Lives

One of the objectives of CRAFT is to help CSOs become psychologically healthier regardless of whether their IP enters therapy. This objective is met, in part, because CSOs are taught to examine their own life goals and to revise their strategies for obtaining them. The Happiness Scale and the Goals of Counseling form (see CRA section) guide this ongoing, behavioral task. CSOs are encouraged to have a subset of goals/strategies that are independent of the IP. For instance, a CSO might be encouraged to take specific steps to reconnect with old friends who could serve as a source of pleasant entertainment as well as emotional support.

Inviting the IP to Sample Treatment

When acquiring positive communication skills, understanding *when* to deliver the communication is as important as knowing *how* to word it. This is certainly the case when CSOs are preparing to extend a therapy invitation to the IP. Given that an individual’s motivation for treatment appears to be a dynamic process that fluctuates, as opposed to being akin to an on/off switch (Miller, 2003; Prochaska & DiClemente, 1986), times of relatively higher IP motivation for treatment are explored. “Windows of opportunity” for suggesting treatment might include: The IP expressing remorse for a drinking-related crisis (e.g., receiving a DWI), or the IP asking why the CSO is suddenly acting differently (e.g., rewarding certain IP behaviors). Prior to raising the treatment issue, the CSO should have a suitable therapist or program arranged in advance so that there is no appreciable delay once the IP agrees to seek professional help (see Chapter 9 in Smith & Meyers, 2004). As far as *how* to present the invitation, CSOs are taught motivational “hooks” that are based on previous IPs’ reports of factors that motivated them to seek treatment. Several of these are: being offered the chance to simply meet the CSO’s therapist and ask questions about the program, hearing that it is standard practice for the IP to have his or her own (different) therapist, or hearing that they would have a major input into the treatment goals – including focusing on areas other than just substance use. But even the most polished requests are sometime met with rejection, and thus the CSO must be prepared for this possible outcome as being part of the engagement process.

Scientific Support

The earliest version of CRAFT, called community reinforcement training (CRT), was tested in a small (N = 12) controlled comparison of CRT with a traditional 12-step program (Sisson & Azrin, 1986). After an average of 7.2 CSO sessions, six of the seven CSOs in the CRT condition (86%) were able to get

their IPs to enter treatment, whereas none of the 12-step trained CSOs were. Interestingly, the drinkers associated with CSOs in the CRT condition cut their number of drinking days in half during the time that just the CSO was in treatment. The second alcohol trial used a much larger (N = 130), ethnically diverse sample of CSOs who had a variety of relationships with the IP (e.g., the IPs' spouse, parent, sibling). CSOs were randomly assigned to CRAFT, the Johnson Institute Intervention, or Al-Anon facilitation therapy – which was an individual therapy version of Al-Anon. The treatment engagement rates were significantly higher for CRAFT-trained CSOs, as 64% of them were able to get their IPs to enter treatment, compared to 30% for the Johnson Institute Intervention and 13% for Al-Anon (Miller et al., 1999). Regardless of treatment condition or engagement status, CSOs' psychological functioning improved significantly on a number of dimensions, and the CSO-IP relationship improved.

The success of the CRAFT program for *illicit drug* abusing IPs has been shown in an uncontrolled pilot project and two randomized clinical trials. A 74% engagement rate was detected for the 62 CRAFT-trained CSOs in the pilot study (Meyers et al., 1999). One controlled study (N = 32) contrasted CRAFT with a 12-step condition (Kirby, Marlowe, Festinger, Garvey, & LaMonaca, 1999). CSOs assigned to CRAFT were successful at engaging their IPs into treatment in 64% of the cases, whereas those assigned to 12-step meetings were only successful 17% of the time. The second controlled drug study was conducted with 90 CSOs who were randomly assigned to CRAFT, CRAFT plus Aftercare, or Al-Anon/Nar-Anon facilitation therapy (Meyers et al., 2002). The purpose of including aftercare for one of the CRAFT conditions was to mirror the ongoing availability of community support groups such as 12-step meetings, and test whether it enhanced the engagement rates of CRAFT. Engagement rates for both the CRAFT (59% engaged) and the CRAFT plus Aftercare (77% engaged) conditions were significantly higher than those of the Al-Anon/Nar-Anon condition (29% engaged), but the CRAFT plus Aftercare rates were not significantly better than the CRAFT rates.

Conclusions

Given the solid findings of both the CRA and CRAFT studies, one might wonder why the treatments are not more widely known and utilized. Although the CRAFT findings are relatively new and a manual is only recently available (Smith & Meyers, 2004), a CRA treatment manual was published on the basis of strong empirical results years ago (Meyers & Smith, 1995). As noted by Miller and Meyers (2001), the limited adoption of CRA is probably the result of a number of factors: the conviction of many clinicians that they are already “doing CRA” since they use several (isolated) behavioral techniques, the perhaps unappealing high energy level required of CRA therapists, and the emphasis on social reinforcement contingencies that is not particularly popular in many alcohol programs in the United States. Nevertheless, one would expect that if “the word gets out” about the efficacy of CRA and CRAFT, then clinicians who are reinforced by seeing their clients obtain positive outcomes would be interested in incorporating these treatments into their therapy repertoire.

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