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**Aboriginal-specific Community Reinforcement  
Approach (CRA) Training Manual**

**NDARC Technical Report No. 326**



# Reducing substance misuse

Community Reinforcement Approach (CRA)  
Training Manual



The Lyndon Community



# **Aboriginal-specific Community Reinforcement Approach (CRA) Training Manual**

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Anthony P. Shakeshaft**

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## **Table of Contents**

|  |           |
|--|-----------|
| <b>Introduction.....</b>                                   | <b>2</b>  |
| <b>About This CRA Manual.....</b>                          | <b>2</b>  |
| <b>How To Use This Manual .....</b>                        | <b>3</b>  |
| <b>Section 1: Introduction to CRAFT .....</b>              | <b>6</b>  |
| <b>Section 2: CRAFT in Communities .....</b>               | <b>12</b> |
| <b>Section 3: CRA Strategies.....</b>                      | <b>16</b> |
| <b>Suggested CRA Session Plan .....</b>                    | <b>17</b> |
| <b>Section 4: Glossary.....</b>                            | <b>60</b> |
| <b>APPENDIX 1: SAMPLE CRA SESSION PLAN .....</b>           | <b>66</b> |
| <b>Section 5: Some Useful Resources and Contacts .....</b> | <b>70</b> |

## **Introduction**

There is substantial evidence that Indigenous Australians are more likely to drink alcohol at risky levels and to suffer a higher burden of physical, social and psychological alcohol-related harms than other Australians. For example research shows that Indigenous people are admitted to hospital at higher rates for alcohol related conditions such as acute intoxication, liver disease, and dependence, while communities experience more alcohol related social problems such as family violence and incarceration.

At the same time, there is little evidence to show which strategies might work best to reduce these harms. In trying to change this situation UNSW is working with a number of community health organisations to trial and evaluate a comprehensive family based approach for alcohol problems adapted for use with Indigenous people. Called Community Reinforcement and Family Training (CRAFT), this approach has already been used in a number of settings with different population groups. The approach includes two components; the Community Reinforcement Approach (CRA) for working with individuals who are at risk of alcohol related harm and Family Training (CRAFT) for working with their families and loved ones. Evaluations suggest this two-sided approach is more effective for encouraging individuals into alcohol treatment and for assisting family members to feel less depressed, anxious and angry. Most importantly CRAFT appears to fit well with Indigenous views of health and health care that are holistic and dedicated to ‘... the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community’ (NACCHO 2006).

There are two manuals that each describe the components of the CRAFT approach. One manual describes the Community Reinforcement Approach (CRA) while the other describes Family Training (CRAFT). This manual is about CRA. It provides Workers with a step by step guide to using CRA with individuals assessed as at risk for alcohol related harm. The CRAFT manual is for assisting families and loved ones who are affected by their relative’s alcohol use

## **About This CRA Manual**

The Community Reinforcement Approach (CRA) as it is described in this manual has been adapted from a comprehensive explanation as published in Meyers and Smith (1995) *Clinical Guide to Alcohol Treatment: The Community Reinforcement Approach*. This adapted CRA manual is designed for Indigenous Health and Family Workers<sup>1</sup> and other Workers within Australian Indigenous community settings to support people who are at risk for alcohol related harm. It is likely that Workers using this manual will have a variety of qualifications. Consequently some will have more knowledge and experience of alcohol related issues than others, including an understanding of the information in this manual. Some may also have completed the CRAFT training workshop conducted by Dr Robert Meyers in Orange in May 2011. But it is the view of the project team that this manual should take an equitable approach to ensure all Workers are similarly equipped with the specialist skills and knowledge they need to confidently use CRAFT

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<sup>1</sup> In this manual the term *Indigenous Health and Family Workers* and other generalist and specialist Indigenous Workers will hereafter be referred to as *workers*.

with Indigenous people. For this reason the manual acknowledges the range of existing skills and knowledge that Workers might bring to this field. It also recognises the useful resources that already address alcohol issues as they affect Indigenous communities and does not attempt to duplicate them. Rather the manual focuses on information specific to the CRAFT approach as it might be used and adapted by all Workers who provide health care to Indigenous people. The manual is written in plain English but uses technical and specialist terms when necessary. Detailed explanations and a glossary of terms and acronyms aim to ensure meanings are clear.

The manual has five sections as follows:

**Section 1** outlines CRA's structured approach to assist people who misuse alcohol and to help their families. It includes a brief overview of some of the research evidence showing that CRA strategies are more effective than others.

**Section 2** describes the physical and social alcohol related harms that affect individuals who drink and their families and communities. It also describes how CRA fits in with Indigenous health service provision and a holistic approach to health care, primary health care (PHC) and community development. The section concludes by describing the individual and team roles of health practitioners, families and the community in CRA.

**Section 3** explains the CRA strategies for one on one use with individual clients who have been identified being at risk of alcohol related harm. The information in this section is based on the understanding that clients will participate in a series of treatment sessions. The section therefore outlines the procedures and steps that Workers can take to implement CRA with clients in these sessions. The section includes descriptions and explanations about how to:

- use the CRA screening tools to assess a client's alcohol use and the effects of this use;
- use motivational interviewing to conduct an extended brief intervention;
- implement sobriety sampling;
- implement CRA treatment
- plan and implement skills training to meet each client's needs

**Section 4** is a glossary that lists and explains useful technical terms and concepts used to talk about alcohol in health service settings.

**Section 5** lists helpful contacts and additional resources to support the delivery of CRA.

## How To Use This Manual

There are a number of ways to use this manual. For experienced Workers it can be used to refresh, reflect on and extend existing skills and knowledge about alcohol dependence and the strategies used in the CRA approach. For those with less experience it provides both theoretical and practical information about alcohol addiction and a detailed explanation of CRA. This includes a step by step guide that shows Workers how to plan and implement the CRA procedures one on one with individual clients.

All Workers who use the manual will find that it reinforces information learnt in the CRA and CRAFT training workshop. It may also be useful for stimulating new ideas and/or supporting the adaption of existing strategies to fit with the CRA & CRAFT approach.

The information in this manual is designed to offer Workers some flexibility. This means users can choose individual sections for use according to their needs and those of their clients.



## Section 1: Introduction to CRA

This section includes information about:

- the definition of Community Reinforcement (CRA)
- research evidence for CRAFT
- the CRAFT research project
- conditions for participation in CRAFT

### **Leah's Story**

Leah is at her wits end. She has lost count of how many times she has tried to persuade her 18 year old son Jason that he should go to the Drug and Alcohol Centre to get support for his out of control drinking. Leah has tried talking, getting angry and even pleading with Jason to understand how much damage he is doing to himself and to his family. Jason's grandmother and aunties have also tried. But Jason thinks it is his legal right to drink as much as he likes, especially on weekends when he can spend Friday and Saturday nights with his mates drinking at different clubs in town. He also thinks that because he is still going to footy training every week that his drinking is not having a bad effect on his health. Anyway, as Jason tells his mother, at the weekend he has access to his father's car and the beer is cheap, so its only fair that he and his mates should be able to charge up, hang out and have a good time.

Leah sees things differently and has noticed Jason is becoming aggressive and his behaviour unpredictable, so much so that when she recently caught him taking money from her wallet he threatened to hit her. These days Jason is also more, secretive and distancing himself from his sisters and brothers.

The situation is making Leah so sad and angry she is thinking of telling Jason to move out of the house. She feels really bad about this but doesn't know what else to do or who to turn to.

### **1.1 What is CRA & CRAFT?**

Community Reinforcement and Family Training, or CRAFT as it is known, is a structured but flexible approach to support people who are adversely affected by alcohol. This includes:

- people such as Jason who are at risk of harm as a result of their patterns or unhealthy levels of drinking,
- and
- family members such as Leah, other relatives such as Jason's grandmother and aunties, loved ones or close friends

To ensure that both groups of people receive the support they need, CRAFT has two components. These are:

1. Community Reinforcement (CRA) for individuals whose drinking impacts on their health
2. Family Training (CRAFT) for the families and friends of people who drink

Both the CRA and CRAFT use strategies and procedures that aim to:

- remove positive rewards for drinking;
- strengthen positive rewards for abstinence (not drinking);
- encourage the participation and wellbeing of family, friends and other relatives.

In general these strategies and procedures are based on **changing the way people think about and behave** towards alcohol and those who misuse it. In technical terms, this focus on changing people's behaviour is a type of 'cognitive-behavioural therapy' or CBT. The CRAFT strategies and procedures focus on supporting and encouraging people to consider their personal lives and environment and to use positive aspects of these to improve their health and wellbeing. This includes teaching people the skills they need to achieve this.

Relating the CRAFT approach to Leah's story we can see that the CRA component would be useful for supporting Jason to:

- think about his drinking behaviour and its negative health impact
- learn how to strengthen the positive parts of his life that could assist him to reinforce his non-drinking behaviour.

We can also see that the CRAFT component could help Leah, and others in Jason's family to:

- think about how they can support Jason to enter treatment for his alcohol use
- learn the skills they might need to strengthen their own wellbeing.

An important advantage of CRAFT is that it is a standardised approach with set procedures, but is also flexible so it can be adapted to people's personal stories and individual needs. This includes taking more or less time to assist people to achieve their goals.

The following section explains the CRA approach in more detail.

## 1.2 What is CRA?

The Community Reinforcement Approach or CRA is for people who:

*'feel a strong need to drink so that drinking is given priority over other behaviours that they had previously found much more important. This will include people whose dependence on alcohol may range from mild to severe. People with severe dependence drink regularly at high-risk levels, often find it hard to limit how much they drink, and generally have marked tolerance to the effects of alcohol.'* (2009 NHMRC Australian Guidelines to Reduce Health Risks from Drinking Alcohol)

This means CRA is for anybody whose alcohol consumption has resulted in:

- diseases such as cardiovascular, cancer, diabetes, liver disease, mental health conditions, foetal alcohol syndrome, malnutrition, obesity

and/or

- alcohol related injury such as assault, vehicle accident, drowning, violence, sports injury, falls, recreational injury, self-harm, poisoning.

and/or

- social problems such as relationship difficulties, family problems, time off work and money troubles.

The main goal of CRA is to help people whose alcohol consumption is impacting on their health and wellbeing to ‘discover and adopt a pleasurable and healthy lifestyle that is more rewarding than a lifestyle filled with using alcohol or drugs’ (Meyers, Roozen Smith 2011). The approach focuses on **the elimination of positive reinforcement for drinking**, and **enhancing positive reinforcement for reduction or abstinence**. If we apply CRA to Jason’s story described earlier, we can see that if Jason did not have such easy access to his father’s car on the weekends and if his football was used as a positive reinforcement then perhaps his alcohol use and alcohol related behaviour would decrease.

### **1.3 What is CRAFT?**

The CRAFT part of the approach is designed for the families, loved ones and close friends of individuals who are alcohol dependent or whose alcohol consumption results in problems. Family Training is described in detail in the CRAFT manual, but is outlined here to ensure Workers recognise the relationship between CRA and CRAFT.

CRAFT has three main goals:

1. to assist families/ friends to get their alcohol dependent relative into treatment
2. to support families/ friends to provide their relative with social support to promote positive behaviour change and decrease their alcohol use
3. to promote health and wellbeing of families/ close friends through reducing the negative impact their relative’s drinking is having on their health

There are a number of advantages to CRAFT that make it equally as important as CRA. Firstly, CRAFT prioritises and addresses the emotional and social wellbeing of family and friends because it is often as much at risk as that of the person who misuses alcohol. Secondly, CRAFT acknowledges that families can influence how their relative uses alcohol. Thirdly, CRAFT includes skills training to increase the knowledge and skills of families who are caring for a relative who is alcohol dependent. This training ensuring that families are better equipped to deal with issues as they may arise. Finally, CRAFT is designed to help improve outcomes for families who may also drink by assisting them to reduce the negative effects of their own alcohol use.

There are also advantages for Workers using CRAFT. For example, CRAFT sessions provide Workers with an opportunity to get to know each family and their needs. This in turn means Workers are better able to develop trusting relationships and teach families the skills and knowledge they require to assist their relatives who drink. Training sessions are also an opportunity for Workers to motivate families and share the care and support that their alcohol dependent relative requires.

Applying CRAFT to the case study at the beginning of this section, it’s possible to see that Leah and Jason’s aunties could benefit from CRAFT. For example, their participation in CRAFT might assist them to change their behaviour by not confronting Jason and finding more positive ways to talk to him. If this was achieved it might improve family communication and reduced family conflict. This in turn could benefit the whole family including Leah as well as Jason’s grandmother and aunties. It might also motivate Jason to reconsider the effects of his drinking behaviour.

#### **1.4 Evidence for CRA & CRAFT**

Although Aboriginal populations in Australia generally suffer much more from the physical, social and psychological harms caused by alcohol, there is little reliable research evidence to show which are the best ways to reduce such harms. While research conducted in Aboriginal communities has mainly evaluated individual (e.g. education), and community-based (e.g. supply reduction) interventions, other research has shown that the way people use alcohol is commonly influenced and reinforced by different factors within the family. This is particularly relevant to Aboriginal communities where family relationships have a central role in defining their member's identity (Memmot, Long Thompson 2006), maintaining their sense of connectedness to kinship and in protecting family wellbeing. As a result, CRAFT's two-pronged approach to strengthen families and support individual drinkers to quit drinking, may be more effective for use with Aboriginal communities.

CRAFT is well supported by international research which has compared it to other approaches such as Alcoholics Anonymous (AA) to show it is more effective for encouraging alcohol dependent people to enter and commit to treatment and for improving the overall functioning of families. Research also shows CRAFT works well in a range of settings with diverse populations for example: inpatients and outpatients, culturally diverse groups, those refusing to seek treatment for substance abuse and homeless people (Smith, Meyers, Miller 2001). In addition, other studies that evaluated individual components of CRAFT reported advantages on at least some outcome measures. For example, CRAFT was significantly better at engaging resistant problem drinkers into treatment within the 6 months following the intervention which in turn lessened the physical and psychological symptoms experienced by family members (Copello, Velleman, Templeton 2005). An equally important outcome was that family members participating in CRAFT also experienced direct and personal benefits whether or not their relatives did or did not enter treatment.

#### **The Community Reinforcement Approach (CRA) for Aboriginal Australians in Rural New South Wales (NSW)**

A survey of 116 Aboriginal people recruited through an Aboriginal Community Controlled Health Service (ACCHS) or drug and alcohol treatment agency in rural New South Wales asked about the Community Reinforcement Approach (CRA). Of those surveyed, 95% indicated that CRA was acceptable for delivery in their local community. Participants expressed a preference for counsellors they knew and trusted, and who had experience working in their local community. CRA was deemed most acceptable for delivery to individuals after withdrawal (Calabria et al., 2013). CRA was tailored for Aboriginal Australians using information collected by this survey and from meetings and interviews with health care providers who would deliver the interventions (Calabria et al., submitted). At the time this manual was published outcome data was being collected from participants who were taking part in CRA with the aim of investigating the impact of CRA on participants' alcohol and drug use, psychological distress, and social and emotional wellbeing.

## Notes Page

On this page make notes, record your thoughts, ideas or any questions you might have about Section 1 that you would like to share with your team.



## **Section 2: CRA in Communities**

This section begins with a brief overview of the effects of alcohol on individuals, their families and communities. It includes an outline of principles at the heart of many Indigenous health interventions including CRA. The section finishes with a description of the roles of health practitioners who may deliver CRA and focuses in particular on the role of Aboriginal Alcohol and Drug<sup>2</sup> and Health and Family Workers.

### **2.1 Understanding alcohol related harms**

Drinking alcohol at risky and high-risk levels results in short and long term physical, psychological and social harms that affects the health and wellbeing of individuals, families and communities.

#### **Physical Effects**

People who drink alcohol where the ‘risk of harm is significantly increased beyond any possible health benefits’ (Australian alcohol guidelines: Health risks and benefits NHMRC 2001) may experience a range of negative physical effects.

These may include for example:

- altered brain function e.g: mood swings, memory loss, seizures, dementia
- gastrointestinal disease;
- liver disease (cirrhosis, cancer);
- cardiovascular disease (weakening of heart muscle, heart failure, arrhythmias, high blood pressure, ischaemia, myocardial infarction);
- peripheral vascular disease (poor blood circulation to the lower parts of the body e.g. legs and arms) ;
- cancers;
- diabetes;
- anaemia (shortage of red blood cells, which can lead to weakness, breathlessness and low levels of energy);
- osteoporosis (fragile, weak bones);
- gout (inflamed joints, particularly feet);
- Foetal Alcohol Syndrome (a disorder affecting the foetus that is caused by alcohol );
- accidents, injuries and/or death.

#### **Psychological Effects**

As well as having an impact on physical health, alcohol use also impacts on people’s psychological wellbeing. For example some people may use it to feel relaxed, confident and less inhibited in social situations. Others however use it as a self-medication to cope with their distress, emotional

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<sup>2</sup> Referred to hereafter as *Workers*

and/or physical pain or symptoms of mental health problems e.g. depression, anxiety, hallucinations, agitation or panic. Regardless of the reasons why people use alcohol, the problem is that when they do drink at risky and high risk levels they are likely to make their symptoms and/or illnesses worse. For example the heavy use of alcohol has a mood depressant effect that can make the symptoms of clinical depression worse or bring on a depression like condition (Alcohol Treatment Guidelines for Indigenous Australians p11.137). In addition heavy alcohol use and depression are also associated with a higher risk of suicide. (Gordon 2008 p 21). This may be a particularly important point considering suicide rates among Australian Indigenous people are greater than for the whole population. (SCRGP 2009 p 7.65) There is also a relationship between high risk drinking and anxiety, with both worsening each other (Brady, Tolliver Verduin 2007 p 762).

### **Social Effects**

Individual alcohol consumption also impacts on the social wellbeing of families, loved ones and friends. This is especially the case in Indigenous communities where families have close ties and the effects are more likely to take a wider toll and influence the overall functioning of the whole community.

In a number of Indigenous communities the excessive use of alcohol by some people may cause social disruption. This is evident in reports of higher rates of family stress, time off work and school, social withdrawal, harmful behaviour, money troubles, community disturbances, increased risk of injury, violence, trauma, motor vehicle accidents, incarceration, and loss of self esteem (Kelly, Kowalszyn 2003, p 761-767).

The CRAFT approach acknowledges that assisting families and friends to strengthen their social and emotional wellbeing is just as important as supporting relatives to address their alcohol use. Therefore a primary focus of CRAFT is to teach families the skills and knowledge they need to improve their own lives as well as that of their relatives who drink.

### **Short and Long Term Effects**

The physical, psychological and social effects of drinking alcohol at risky and high-risk levels maybe short or long term. These are outlined in brief below. A more detailed description can be found in the Alcohol Treatment Guidelines for Indigenous Australians (Department of Health and Ageing 2007) and available for download at:

<http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/AGI02>

### **Short term effects**

For individuals the short term physical and psychological effects of increasing blood alcohol concentration depend on a number of factors such as:

- the type and quantity of alcohol consumed
- age, weight and gender
- body chemistry
- whether a person has food in their stomach
- drinking experience and tolerance for alcohol
- the situation in which drinking occurs

- whether a person has existing health problems
- is taking certain medications
- and/or is undergoing other medical treatments

Regardless of these factors however, it is always the case that drinking alcohol above recommended levels, will increase the risk of harm and make any existing conditions worse. The Alcohol Treatment Guidelines for Indigenous Australians (2007) is a helpful resource for Workers. It classifies the likely primary effects of alcohol on a non-dependent drinker according to a number of stages as follows:

- **Feelings of wellbeing** that may result in a person becoming more talkative, relaxed, confident.
- **Risky state:** where a person's attention, judgement and movement become weakened and their shyness is reduced
- **Dangerous state:** that results in slurred speech, a lack of coordination and balance, slowed reflexes, weakened visual attention, unstable emotions, nausea and vomiting.
- **Stupor:** when a person can no longer stand or walk without help, feels sleepy, has difficulty breathing, cannot control their bladder and becomes unconscious
- **Death:** which may follow coma, and shock.

Detailed information about how to manage someone experiencing an overdose of alcohol which may be life threatening is described in Part II: Clinical Management of Alcohol Problems – Tool Kit of the Department of Health's Alcohol Treatment Guidelines for Indigenous Australians.

### **Long term effects**

The long term physical and psychological effects of alcohol also impact on individuals and families in different ways. The following descriptions of the long term effects of alcohol consumption provide a broad overview only. More complete information can be found in sources listed in Section 6 at the end of this manual.

## **2.2 Principles of CRA for Indigenous communities**

The CRA approach for managing the effects of alcohol in Aboriginal communities has been designed with three key principles in mind. These are:

1. A holistic approach
2. Primary Health Care
3. Community Development

### **1. Holistic approach**

The term 'holistic' is commonly used to describe Indigenous health and health care. It is best understood through the National Aboriginal Health Strategy's definition of "not just the physical well-being of the individual, but the social, emotional and cultural well-being of the whole community. This is a whole of life view and it includes the cyclical concept of life-death-life' (National Aboriginal Health Strategy Working Party 1989).

Indigenous people's holistic understanding of health fits well with the CRAFT approach. Firstly because the approach views alcohol related harm not just as a problem for the individual drinker, but also for all those people with whom they share their lives. Secondly, because CRAFT strategies are directed at reinforcing the positive aspects of the lives of both the individual drinker and their families, friends and relatives. This includes addressing people's whole environment (family, social, recreational, work) rather than just selective components of it.

## **2. Primary Health Care**

Primary Health Care (PHC) was first defined by the World Health Organisation (WHO) in 1978 as: '... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community...'

To achieve the above, PHC activities work to promote health, prevent ill health, treat illness/disease and rehabilitate people to reduce the long term effects or complications of illness/disease.

This means that Primary Health Care activities are those that:

- people and communities can access and afford
- encourage everyone in the community to participate so they can look after themselves and each other; and each
- bring the care as close as possible to where people live and work;
- are often the first point of contact that people have with the health care system;
- are offered by different services working together;
- use appropriate health care methods (hospitals, community care, homes)
- are the beginning of a continuing process (WHO 1978.)

Activities and programs that are based on the above ideals are the core business of most Aboriginal community controlled health organisations and other community based health services. The CRA approach to alcohol treatment is an example of such a program that fits well within the PHC framework

## **3. Community Development**

Community development (CD) is a term used to describe strategies that support individuals and communities to acquire the knowledge and skills they need to bring about change in their own communities. These skills are often developed when groups of people work together to raise awareness about certain issues and to achieve a common goal. Community development (CD) goes hand in hand with PHC because it is based on many of the same principles for example: fairness, equality, responsibility, opportunity, choice, participation, advocacy, reciprocity and continuous learning.

A number of CD strategies are used in the CRA approach. One strategy is the training workshops that teach people the skills they need to restructure their lives and change their drinking behaviour so they can achieve a healthier lifestyle. Another is the collaboration that is encouraged and which aims to get between services and families working together at the local level.

## Section 3: CRA Strategies

This section gives a detailed description of the specialised CRA procedures that Workers can use with individual clients identified as alcohol dependent or high-risk drinkers. These procedures are for use in one-on-one sessions in community health service settings. As each client will have their own unique needs, Workers can pick and choose which procedures will best match these needs. However, in the first session Workers will need complete certain baseline procedures. These will assist Workers to:

1. Identify and enhance the client's motivation for change
2. Gather background and basic alcohol use information
3. Conduct the CRA Functional Analysis for Drinking

Having collected this information Workers can then develop a treatment plan suited to the needs of the client. This plan which will be implemented in the remaining sessions may utilise some or all of the other CRA procedures.

### 3.1 What are the CRA procedures?

The CRA procedures which assist Workers to assess, motivate and treat clients, can be undertaken over a series of sessions. The first session may be the most critical as it is likely to influence whether or not the client chooses to return to subsequent sessions.

In this session the first step is for Workers to screen all clients using the **CRA Survey**. The second step entails interviewing clients using the **Functional Analysis of Drinking** procedure to find out about their drinking and its consequences. While the third step consists of a brief intervention using motivational interviewing to counsel clients and get them thinking about changing their drinking behaviour so as to improve their health (Meyers & Smith 1995). In following sessions Workers can then draw on a variety of the other CRA procedures. These might include the use of:

- **Sobriety Sampling** for persuading people to commit to a period of non-drinking;
- **Happiness Scale** to assist clients to identify specific areas of their life they want to change;
- **Goals for Counselling** which enables clients to set goals and plan ways to achieve them.

Other CRA strategies are:

- Treatment Plan Development
- Skills Training

The following flow chart outlines a possible CRA session plan. Although the session plan is described as a particular sequence, all sessions other than Session 1 can be adapted to meet the individual needs of clients and health services.

## Suggested CRA Session Plan

### **SESSION 1: SCREENING ASSESSMENT, FUNCTIONAL ANALYSIS & BRIEF INTERVENTION (BI) USING MOTIVATIONAL INTERVIEWING**

Assess: Severity of alcohol dependence using AUDIT, GEM, K5

FA Phase 1: Functional Analysis (FA) of Drinking:

Triggers for drinking

Link triggers to initial screening

Short term positive & long term negative consequences of drinking

FA Phase 2: Functional Analysis (FA) of Non- drinking

Triggers for non-drinking

Short term negative & long term positive consequences of non-drinking

Brief intervention using Motivational interviewing to change behaviour



### **SESSIONS 2 -8: SOBRIETY SAMPLING**

Phase 1: Persuading the client to agree to a trial period of non-drinking, which may or may include attendance at an alcohol withdrawal facility.

Phase 2: Planning for a trial period of non-drinking



### **CRA TREATMENT PLAN**

Phase 1: Happiness Scale

Phase 2: Goals for Counseling



### **SKILLS TRAINING**

Communication Skills, Problem Solving, Drink refusal, Duration training, Independence training, Social & Recreational counseling

### **3.2 Session 1: CRA Screening Assessment, Functional Analysis and Brief Intervention using Motivational Interviewing**

The first CRA session is possibly the most critical and intensive. It is during this session that Workers will be aiming to make the most of the time they have with the client regardless of whether the client is motivated to change their drinking behaviour or returns for a second CRA session.

The first session therefore involves the following procedures:

- **CRA Survey** to gather information from the client and assess their alcohol use and psychological wellbeing,

- **Functional analysis** of the client's drinking make an accurate and holistic assessment of factors that reinforce or reward client's drinking and non-drinking behaviour and the consequences of this behaviour;
- **Brief intervention (BI)** using motivational interviewing to encourage every client to take a step, no matter how small, towards changing their alcohol use.

It is the case that some clients may elect to withdraw after Session 1.

Before Workers begin the first CRA session, they first need to:

- consider how to motivate clients to get them thinking about their drinking
- what clients think of as 'rewards' or 'reinforcements' for drinking or non-drinking behaviour

Client motivation and reinforcements for drinking behaviour are described below.

### **Understanding client motivation**

At the heart of CRA is the belief that 'people will be motivated to change their substance abusing behaviour if they are reinforced (rewarded) in doing so' (Meyers, Smith 1995 p 17). A person's level of motivation to do something about their alcohol use is often at its highest when they have been involved in some sort of crisis. The Community Reinforcement Approach recommends taking advantage of the client's motivation during crises so that during the CRA assessment process Workers:

- schedule the first few CRA sessions as close together as possible
- show a positive attitude
- show respect
- replace negative terms such as alcoholic with 'alcohol related problems'
- set positive treatment outcomes , eg: discuss the negative consequences of drinking but emphasize possible solutions
- show clients that CRA works to motivate and reinforce healthy behaviour
- where possible involve another family member, relative or friend in the CRA process to support the client through the treatment process

### **Reinforcement for drinking or non-drinking behaviour**

Another key idea in CRA is that people who drink do so because it 'performs a survival function' by helping them to cover up or cope with their anxiety, depression or unhappy relationships (Meyers, Smith 1995 p 20). To understand each client's situation the CRA assessment focuses on identifying what reinforces their non-drinking or drinking behaviour. Reinforcers might be positive or negative.

**Positive reinforcers** are **fulfilling/enjoyable** things that motivate a person to **choose healthy non-drinking behaviour**. Some examples of common positive reinforcers might be:

- spending quality time with family
- having enough money to go on holidays
- having time to participate in recreational activities
- enrolling in a course

**Negative reinforcers** are **unpleasant/disagreeable** things that motivate a person to **avoid unhealthy drinking behaviour**. Some examples of common negative reinforcers might be:

- threats from probation and parole
- loss of income
- loss of time to spend participating in recreational activities
- threatened loss of a job or study

Once the positive and negative reinforces that influence a client's behaviour have been identified Workers can then use them to motivate the person to choose healthy (non-drinking) over unhealthy behaviour (drinking).

### Reflection Activity

Read the following story about Brian and identify the positive and negative reinforcers that influence his drinking behaviour and that Workers could then use to motivate him to think about choosing non-drinking rather than drinking behaviour.

#### Brian's Story

Brian separated from his wife Gail and two young children after he was released from jail. Brian now has access visits every second weekend when he takes his children to visit his parents and their cousins who live on a property about 50 kms out of town. The children love these visits because they spend time with their grandparents, swim in the river and go fishing with their father. The visits also make Brian feel really happy so he has been talking to Gail about seeing the children more often. But on his recent access visits he has been leaving his children with his parents then returning to town to drink all night with friends. The family has noticed that when Brian returns from these drinking bouts he is short tempered and verbally abusive. This behaviour scares Brian's children and his parents, but he says it doesn't mean anything. Brian's family have been so concerned they have asked Gail to stop the children's visits. Gail has threatened to tell Brian's probation officer but has also told Brian his access visits could restart and even be increased if he stopped drinking and got help.

Brian's story shows how much he enjoys weekends with his children, parents and extended family and how happy he is relaxing and sharing healthy activities (spending time with family, swimming, fishing). It is only when Brian drinks heavily that he behaves aggressively and that Gail makes threats to tell probation and stop Brian from seeing his children.

According to the CRA approach, **the time Brian spends with his children and family** is a **positive reinforcer** because he enjoys it. This enjoyment can be used to motivate Brian to choose healthy non drinking behaviour.

In contrast, **Gail's threat to tell Brian's probation officer** is a **negative reinforcer** because Brian perceives it as unpleasant. Brian's desire to avoid this unpleasantness could be enough to motivate him to stop his unhealthy drinking behaviour.

In the story above the worker can identify the positive and negative reinforcers to remind Brian why he has sought treatment and to boost his motivation.

### **CRA Survey and Screening Assessment**

In session 1 Workers will review each client's:

1. level of dependence on alcohol
2. level of motivation to change their behaviour

Each of these is discussed below.

#### **Assessing Alcohol Use**

Screening people to assess their patterns and level of alcohol use is the responsibility of all trained Workers and a part of routine care for Indigenous families and communities. It is an important beginning step in the first CRA session that includes the accurate identification of all health issues that may be associated with the client's alcohol use. Screening for alcohol enables Workers to develop effective, treatment and or referral plans of action that meet the individual needs of all clients.

To achieve an accurate understanding of an individual's alcohol use a number of different screening tools have been developed. These tools have been scientifically **validated**. This means they have been tested in strict conditions to make sure they work effectively and accurately.

The screening tools and procedures that Workers use will depend on the circumstances of each client. However a universal consideration that applies to all clients is described in the Alcohol Guidelines for Indigenous Australians (2007). These guidelines point out that:

*It is only appropriate to screen for alcohol-related problems when the client is able to understand and respond effectively. It is not appropriate if they are intoxicated, injured or acutely ill.* (Alcohol Guidelines for Indigenous Australians p11.62)

Other considerations that influence which screening tools Workers choose to use with clients are those such as :

- the complexity of the tool and how long it takes to use;
- how much time Workers have to spend with the client;
- the skills and knowledge Workers need to confidently use the screening tool;
- whether the health service has a preference for using a specific tool.

Alcohol screening tools that are suitable for use with CRA are: AUDIT, AUDIT C. Each of these tools is explained in detail in the *Alcohol Guidelines for Indigenous Australians in Section 3, General Care* p11.62 – 11.67.

To make screening easy these guidelines also include a useful desk top tool card with the AUDIT and AUDIT C questions

The AUDIT and AUDIT C screening assessments are summarised below.

## AUDIT

The term AUDIT stands for the Alcohol Use Disorders Identification Test. This test is a health assessment questionnaire used by health practitioners to screen people for hazardous and harmful alcohol consumption. The questionnaire can also be used by individuals themselves to assess their own drinking. The screening consists of ten questions that ask a person about:

- **how often** they drink alcohol (frequency);
- **how much** they drink (quantity);
- **the consequences** of their drinking, for example having feelings of guilt or remorse, causing harm to others and/or being told by others that they should cut down.

The following Table 3.1 outlines the ten AUDIT interview questions.

**Table 3.1: AUDIT.**

| AUDIT   | Score  |                   |                               |                  |                           |
|---|--------|-------------------|-------------------------------|------------------|---------------------------|
| Questions   | 0      | 1                 | 2                             | 3                | 4                         |
| 1. How often do you have a drink containing alcohol?  | Never  | Monthly or less   | 2-4 times a month             | 2-3 times a week | 4 or more times a week    |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking?                                     | 1 or 2 | 3 or 4            | 5 or 6                        | 7 to 9           | 10 or more                |
| 3. How often do you have six or more drinks on one occasion?  | Never  | Less than monthly | Monthly                       | Weekly           | Daily or almost daily     |
| 4. How often during the last year have you found you were not able to stop drinking once you started?                         | Never  | Less than monthly | Monthly                       | Weekly           | Daily or almost daily     |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking?                | Never  | Less than monthly | Monthly                       | Weekly           | Daily or almost daily     |
| 6. How often during the last year needed a first drink in the morning to get yourself going after a heavy drinking session?   | Never  | Less than monthly | Monthly                       | Weekly           | Daily or almost daily     |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking?                                  | Never  | Less than monthly | Monthly                       | Weekly           | Daily or almost daily     |
| 8. How often during the last year have you been unable to remember what happened the night before because of your drinking?   | Never  | Less than monthly | Monthly                       | Weekly           | Daily or almost daily     |
| 9. Have you or someone else been injured because of your drinking?  | No     |                   | Yes, but not in the last year |                  | Yes, during the last year |
| 10. Has a relative, friend or doctor or other healthcare worker been concerned about your drinking or suggested you cut down? | No     |                   | Yes, but not in the last year |                  | Yes, during the last year |

Completing the questionnaire requires Workers to instruct clients to mark the box that best describes their answer to each question. Each question is worth a score. When the scores are added together the total will give an indication of a person's alcohol dependence. Directions for how to score the questions are as follows:

- Questions 1 to 8 are scored as 0, 1, 2,3 or 4.
- Questions 9 and 10 are scored as 0,2 or 4 only
- The minimum score is 0 (non-drinkers).
- The maximum possible score is 40.
- A score of 8 is associated with risky or high-risk drinking.

As a general guide, a score of 13 or more is likely to indicate alcohol dependence.  
(Babor, Higgins-Biddle, Saunders, Monteiro 2001)

### **AUDIT C**

This screening tool is also used to assess people's alcohol consumption. It differs from AUDIT in that it is a much shorter questionnaire and includes only 3 items. These are the first three questions from the full version of AUDIT. Because the questionnaire is much shorter it is much quicker to administer and therefore may be more convenient and easier to use. The following Table 3.2 includes the three interview questions asked in AUDIT.

**Table 3.2 AUDIT C**

| <b>AUDIT C</b>   | <b>Score</b>     |                   |                   |                  |                        |
|--|------------------|-------------------|-------------------|------------------|------------------------|
|  | <b>Questions</b> | <b>0</b>          | <b>1</b>          | <b>2</b>         | <b>3</b>               |
| 11. How often do you have a drink containing alcohol?                                      | Never            | Monthly or less   | 2-4 times a month | 2-3 times a week | 4 or more times a week |
| 12. How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2           | 3 or 4            | 5 or 6            | 7 to 9           | 10 or more             |
| 13. How often do you have six or more drinks on one occasion?                              | Never            | Less than monthly | Monthly           | Weekly           | Daily or almost daily  |

Source: Alcohol Treatment Guidelines for Indigenous Australians Department of Health and Ageing.

### **Functional Analysis of Drinking**

The Functional Analysis of Drinking procedure used in Session 1 enables Workers to collect additional information about the client's drinking behaviour and to set up a positive, reinforcing environment that will assist the client to remain sober. The functional analysis centres on a semi-structured in-depth interview. The interview has two phases: one phase which is concerned with finding out more detailed information about the client's drinking behaviour and the second which is concerned with finding out about the client's non-drinking behaviour. A possible summary outline of how to schedule Session 1 procedures is provided below.

## Session 1: CRA Survey

Step 1 Administer CRA survey using screening tools e.g. AUDIT or AUDIT C



Step 2 Functional Analysis of Drinking

Introduce and explain CRA Functional Analysis of Drinking

Phase 1: Ask about triggers to drinking questions & record responses

Link above answers to client's AUDIT score

Identify the short term positive and long term negative consequences of a client's drinking behaviour.

Phase 2: Assess client's non-drinking behaviour

Ask about the **positive triggers** of the client's **non-drinking behaviour**

Ask about the **negative and positive consequences** associated with the client's **non-drinking behaviour**

We begin by describing Phase 1 of the Functional Analysis of Drinking. This phase asks the client about:

- what triggers their drinking behaviour
- the short and long term consequences of their drinking behaviour

### CR Functional Analysis Phase 1: Assessing drinking behaviour

#### 1. Triggers to drinking

The first phase of the CRA Functional Analysis of Drinking focuses on the triggers that prompt a client to start drinking. Triggers are the thoughts, feelings, behaviours and/or situations that come before a drinking episode. Triggers may be external or internal. **External triggers** are associated with **who** the client drinks with, as well as **where** and **when** they drink.

For example a client may be more likely to drink if they are with their mates (who), at the football (where) on the weekend (when). **Internal triggers** are associated with what the client is **usually thinking**, and **physically and emotionally feeling** right before they drink. For example a client may be:

- thinking how good it is to not be at work and to be free to drink;
- physically feeling a bit tense in anticipation of who might win or lose the football game;
- emotionally excited as he joins his mates to watch the match.

Another important consideration when talking to a clients about possible triggers for a drinking episode is to acknowledge possible underlying factors that may not be talked about, but which could contribute to a client feeling depressed, anxious or angry and therefore possibly more vulnerable to unhealthy alcohol use . Researchers investigating the use of alcohol in Indigenous communities for example report that basic political and economic inequalities as a result of colonisation and dispossession are key reasons that maybe associated with drinking (Saggers and Gray in Saggers, Gray, Sutore, Bourbon 2000).

The table on the following page provides examples of the functional analysis questions to ask a client about their triggers for drinking. The second column of the table outlines some of the issues that Workers should listen for when they ask each question.

**Table 3.3 Triggers for drinking**

| <b>Questions about external triggers</b>                                | <b>Responses to encourage</b>   |                               |
|---|---|-------------------------------|
| Who are you usually with when you drink?                                | Specific friends or family may be a trigger but clients may not realise this.   |                               |
| Where do you usually drink?   | Particular places that may be higher risk than others, e.g. certain friend's houses, clubs, parks.  |                               |
| When do you usually drink?  | Times that may also be higher risk, eg. weekends, Friday night  |                               |
| <b>Questions about internal triggers</b>                                |   | <b>Responses to encourage</b> |
| Right before you drink, what are you usually thinking about?            | Encourage as many thoughts as possible to show the client that drinking is a deliberate thought process not an automatic or accidental one. A client's thoughts give clues about how they explain their drinking to themselves and about how they feel. |                               |
| Right before you drink, what are you usually feeling physically?        | Physical feelings are often linked to emotions. If a client states that they often have a headache before they drink this might be a clue that they are also feeling anxious or afraid when they decide to start drinking.                              |                               |
| Right before you drink, what are some of your usual emotional feelings? | Clients may be unable to label their feelings. But answers to the previous question can enable HWs to help clients recognise their emotions when they drink.  |                               |

### Activity

Apply a functional analysis to Brian's story, and think about the answers that Brian might give to questions about the external and internal triggers to his drinking behaviour. Use the table below to write the answers in the column on the right.

| <b>Functional analysis of external and internal triggers to drinking</b> |                   |
|--|-------------------|
| Health Worker's questions to Brian                                       | Brian's responses |
| Who are usually with when you drink?                                     |                   |
| Where do you usually drink?  |                   |
| When do you usually drink?   |                   |
| Just before you drink, what are you usually thinking about?              |                   |
| Just before you drink, what are you usually feeling physically?          |                   |
| Just before you drink, what are you usually feeling emotionally?         |                   |

Once Workers have asked about the external and internal triggers to a drinking episode they should refer back to the client's AUDIT assessment. Reviewing the AUDIT score ensures that Workers know how much alcohol the client actually drinks and their level of health risk. This information can then be linked to the client's answers to the 'triggers to drinking' questions.

### **How to start the first phase of the functional analysis interview**

Before Workers start the triggers to drinking questions, they should explain the CRA functional analysis procedure to the client. To assist, Workers can use the CRA Functional Analysis chart for drinking behaviour (see page 38) which outlines the questions in a written format. The chart might help clients to participate fully and focus their attention on each question as it is asked. The chart is also something clients can take home and use at a later time when they might want to reflect further on the questions and their answers.

Workers who are new to the field of drug and alcohol work, may feel unsure about how to kick start a Functional Analysis of Drinking with a client. Similarly some clients may feel uncomfortable about discussing such a sensitive topic and being asked personal questions about their private life. Workers should take time to find out about any health assessments that the client has already completed. This prevents the collection of information that may exist on file and saves the client's and Workers' time. It also shows the client that the service has a genuine interest in providing assistance and connecting with the problem as quickly as possible. Most importantly existing information can assist Workers to motivate the client to share more details about their day to day life.

## Activity

Read the following interaction as the worker introduces the Functional Analysis of Drinking to the client. Thinking about a client you may have dealt with, make up your own case study example. Then, in the space provided try writing how you would talk to a client about the functional analysis.

**Health Worker (HW):** Brian, I have just been looking at the last health assessment you did when you were here in August and you told us that your family was worried about your drinking. Do you remember that?

**Brian (B):** Yeah, sort of.

**HW:** Well, I thought we could spend this session catching up with what's happened since then. We are using a new way of helping people whose drinking might be causing problems. Can I tell you about it?

**B:** I'm not drinking like that anymore.

**HW:** That's good. Can you tell me how you have done that?

**B:** I don't want people riding me about my drinking.

**HW:** I don't want to do that. Is someone riding you about drinking?

**B:** My family, probation officer... They think I have a problem. That's why I have to come here.

**HW:** Sounds like you have a few people on your back. Would you be willing to spend some time working with me to get them off your back?

**B:** And how do you suppose we can do that?

**Worker:** Well, that's what I would like to work on together. We could look at when you're drinking and see what they think the problem is. Because you know yourself and you know all those people riding you a lot better than I do.

**Note:** At this point the HW might consider showing Brian the functional analysis chart

## **2. The short term positive and long term negative consequences of a client's drinking behaviour.**

The next step in phase 1 of the CRA functional analysis assessment follows on immediately after the questions about triggers for drinking. This next step is focused on finding out about the effects a client's drinking has on themselves and others. The information gathered in this part of the interview can be used by Workers to support clients to recognise that their alcohol use has both **short-term positive** and **long-term negative consequences**.

As regards the short term positive consequences, shy people for example may find that alcohol assists them to feel more outgoing in social situations, while people who experience worry or stress may find it helps them to relax and stop thinking about their troubles. Contrastingly, those who are easily bored, might find that alcohol acts as a stimulant or helps to fill in time, whereas for others it can be a reason for bringing people together to share.

However, long-term physical, social and economic negative consequences are much more likely when alcohol use goes unchecked. Common problems associated with excessive alcohol use include for example illness and disease, relationship and/or family breakdowns, violence, and mental health problems. It may also affect work and/or study, lead to financial difficulties and sometimes crime and/or incarceration.

The client's answers to questions about the short-term positive and long-term negative consequences of their alcohol use will assist Workers to build a picture about what exactly is going on for that client when they drink. At all times during these conversations, Workers should use a positive approach and reinforce the client's efforts to answer the questions with as much appropriate detail as possible. They should also emphasise that the positive effects of drinking are usually always short term, whereas the negative effects are always likely to be long term.

Questions about the consequences of drinking are listed in Table 3.4 below. The table includes an outline of what Workers can listen for when they ask each question, including possible links between a client's drinking and other aspects of their life. For example the first question asks the client what they like about drinking with a particular person/people (short term positive consequences). If the client just names the person/people it may not be possible to identify the relationship between this person and the client. Yet the nature of the relationship between the client and their drinking partners might be associated with other parts of the client's drinking behaviour. For this reason it is important for the worker to clarify who the client's drinking partners are. They might do this by asking the client are they a relative, friend, work mate, lover?

**Table 3.4      Consequences of drinking**

| <b>Short term positive consequences</b>   | <b>Worker considerations</b>   |
|---|--|
| 1. What do you like about drinking with ? (who the client usually drinks with)        | Is the drinking partner a relative, friend, work mate, significant other? Are there other links between the client and their drinking partners?                      |
| 2. What do you like about drinking at ... ? (where the client usually drinks)         | Does the venue offer cheap drinks and/or other attractions e.g pokies, TAB, music, quiz nights, dancing? Is the venue easy to get to? Is it the people who go there? |
| 3. What do you like about drinking ? (when the client usually drinks)                 | This will give some indication of how often the client drinks, e.g. is it after work (5 days a week) or only on weekends?  |
| 4. What are some of the enjoyable thoughts you have while you are drinking?           | Responses to this question might indicate underlying issues that have gone unnoticed.  |
| 5. What are some of the enjoyable physical feelings you have while you are drinking?  | Responses to this question could also indicate other issues. For example a client may say 'it makes me forget my worries' ...what worries?                           |
| 6. What are some of the enjoyable emotional feelings you have while you are drinking? | As above.  |

**Long term consequences**

|   |   |
|---|---|
| 1. What are the negative results of your drinking in each of the following areas? <ul style="list-style-type: none"><li>• Interpersonal</li><li>• Physical</li><li>• Emotional</li><li>• Legal</li><li>• Work/Study</li><li>• Financial</li><li>• Other</li></ul> | During this part of the interview Workers need to ensure they are familiar with all of the client's assessment information because it is likely that clients will play down any of the negative consequences of their drinking. It is in this part of the interview that Workers should support the client to see the connections between their alcohol use and its unpleasant and harmful effects. |
|---|---|

### Sample CRA Functional Analysis Form of Drinking

| External Triggers                            | Internal Triggers  | AUDIT/ AUDIT C  | Short-term positive consequences                 | Long-term negative consequences   |
|--|--|---|--|---|
| When you drink<br>who are you usually with   | What are you usually thinking about right before you drink       | How often do you drink?   | What do you like about drinking with ... ? (who) | What are the negative results of your drinking in each of the following areas:  |
| When you drink<br>where do you usually drink | What are you usually feeling physically right before you drink?  | How many drinks containing alcohol do you have on a typical day when you're drinking? | What do you like about drinking ... ? (where)    | <ul style="list-style-type: none"> <li>• interpersonal</li> <li>• physical</li> <li>• emotional</li> <li>• legal</li> <li>• work/study</li> <li>• financial</li> <li>• other</li> </ul> |
| When do you usually drink?                   | What are you usually feeling emotionally right before you drink? | How often do you have six or more drinks on one occasion?                             | What do you like about drinking ... ? (when)     |   |

Adapted from Meyers and Smith 1995. Clinical Guide to Alcohol Treatment: The Community Reinforcement Approach.

## Activity

Read the following case study and think about how you might use the Functional Analysis of Drinking to find out as much as you can about Helen's alcohol use. Then, using the questions in the chart above, write down how you think Helen might answer them.

### Helen's Story

Helen is married, has grown up children and four grandkids she adores spending time with. She works part time as an administrative officer for the local council, a job she really enjoys but which has irregular hours that she finds stressful. Helen has a long standing history of alcohol dependence but restricts her drinking to when she goes to the club for a couple of hours every day after work. It was on one of these occasions when driving home that she was charged with being over the limit. Because this was Helen's second DUI in the last 3 years she has to attend an alcohol treatment program. Bill, Helen's husband is really fed up and has threatened to leave her but is feeling guilty because she has had two alcohol related hospital admissions for liver problems and was off work for six weeks. Helen's boss has also warned her that her employment at the council is at risk. Helen's children have tried to be understanding but now they are also frustrated and angry with their mother's reckless behaviour. Together they have decided to stop showing Helen any sympathy and have also told her they will not visit her with her grandchildren until she does something about her drinking. This situation has made Helen feel that it doesn't matter what she does, she doesn't care and nobody understands her.

### CR Functional Analysis Phase 2: Assessing non-drinking behaviour

The next phase of the CRA functional analysis deals with the **positive triggers** and the **negative and positive consequences** associated with the client's **non-drinking behaviour**. The purpose of this second phase is to help people think about what they enjoy in their lives that doesn't involve alcohol. Helping people to think about the pleasurable activities in their lives can provide Workers with a way to motivate them.

The beginning of this phase deals with the **positive triggers for non-drinking behaviour**. In Helen's story above for example, we can see there are at least 2 positive triggers for her non-drinking behaviour. These are her grandchildren and work at the council. Workers assisting Helen, can work with these positive triggers to encourage her to think about how she can strengthen or extend them so they become a motivation to quit drinking.

Sometimes however there are also **negative consequences** associated with the non-drinking pleasurable activities. The problem with negative consequences is that they can discourage people from strengthening those activities in their lives that they find enjoyable. For this reason the next part of the CR functional analysis focuses on the associated negative consequences. Once these negatives have been identified Workers can assist clients to think about ways to tackle them. In Helen's story for example we know she enjoys her job (positive trigger) but finds the irregular hours stressful (negative consequence). It is possible that this stress is preventing her from thinking about solutions to her work situation, while it might also contribute to her alcohol use. In Helen's case this might mean that the worker encourages her to think about requesting more regular hours of work to reduce her stress, which in turn might help her to cut back her drinking.

The CRA functional analysis in this second phase also asks clients about the **positive consequences of their non-drinking behaviour**. The positive consequences can be used as positive reinforcers or rewards to motivate clients to replace their drinking behaviour with healthy non drinking behaviour. If we consider Helen's story again we know that she doesn't drink when she spends

time with her grandchildren. We also know that this time is enjoyable. This means that Helen's time with her grandchildren is a positive reinforcement that could help to motivate her to stop drinking.

This part of the CRA Functional Analysis of Non- drinking uses a question format similar to that used earlier in phase 1, but this time asks the client about their non- drinking behaviour.

The table on the following page outlines each question in the CRA Functional Analysis for Non drinking Behaviour. To show how the table might be used with a client, the table includes the answers that Helen might give.

Completed sample CRA Functional Analysis Assessment Form of Non-drinking Behaviour (adapted from Smith and Meyers 2004)

| External Triggers   | Internal Triggers  | Behaviour  | Short-term negative consequences  | Long-term positive consequences   |
|---|--|--|---|---|
| Who are you usually with when you <u>see your grandchildren?</u> (behaviour/activity)<br>With Bill. | What are you usually thinking about right before you <u>see your grandchildren?</u> (behaviour/activity)<br>Looking forward to doing something with them like going to the park. | What is the non drinking behaviour/activity?<br>Seeing the grandchildren   | What do you dislike about <u>seeing your grandchildren</u> (behaviour/activity) with Bill (who)?<br>He's such a good man, it makes me feel guilty.<br>What do you dislike about <u>seeing your grandchildren</u> at your home?(where)<br>Sometimes its boring for them.<br>What do you dislike about <u>seeing your grandchildren at weekends?</u><br>Sometimes I have to work and then I miss out on them.   | What are the positive results of <u>seeing your grandchildren</u> in each of the following areas:<br><b>interpersonal</b><br>it helps keep the family together<br><b>physical</b><br>I get more active<br><b>emotional</b><br>I'm happier<br><b>legal</b><br>I cant get into trouble with the grog<br><b>work/study</b><br>I think my working sets a good role model for the kids<br><b>financial</b><br>they motivate me to save money to do things with them. |
| Where do usually <u>see your grandchildren?</u><br>At our home.                                     | What are you usually feeling physically right before you <u>see your grandchildren?</u><br>Not sure but maybe I feel I have some energy.   | How often do you usually <u>see your grandchildren?</u><br>Usually every weekend.                                    |   |   |
| When do you usually <u>see your grandchildren?</u><br>At weekends and during school holidays.       | What are you usually feeling emotionally right before you <u>see your grandchildren?</u><br>Happy, and good to be alive.   | How long does <u>seeing your grandchildren</u> usually last?<br>Depends, but for the afternoon or sometimes all day. | What are some of the unpleasant thoughts you usually have while you are <u>seeing your grandchildren</u> ?<br>I think I'm a bad grandmother, selfish for not giving up the grog.<br>What are some of the unpleasant physical feelings you usually have while you are <u>seeing your grandchildren</u> ?<br>I run out of energy, they're so active.<br>What are some of the unpleasant emotional feelings you usually have while you are <u>seeing your grandchildren</u> ?<br>I worry that I wont see them grow up. |   |

## **Motivation to change behaviour and the Stages of Change**

Earlier we described that a person's level of motivation to do something about their alcohol use is often at its highest when they have been involved in some sort of crisis. But clients may not always be in a crisis and it is more likely that their motivation will vary considerably over time. A client's changing level of motivation may make it difficult for Workers to know exactly what type of action or approach to take. One model that can make it easier to sort this out is the Stages of Behaviour Change (Prochaska and DiClemente 1986). The model has been used in Indigenous health care settings to identify people's level of motivation or readiness to change their drinking behaviour (Brady, Sibthorpe, Bailie , Ball , Sumnerdodd 2002 p 375-376). Although the model is presented as sometimes having a different number of stages, it usually always includes:

- Pre-contemplation - not really thinking about changing
- Contemplation - thinking about changing
- Action - ready to do something
- Maintenance - keeping going once a decision has been made
- Relapse – a return to the unhealthy behaviour usually as the result of some incident/trigger

The advantage of the 'stages of change' model is that when used with the Functional Analysis it can provide Workers with a framework for undertaking a brief intervention. For example, as Workers listen to each client's story and ask questions about their alcohol use they are able to make an informed assessment about the client's readiness to change. Workers are then able to use motivational interviewing to match the client's stage of change with an appropriate action. Another advantage of the 'stages of change' model is that it ensures Workers do not have to forcibly counsell unwilling clients about issues they are not ready or motivated to tackle. Rather, it recognises that improvements in a client's situation are more likely '... if the client is given room to breathe, if motivation to change is not imposed from without, but elicited from within an atmosphere free of conflict' ( Rollnick & Allison in Heather , Stockwell 2004 p106).

## **Motivational Interviewing**

Motivational interviewing (MI) has been defined as:

A directive, client centred counseling style for **eliciting behaviour change** by helping clients **explore and resolve ambivalence**' (Rollnick & Miller 1995)

In plain English this means MI is a structured way that Workers can talk to clients and encourage them to change their behaviour by:

- thinking about their lives and their behaviour
- sorting out and making up their minds about their thoughts and feelings towards their alcohol use and the effects it has

Rollnick and Allison( in Heather , Stockwell 2004) describe three key ideas that are at the heart of motivational interviewing including: readiness, ambivalence and resistance.

### **Readiness**

In the previous paragraphs we described how the stages of change was a tool for Workers to assess a client's 'readiness' to change their drinking behaviour. As Rollnick and Allison (2004 p 107) point out, in motivational interviewing the importance of assessing client 'readiness' is to ensure

that Workers ‘ always walk [s] beside the client, in step with his/her readiness to change.’ As regards CRA, this means Workers must be able to pick a client’s readiness to change their alcohol use at any moment in their lives and to adjust their motivational interviewing style. This will enable Workers to stay alongside their clients, rather than be one step in front or behind.

### **Ambivalence**

Another word for the term ‘ambivalence’ is ‘uncertainty’. In regards to motivational interviewing in CRA, ‘ambivalence’ or uncertainty is related to the drinking behaviour clients may be thinking about changing. For example as clients talk about their drinking, some may express a feeling of conflict between knowing the disadvantages as well as the benefits of quitting, which in turn leaves them feeling confused and uncertain about how they should proceed. In some cases this uncertainty can be so confronting that clients fight back or dig in their heels, making it even more difficult to motivate them. In these circumstances it is the role of Workers to avoid making the conflict worse. Rather Workers should aim to create a supportive and non-judgmental environment that will help clients to stay on track and explore their confusion and uncertainty about changing their behaviour. This can be achieved by encouraging clients to think more positively and by drawing on those things that they value and which may motivate or reinforce them to keep thinking about why they want to change their alcohol use.

As you progress through this manual you will learn more about the CRA procedures that will assist you to work with clients in this way.

### **Resistance**

In motivational interviewing ‘resistance’ is used to describe the way some clients might end up at logger heads with Workers who are trying to assist them to deal with their alcohol use. Rollnick and Allison (2004) describe resistance from two perspectives. Firstly from the client’s perspective, resistance may be an unwillingness to progress, or be a response where they show opposition to anything that the worker suggests. Secondly, resistance may be thought of as a heroic struggle to defeat a threat, in this case the imposition of ideas from the outside i.e. the worker or health service. Clients might also see it as a way of protecting their own ideas, self-esteem and right to make up their own minds about what they will and won’t do.

Being able to deal with a client’s resistance through motivational interviewing is at the heart of CRA. The skills for managing ambivalence and resistance and for motivational interviewing are described in more detail below.

### **Principles for Motivational Interviewing**

Four main principles are at the heart of motivational interviewing including: showing empathy, going with the flow, supporting self-efficacy and developing discrepancy. (Rollnick and Allison 2004).

#### **1. Show Empathy**

This entails reflective listening which includes Workers making clear, simple statements to summarise the client’s story which are then repeated back to them. Repeating the story back to the client shows their story is being understood and enables them to correct any misunderstandings that the worker may have. Reflective listening also entails Workers making statements to highlight possible dilemmas enabling the client to explore their uncertainty further. An empathetic style entails Workers using open questions and affirming, positive statements.

## **2. Go with the flow**

Workers who create harmony in a session with a client and who avoid confrontation or arguments with resistant clients are more likely to encourage an open conversation.

## **3. Support Self-efficacy**

This principle refers to the way Workers can instill a sense of ‘yes I can’ in clients. As Rollnick and Allison (2004) point out this entails clients (not Workers being in charge of their situations).

## **4. Develop Discrepancy**

Another word for ‘discrepancy’ is ‘inconsistency’. Developing discrepancy therefore refers to the way that motivational interviewing in CRA can be used to support clients to explore the inconsistency or mismatch between their desire to give up drinking and their ongoing behaviour that maintains their alcohol use. Workers must use a motivational approach to develop discrepancy in such a way that clients do not feel uncomfortable or distressed.

### **Method for Motivational Interviewing**

The method for applying a motivational interviewing style to working with clients in a CRA session will draw on the above principles. In general the method relies on Workers taking a number of steps. These include: using empathetic listening, change talk and responding to any resistance that the client might show.

#### **Step 1**

We have already described that **empathetic listening** entails Workers demonstrating sensitive care and consideration for everything the client shares with them. Clients who feel confident that they are being listened to, will be better able to reflect on their thoughts and feelings and feel that they are being understood.

#### **Step 2**

As Workers build a relationship of trust with clients, change talk may become a part of the conversation. **Change talk** occurs when Workers assist clients to come up with their own ideas about how they can change their drinking behaviour. Again this requires Workers to track the conversation, use reflective listening statements, and look for ways that encourage clients to come to new understandings.

#### **Step 3**

This step entails **responding to the client’s resistance** by acknowledging what they are saying, showing respect and ensuring their dignity is maintained. Again reflective listening is the most important skills needed here, because it will enable Workers to come alongside the client and to diffuse any tension that may be simmering.

Workers may use motivational interviewing as the basis of any brief intervention (BI). Brief interventions (BI) for alcohol are short, one on one interactions between a trained health practitioner and client that aim to change the client’s alcohol use and stop harmful drinking behaviour. Brief interventions may be delivered at any opportunity or as a series of planned more extended health care episodes and may include such strategies as screening, brief advice, referral to specialists, counseling and motivational interviewing. As Brady et al (2002) point out, a brief intervention where Workers use motivational interviewing is designed to support clients to explore their drinking behaviour and reflect on their motivation to change. The aim of this

approach is to prevent Workers from wasting their time talking to clients about issues that they are not ready to think about, let alone change. Motivational interviewing may be used to deliver a brief intervention to clients that:

- raises awareness about their alcohol use;
- encourages them to think about the consequences of the way they use alcohol;
- changes the way they use alcohol

In the context of CRA, examples of actions that Workers might use to motivate clients include suggestions that they:

- come back to participate in other CRA sessions;
- enter an alcohol withdrawal facility;
- see a doctor re an alcohol-related health condition;
- commit to sobriety until their next CRA session;
- attend a men's/women's group;
- make a phone call to a worker within two days of attending Session 1 to tell them how they are doing.

## **Sobriety Sampling**

This CRA session entails the introduction of ‘Sobriety Sampling’. Sobriety means ‘being sober’, so ‘sobriety sampling’ means to ‘try out’ being sober. Sobriety sampling is the term used to describe the CRA procedure that aims to motivate clients to try out what it feels like to stop drinking or drug using for a set and agreed period of time (Meyers, Smith 1995 p 42). To achieve this aim it is important to acknowledge that some clients may require medical assistance to stop drinking. Other clients may need even more specialist treatment.

The Sobriety Sampling procedure is based on the idea that people who drink will be more likely to stop if they are not frightened by huge expectations such as ‘you will never be able to drink again’, or by inflexible rules stating what they can and cannot do. Although some people may need to work towards staying sober for the remainder of their lives, Sobriety Sampling takes a more gentle approach than other alcohol treatment programs. The approach also takes a positive stand to support clients to acknowledge their drinking problem and their need to quit. At all times during Sobriety Sampling it is the worker’s role to:

- reinforce the client’s motivations for treatment;
- avoid confrontation and/or arguments or power struggles;
- encourage the client to take one day at a time.

## **Advantages of Sobriety Sampling**

Meyers and Smith (1995) developed and tested the sobriety sampling strategy. They state that it has many advantages including that it:

- assists Workers to build up a relationship with clients at the same time as they support them to come to terms with their drinking problem.
- makes it possible for Workers and clients to agree on and set achievable goals together
- allows clients to experience the positive outcomes of staying sober, even for a short time
- interrupts old unhealthy drinking habits and in the short term gives clients time to replace them with healthier positive pass time
- teaches clients self-control and independence
- supports clients to achieve their short term goals and experience success which in turn boosts confidence and strengthens motivation
- lets clients show their commitment to change, thereby making family members and friends more likely to trust them
- encourages the police to have more confidence in clients over time
- provides a safety net in which relapse can be used to show clients the areas of their lives where more support might be needed

Like the earlier Functional Analysis, Sobriety Sampling also has two phases, each of which includes a number of steps for Workers to follow. These phases are:

1. persuading the client to agree to a trial period of time for staying sober.
2. planning a strategy for achieving a trial period of non-drinking

### **Phase 1 Sobriety Sampling: Persuading the client to agree to Sobriety Sampling**

In this first phase of sobriety sampling, Workers take steps to encourage the client to think about and reach agreement on a period of time for not drinking. Each step in this phase is outlined in the table below.

| <b>Procedure Steps</b> |                                     | <b>Worker Action</b>   |
|------------------------|-------------------------------------|--|
| <b>1</b>               | <b>Review records</b>               | Review all of the client's existing and past records to identify other times that they were sober and how long these periods lasted. Earlier periods can be used to bargain with clients about a new trial period of non-drinking. |
| <b>2</b>               | <b>Identify client's motivators</b> | Note the clients motivation for treatment & use it to reinforce what the client may have achieved in the past and to persuade the client to trial a period of non-drinking.  |
| <b>3</b>               | <b>Suggest non drinking trial</b>   | Introduce the idea that clients sample a non-drinking period and highlight its advantages.   |
| <b>4</b>               | <b>Suggest 90 days</b>              | Discuss advantages of 90 day trial including: <ul style="list-style-type: none"><li>• maximizes benefits</li><li>• high relapse period (Marlett 1980)</li></ul>  |
| <b>5</b>               | <b>Bargain down</b>                 | If necessary bargain for less time until there is a balance between what the client agrees is a challenge but achievable trial time period for non-drinking. This might mean a trial that is as short as 1 day.                    |
| <b>6</b>               | <b>Motivate</b>                     | Always motivate the client by reminding them of their previous non-drinking episodes and current reasons for seeking treatment.  |

*Adapted from Meyers and Smith Clinical Guide to Alcohol Treatment, The Community Reinforcement Approach 1995, p 44.*

## **Phase 2 Sobriety Sampling: Planning for a trial period of non-drinking**

In the second phase of Sobriety Sampling, the worker assists the client work to plan how they will achieve the non-drinking trial period they have decided on. Each step in this phase is outlined in the table below.

| <b>Procedure Steps</b> |                                    | <b>Worker Action</b>  |
|------------------------|------------------------------------|---|
| <b>1</b>               | <b>Making an appointment</b>       | Initial appointments should be spaced as close together as possible to take advantage of the client's motivation for seeking treatment and to start any skills training that may be needed.   |
| <b>2</b>               | <b>Use new methods</b>             | Encourage clients to think about new methods for not drinking, not old ones which have not worked   |
| <b>3</b>               | <b>Check triggers for drinking</b> | With the client review their functional analysis and discuss their usual drinking situation and triggers for drinking. Triggers are likely to be a threat to client's non-drinking trial period.  |
| <b>4</b>               | <b>Develop a plan</b>              | Support clients to draw up a plan of action for the non-drinking period that focuses on different behaviour and activities to avoid possible triggers and to distract clients from wanting to drink during this high risk time. For some clients it will be necessary for them to attend an alcohol withdrawal facility before they stop drinking. In this instance, the initial period of sobriety negotiated with the client should be at least for the duration of the alcohol withdrawal program (5-7 days), with a follow-up appointment scheduled as close as possible to the day the client exits the alcohol withdrawal program to take advantage of the client's withdrawal from alcohol and start skills training required for them to maintain sobriety. |
| <b>5</b>               | <b>Develop a backup plan</b>       | Also support clients to develop a backup plan in case their main plan does not work.  |
| <b>6</b>               | <b>Review motivators</b>           | Support client's motivation to stick to their non-drinking plan.  |
| <b>7</b>               | <b>Reinforce</b>                   | Keep reinforcing clients throughout the procedure.  |

### **Robyn's Story**

Robyn has been married to John for 15 years. It is her second marriage and has always been a struggle, with lots of arguments about money. One reason for this is that Robyn came to the marriage with two little children that John did not like supporting. Another reason is that when the kids grew up and left home Robyn decided to make more of a life for herself and started part time study in a community welfare course she always wanted to. But this has made John even more angry because now Robyn only works part time and doesn't earn as much money as she used to. John harasses Robyn about how much she costs him, and has told her recently that they can't afford to have any more holidays or night outs at the club.

Robyn has always enjoyed having a drink to relax at the end of each day but has had a rule to never drink after dinner. She has found that alcohol helps her forget about the difficulties between her and John. However as things have become worse Robyn has started to drink much more, and now goes through at least half a cask of wine most nights. Recently, everything came to a head when during one of Robyn's drinking episodes she became physically violent towards John so he called the police. An AVO was taken out against Robyn and now she has to appear in court. Robyn is really worried about her future and that she may be charged and never be able to work in community welfare. She is also worried she can't go home and has gone to stay with a friend who has taken her to the health centre to see a drug and alcohol counsellor.

### **Activity**

Read Robyn's story and think about how you might introduce Sobriety Sampling to her and what sort of plan could be developed for a trial period of non-drinking.

Use the following headings to assess Robyn's situation including:

- triggers for drinking (internal and external);
- drinking behaviour: (what does she drink, how much and over what period of time);
- short-term positive and long term negative consequences of drinking;
- positive and negative reinforcers;
- motivation for treatment;
- a realistic and achievable time frame for her to trial a non-drinking period;
- a suitable plan for her to manage a trial non-drinking period;
- a backup plan in case the main plan does not work.

### **The CRA Treatment Plan**

When appropriate Workers will assist clients to develop an individualised CRA treatment plan for choosing non-drinking behaviour over and above drinking behaviour. Each of the procedures already completed with clients, including the screening assessment, functional analysis and the sobriety sampling will inform the development of this plan. Two additional procedures can be used to develop the treatment plan, these are the **Happiness Scale** and the **Goals for Counseling**. Each of these is described in the following section.

## The Happiness Scale

The Happiness Scale is a questionnaire for Workers to use with clients to ask them how 'happy' or 'unhappy' they are about different areas of their **present lives**. The questionnaire includes 10 categories of life. These are:

1. Drinking/non-drinking
2. Job/education
3. Money
4. Social life
5. Personal habits
6. Marriage/family relationships
7. Legal issues
8. Emotional life
9. Communication
10. General happiness

### How do Workers use the Happiness Scale with clients?

Workers use the questionnaire to ask clients to rate their **current level of happiness/satisfaction** about each of the ten categories of their life **as it is now**. To do this clients use a ten point scale. This scale begins at 1 which is equal to 'completely unhappy' and finishes at 10 which is to equal 'completely happy'. The 'X' mark in the following diagram is an example of how someone might respond to the 'drinking/nondrinking' 'area of their life. In this case the client has marked the number 4 to indicate they are unsure about whether they are unhappy or happy about their current 'drinking/non-drinking' (category 1):

| Life Category        | Completely<br>unhappy |   |   |   |   |   |   |   |   | Completely<br>happy |
|----------------------|-----------------------|---|---|---|---|---|---|---|---|---------------------|
| drinking/nondrinking | 1                     | 2 | 3 | 4 | X | 6 | 7 | 8 | 9 | 10                  |

When asking clients to complete the Happiness Scale Workers should support them as they reflect on how they actually feel about their lives. In offering this support Workers can check that the rating is a truthful reflection of what the client feels about that area of their life. To get to the heart of each issue this may require the Worker to ask more than one question about the client's unhappiness. It also requires Workers to ask clients to:

- focus on **how they feel about each area of their life as it is at that moment** rather than how it was last month
- **assess each category by itself** so as to avoid the results of one category influencing another

More than one Happiness Scale may be completed by clients over the course of their participation in CRA. This will enable Workers to monitor changes in each of the life categories as the client's treatment progresses.

### **What is the purpose of the Happiness Scale?**

The Happiness Scale enables Workers to:

- show clients the specific areas in their life that most need attention
- motivate clients by showing them which specific parts of their lives they need to change
- assist clients to decide which areas in their lives are a problem and which are not
- measure the progress clients make in their lives as they change their drinking behaviour

### **Goals for Counselling**

#### **What are Goals for Counselling?**

Goals for Counselling is the next procedure that follows on from the Happiness Scale. Goals for Counselling is based on the problem areas that were identified by the client on their Happiness Scale. The aim of the Goals for Counselling procedure is to support the client to develop a plan of action to change their unhealthy behaviour and thereby reach the goals they want to achieve in each of the problem areas of their life.

#### **How do Workers use Goals for Counseling?**

Workers using the Goals for Counseling form apply the same positive approach they have used throughout CRA to ask clients about each of the problem areas they identified on the Happiness Scale.

Some clients may like to practice using the form before they settle on a final answer to each question. To assist this process Workers can begin by asking clients to choose one of the ten areas from the Happiness Scale that they feel some level of pleasure for. Clients are then asked to set a corresponding goal. Once a goal has been set, Workers assist clients to work out a plan of action to help them achieve it. Some goals may take several stages of action, although it is best if goals are kept small so they are more easily achieved.

In setting goals Workers should assist clients to:

- Keep goals and plans to the point;
- State goals and plans positively as 'I will .. rather than negatively as 'I will not ...';
- Make sure behavioural goals and plans can be measured so progress can be checked

Once clients have identified their goals and developed a plan for achieving them, Workers may notice that some clients do not have the particular skills they need to achieve them. Skills training is therefore another important part of the Goals for Counseling procedure. The skills that clients need to achieve their goals should be identified and noted on their Goals for Counselling form. This will enable Workers to decide whether the training is needed urgently or whether it should be timetabled later in the client's CRA treatment.

At all times during the Goals for Counselling procedure it is the role of Workers is to **assist, motivate and reinforce clients to set and develop their own goals** and plans rather than to do it for them.

### **What is the purpose of Goals for Counselling?**

The Goals for Counselling procedure assists clients to think about what is going on their lives and to prioritize what is important and not so important so they can set goals and develop plans to meet their specific needs. The procedure also enables people to see that perhaps their alcohol use is only one problem area of their lives and that there may be others they have been ignoring. Most importantly the procedure enables Workers to pinpoint the extra skills and knowledge clients may need to work out the problems in their lives. In guiding and supporting clients through the Goals for Counseling Workers must also be aware of problems that may put clients at risk of failure. Some common problems clients may experience are:

- difficulties keeping goals and plans short, simple, to the point and able to be assessed;
- leaving out important steps in plans for achieving goals;
- plans are not realistic or under their (client's) control, thereby putting them at risk for not reaching their goals.

Workers can help to avoid these issues when they actively guide clients to shape their goals by breaking them down into small, easy to follow, measurable steps.

The following is an example of the Goals for Counselling form

| <b>Client's Problem Areas/Goals</b>                          | <b>Action Plan</b> | <b>Time Frame</b> |
|--|--------------------|-------------------|
| 1. In the area of drinking/non-drinking I would like to ...  |                    |                   |
| 2. In the area of job/education I would like to ...          |                    |                   |
| 3. In the area of money I would like to ...                  |                    |                   |
| 4. In the area of social life I would like to ...            |                    |                   |
| 5. In the area of personal habits I would like to ...        |                    |                   |
| 6. In the area of marriage/relationships I would like to ... |                    |                   |
| 7. In the area of legal issues I would like to ...           |                    |                   |
| 8. In the area of emotional wellbeing I would like to ...    |                    |                   |
| 9. In the area of communication I would like to ...          |                    |                   |
| 10. In the area of general happiness I would like to ...     |                    |                   |

### **Activity**

With guidance from the Worker, Robyn (see earlier case study) has completed her Happiness Scale and started to complete the Goals for Counselling form but has not yet thought about an Action Plan or time frame. Use the information from both of Robyn's forms to assist her to complete the Action Plan part of her Goals for Counseling. Use the sheet on the following page. The first category has been completed as an example.

### Robyn's completed Happiness Scale

| Life Category          | Completely unhappy |   |   |   |   |   |   |   |   | Completely happy |
|------------------------|--------------------|---|---|---|---|---|---|---|---|------------------|
| drinking/nondrinking   | 1                  | 2 | 3 | 4 | X | 6 | 7 | 8 | 9 | 10               |
| job/education          | 1                  | 2 | 3 | 4 | 5 | 6 | 7 | 8 | X | 10               |
| money                  | 1                  | 2 | X | 4 | 5 | 6 | 7 | 8 | 9 | 10               |
| social life            | 1                  | 2 | 3 | 4 | 5 | 6 | X | 8 | 9 | 10               |
| personal habits        | 1                  | 2 | 3 | 4 | 5 | X | 7 | 8 | 9 | 10               |
| marriage/relationships | X                  | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10               |
| legal issues           | 1                  | 2 | X | 4 | 5 | 6 | 7 | 8 | 9 | 10               |
| emotional life         | 1                  | X | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10               |
| communication          | 1                  | X | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10               |
| general happiness      | 1                  | X | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10               |

**Robyn's partly completed Goals for Counseling form.**

| Robyn's Problem Areas/Goals   | Action Plan | Time Frame |
|---|-------------|------------|
| 1. In the area of drinking/non-drinking I would like to <b>stay a non-drinker for 21 days</b>   |             |            |
| 2. In the area of job/education progress I would like to <b>complete my Diploma in Community Services</b>   |             |            |
| 3. In the area of money I would like to <b>learn how to control my spending on things I don't need</b>  |             |            |
| 4. In the area of social life I would like to <b>make friends outside of work</b>   |             |            |
| 5. In the area of personal habits I would like to <b>make more time to get fit</b>  |             |            |
| 6. In the area of marriage/relationships I would like to <b>stop fighting with John about money</b>   |             |            |
| 7. In the area of legal issues I would like to <b>make sure the AVO doesn't get recorded as a criminal offence</b>  |             |            |
| 8. In the area of emotional wellbeing I would like to <b>meet some women to share the things I enjoy doing</b>  |             |            |
| 9. In the area of communication I would like to <b>A: be able to talk to John about the children without it turning into a fight, B: feel more confident when I talk to people I don't know that well</b> |             |            |
| 10. In the area of general happiness I would like to <b>A: improve my marriage, B: have more non-drinking friends C: feel less angry</b>  |             |            |

## Robyn's Goals for Counseling

| Robyn's Problem Areas/Goals   | Action Plan   | Time Frame   |
|---|---|--|
| 1. In the area of drinking/non-drinking I would like to <b>stay a non drinker for 21 days</b>   | 1. Go to weekly CR sessions<br>2. Remove all alcohol from the house & draw up a non-drinking calendar<br>3. Make appointment to see the doctor for a health check | 1st Feb -21 <sup>th</sup> Feb<br>check 7 <sup>th</sup> , 14 <sup>th</sup> and 21st |
| 2. In the area of job/education progress I would like to <b>complete my Diploma in Community Services</b>   |   |  |
| 3. In the area of money I would like to <b>learn how to control my spending on things I don't need</b>  |   |  |
| 4. In the area of social life I would like to <b>make friends outside of work</b>   |   |  |
| 5. In the area of personal habits I would like to <b>make more time to get fit</b>  |   |  |
| 6. In the area of marriage/relationships I would like to <b>stop fighting with John about money</b>   |   |  |
| 7. In the area of legal issues I would like to <b>make sure the AVO doesn't get recorded as a criminal offence</b>  |   |  |
| 8. In the area of emotional wellbeing I would like to <b>meet some women to share the things I enjoy doing</b>  |   |  |
| 9. In the area of communication I would like to <b>A: be able to talk to John about the children without it turning into a fight, B: feel more confident when I talk to people I don't know that well</b> |   |  |
| 10. In the area of general happiness I would like to <b>A: improve my marriage, B: have more non-drinking friends C: feel less angry</b>  |   |  |

## **CRA Relapse Prevention**

Dealing with relapse is an important part of any alcohol treatment program including CRA. Relapse is always a possibility and so its management should always be on the minds of Workers, regardless of where the client might be up to in their treatment. Smith and Meyers (2004 p 180) outline a comprehensive CRA relapse prevention and intervention strategy that draws on some of the CRA procedures described in this manual. Workers for example can use a special relapse version of the Functional Analysis of Drinking Behaviour to assist clients to explore the relapse in detail including the external and internal triggers that brought it on.

During this time, other realistic non-drinking options for use during high risk situations are also discussed and checked to ensure they will result in some short term positive consequences. A solutions approach to problem solving is also used by Workers to assist clients as they consider effective actions to get themselves back on a non-drinking track. The role of Workers in relapse prevention is explained here in further detail.

### **Functional Analysis: Relapse Version**

The Functional Analysis of Drinking Behaviour: Relapse Version, has the same structure as others but aims to get to the heart of the relapse event. As Workers discuss the relapse with a client, they may want to allow the client to explain what happened while they complete the analysis form. While the client's story unfolds, Workers can refer to the Functional Analysis form to ask clients relevant questions and get additional information that will fill in any gaps and assist a more complete understanding of the relapse. Once all the necessary information has been collected and a full picture of the relapse event has been created, Workers can use the form to summarise and instruct the client. Quickly review the Functional Analysis of Drinking Behaviour: Relapse Version to remind yourself of its structure and the questions Workers ask clients.

### CRA Functional Analysis for drinking Behaviour: Relapse Version

| Triggers                          |   | Behaviour                                     | Short-term positive consequences  | Long-term negative consequences   |
|-----------------------------------|---|---|---|---|
| External                          | Internal  |   |   |   |
| Who were you with when you drank? | What were you thinking right before you drank?            | What were you drinking?                       | What did you like about drinking with ... (who)?<br><br>What did you like about drinking ... (where)?   | What were the negative results of your drinking in each of these areas: <ul style="list-style-type: none"> <li>• interpersonal</li> <li>• physical</li> <li>• emotional</li> <li>• legal</li> <li>• work/study</li> <li>• financial</li> <li>• other</li> </ul> |
| Where were you when you drank?    | What were you feeling physically right before you drank?  | How much did you drink?                       | What did you like about drinking ... (when)?<br><br>What were some of the pleasant thoughts you had while you were drinking?  |   |
| When did you drink?               | What were you feeling emotionally right before you drank? | Over how long a period of time did you drink? | What were some of the pleasant physical feelings you had while you were drinking?<br><br>What were some of the pleasant emotional feelings you had while you were drinking? |   |

Source: Meyers and Smith 2004 *Clinical Guide to Alcohol Treatment, The Community Reinforcement Approach.*

### **Behaviour sequence that leads to relapse**

Relapse is more likely after a series of triggers, rather than just one. Therefore another important and basic CRA skill that clients can learn is how to recognize the chain of events that might lead to a relapse, how to interrupt it and how to prevent the relapse from occurring. Workers can show clients how their relapse unfolded using a white board to record each particular link in the chain of events. As they do this Workers can ask clients to reconsider some of the different actions or decisions they could have made to change the relapse outcome.

### **Early Warning System**

The Early Warning System is a process that may be used either after a relapse or to prevent one. The aim of the process is for clients to:

- track their behaviour so they can identify possible triggers that may place them at risk of a relapse
- have a prearranged plan to manage high risk situations.

A family member may agree to be involved in this process and to offer the client support in such situations. Depending on the situation such support could consist of a discussion between the client and their family member about the situation at the time it was occurring or perhaps a phone conversation between the client and a Worker

### **Cognitive Restructuring to Prevent Relapse**

Cognitive restructuring is a way for Workers to assist clients to identify and change their potentially faulty unhelpful thought patterns. Some examples of comments that may be an indicator of faulty thinking as adapted from Meyers and Smith (2004 p 190) are:

*I can't help it I'm a drunk*

*It's too hard to cope with this pain without a drink*

*He drove me to drink and its too late to stop now.*

*Nobody cares if I drink or not.*

Workers can assist clients to challenge their faulty thinking by showing them the links between their internal triggers and their alcohol use. When clients recognise these links they can then be encouraged to challenge and replace their negative thinking with positive thoughts that will in turn encourage them to develop positive feelings. The logic behind this process is that with practice and in high risk situations, clients will routinely be able to replace their negative thoughts with positive ones which in turn may act to prevent a possible relapse.

### **CRA Skills Training**

This section of the manual describes the different skills that clients have identified as necessary for achieving the goals they have set themselves. Client's need for skills will depend on their individual situations, which means some clients will already have some of these skills while others may not. It is the role of Workers to support clients to identify the skills they need.

Information in this section is brief, and designed to be flexible and easily adapted. More detailed information about the skills described here can be found in resources dedicated to their explanation such as Meyers and Smith's (1995) *Clinical Guide to Alcohol Treatment, The Community Reinforcement Approach*.

## **Positive Communication**

The purpose of positive communication training is to teach clients improved and more positive ways of talking to their relatives. Communication skills are a key part of CRAFT and are included because many studies show that communication difficulties often occur in relationships where alcohol use is an issue (Monti et al 2001, Kadden et al 1994, Marshall 2003.). In addition, other studies show that communication problems may also trigger alcohol misuse (Smith and Meyers 2004 p 109) Typical communication problems that may arise in situations where alcohol is a factor include: blaming others, resentment and negativity. CRA addresses these problems and teaches clients positive communication skills so they can:

- increase the influence they have over others
- improve other areas of their lives
- extend their social support networks
- get what they want because people will be more likely to listen to them
- explain changes in their own behaviour to their family/friends

## **Guidelines for Positive Communication**

To support clients to communicate positively with their family Workers can introduce the seven step set of guidelines as described by Smith and Meyers (2004 p 111-115). These steps recommend that to communicate positively clients are:

1. brief
2. positive
3. refer to specific behaviour
4. label feelings
5. offer an understanding statement
6. accept some responsibility
7. offer to help

Before outlining each step and giving examples of how to put them into practice, clients should be reminded that their communication goal is to be heard and understood. This means that before trying their new positive communication style, clients should choose a time when they are not drinking or suffering from a hangover and when everyone is in a good mood.

### **1. Be brief not long winded**

It is best when communicating to achieve a positive outcome, that clients state their issues as briefly as possible and stick to the main points. This helps the listener to maintain their attention and keeps old and inappropriate information out of the conversation. It is also more likely to keep the conversation quiet and unemotional.

### **2. Use positive words**

The use of positive words means no blaming, name calling, or over generalizing, all of which are more likely to annoy the listener and make them feel guilty, distrustful, or defensiveness. A positive approach to a conversation is also more likely to help avoid arguments, particularly if

clients clearly talk about what they ‘would like’ rather than what they ‘don’t like’. Stating a request or demand to in positive terms makes it quite clear what clients want.

### **3. Refer to specific behaviour and not to thoughts or feelings**

Communicating a specific behaviour requires clients to make absolutely clear which behaviour they are talking about. Talking about a precise behaviour is also more productive than referring to thoughts of feelings which are easily open to misunderstanding.

### **4. Label feelings**

Clients who label their feelings quietly and who avoid using judgmental or critical language when they are talking about a problem will help convey their message from their perspective.

### **5. Offer an understanding statement**

This requires clients to express empathy, which means putting themselves in the position of others. If people are able to adopt a more empathetic approach it is likely the listener themselves will also respond with understanding.

### **6. Accept partial responsibility**

Although taking some responsibility for a problem is not easy, clients who can acknowledge that they are not interested in blaming anyone for the problems being discussed will be more likely to get what they want in the long run.

Examples of negative and positive communication styles according to each of the seven steps above are given in the following table.

| <b>Steps</b>                  | <b>Negative communication</b>  | <b>Positive communication</b>   |
|-------------------------------|--|---|
| <b>Be brief</b>               | I'm sick of you being on my back all the time. You do nothing but criticize me no matter what I do. I can't do anything right. It's no wonder I want to drink. It's my only way of putting up with your garbage. | I'm tired of being criticized.  |
| <b>Be positive</b>            | You're always busy doing something. You never listen to anything I say.  | You're easier to talk to when you're sitting down listening to me.                    |
| <b>Specific behaviour</b>     | How come you're always so hard on me?  | I don't find it easy to handle things when you criticize me in front of the children. |
| <b>Label feelings</b>         | I can't stand this anymore; you're sending me round the bend.  | I feel so ashamed when you tell me I'm a no hoper.                                    |
| <b>Offer understanding</b>    | I can't stand being around you while you're banging on.  | I'm sorry that drinking with my mates has such a bad effect on you.                   |
| <b>Partial responsibility</b> | I knew you'd blame me for forgetting that appointment.   | I'm sorry I didn't remember that appointment.   |

## **Problem Solving**

Problem solving skills are essential for clients who are learning to manage their day to day lives without turning to alcohol. In CRA, the role of Workers includes teaching clients how to take a 'solutions oriented approach'. This entails assisting clients to think of all their problems as having a solution. As Workers assist clients to develop the problem solving skills they need to find solutions to their problems and to take charge of their lives without using alcohol, clients are also learning to be independent.

Problem solving in CRA is based on an approach with 4 steps (D'Zurilla, Goldfried in Meyers and Smith 1995 p 106). The actions that Workers assist clients to take in each step are as follows:

### **Step 1**

**Name the problem** by describing its details and dividing it into its different parts so that smaller problems are separated out.

### **Step 2**

**Brainstorm different solutions** to the problem (as many as possible). Make sure solutions are stated in specific not vague terms.

### **Step 3**

**Decide on a solution.** First get rid of all solutions that are not realistic or practical. Of the solutions that are left, consider how they might be implemented and then choose the one that is most likely achievable. Consider any obstacles that might get in the way and develop a second back up plan just in case. Agree to practice trying out the solution.

### **Step 4**

**Evaluate the outcome.** After the solution has been tried, the outcome is evaluated and modified according to its success. If the solution was unsuccessful the problem solving procedure should be used again.

The following table presents an example of a problem solving approach that Gail uses to manage the stress she experiences and that is associated with her brother Mark's mental health problem.

| Gail's Problem Solving Steps | Example   |
|------------------------------|---|
| define the problem           | <ul style="list-style-type: none"> <li>I can see Mark's condition is getting worse, and I worry because there's only me to manage it. But I'm already working and trying look after my own family. Drinking after work just helps me stay on top of the problem</li> </ul>                                |
| possible solutions           | <ul style="list-style-type: none"> <li>Talk to Mark about his health &amp; arrange an appointment for him to see community health</li> <li>Go to community health myself to see if they can help me and Mark</li> <li>Go for a walk in the afternoon instead of drinking</li> </ul>                       |
| unwanted suggestions         | <ul style="list-style-type: none"> <li><del>Talk to Mark about his health &amp; arrange an appointment for him to see community health</del></li> <li>Go to community health myself to see if they can help me and Mark</li> <li><del>Go for a walk in the afternoon instead of drinking</del></li> </ul> |
| one solution                 | <ul style="list-style-type: none"> <li>Go to community health myself to see if they can help me and Mark</li> </ul>   |
| possible obstacles           | <ul style="list-style-type: none"> <li>Putting off calling to make an appointment</li> <li>Mark might get angry</li> </ul>  |
| addressing obstacles         | <ul style="list-style-type: none"> <li>Making a date to call for the appointment within the week</li> <li>Explain to Mark what I'm going to do</li> </ul>   |
| decide assignment and do it  | <ul style="list-style-type: none"> <li>Mark always comes on a Saturday morning. he likes seeing the kids. So it's a good time to talk to him.</li> </ul>  |
| evaluate outcomes            | <i>After trying the plan</i>  |

## Drink refusal

Drink refusal is another critical skill that assists clients to maintain their non-drinking behaviour and keep charge of their lives. Guided role play activities are an ideal way of assisting clients to practice these skills. Adapted from descriptions by Meyers and Smith (1995 p111- 120), the development of drink refusal skills requires clients to:

1. **Recruit the support of family and friends** who support their decision to stop using alcohol.  
This might not always be easy, as family members and friends who drink themselves may see it as a judgment of their own behaviour. In such situations clients should make it clear that while their decision to not drink is a personal one they respect the rights of others to make up their own minds about their own behaviour. Encouraging clients to show a non-judgmental attitude towards others may help to ensure that clients are not rejected by their family and friendship groups. However it is also important that as clients participating in CRA continue their non-drinking behaviour they will begin looking for non-drinking recreational activities they can share with non-drinking friends.
2. **Review high risk situations** that might place extra pressure on a client's decision to not drink.  
In collaboration with the client, Workers can review the Functional Analysis of Drinking to identify the client's external triggers, i.e. who with, where, when the client usually drinks. Meyers and Smith (1995), recommend that Workers use index cards describing possible scenarios as an activity to help clients to consider possible social and other situations where they may be at high risk for drinking.

3. **Refuse drinks strongly** by following five steps e.g. 1. say ‘no thanks’, 2. watch body language, 3. suggest alternatives, 4. change the topic of conversation and 5. confront the aggressor/pusher. As regards the first step, Worker advice to clients about how to say ‘no thanks’ should include telling them that they do not need to provide an explanation about their refusal to drink, and that drink refusal is normal. What is important however is that the refusal is given firmly and assertively and that false excuses are avoided. For example an excuse such as ‘no thanks I have a stomach upset’, does not send the message that the client has decided to quit drinking, rather it may encourage people to offer the client a drink on another occasion. The second step in drink refusal requires clients to ensure that when they refuse a drink firmly they make their body language match so it also conveys a firm decisive decision, rather than an unsure one that might easily change with some persuasion. The third step suggests that when clients refuse an alcoholic drink they ask for an alternative. For example ‘I won’t have a beer, but an iced soda would be great’. Alternatively step four suggests that clients can change the subject, so when someone asks them about a drink, the response is ‘no thanks Brendan, but its ages since we talked, last time I saw you, you were heading off to Brisbane....’ The final step in drink refusal is reserved for situations where the person offering the drink is unwilling to take ‘no’ for an answer. In these situations, clients can be encouraged to be even more forceful and ask the person why they are continuing to ask. An example of such a response might be; ‘Hey Jim I’ve told you a few times I’m off the grog, but you keep pushing. What’s the go, why do you keep asking?’
4. **Restructuring negative thoughts** is similar to Step 2, in that it involves a review of the client’s Functional Analysis of their Drinking Behaviour to identify internal triggers, i.e. their feelings and thoughts that trigger their alcohol use. Clients are asked to discuss each negative thought and feeling and replace it with a more positive one. An example of how to structure this activity using a table to guide the client’s positive thinking is given below. The last row is left for to practice this activity with clients.

### Activity

| Negative thoughts/feelings   | Restructured positive thoughts/feelings   |
|--|---|
| It's been a shocking day, my nerves are shot, but a few beers will make it better.                       | This was not my best day. I hope tomorrow's better. A cup of tea and a chat with Lisa might make me feel better.  |
| It's been a shocking day, that boss is an idiot. Time for the pub and a drink to fix it.                 | Yep that was not a good day. But I don't need the pub, it'll only make it all seem worse, anyway that boss is on another job for the rest of the week. So things have to improve. |
| I cant stand this anymore, the shame is making me feel like I need to get out of this job and this town. |   |

## **Duration training**

Duration training refers to the skills that clients need to limit the amount of time they spend in inescapable situations where they might be at high risk for drinking. An example of such a situation may occur if a client is asked to attend a farewell function for a work colleague where there is likely to be large amounts of alcohol and there is an expectation that everyone will participate.

To manage this high risk situation and others like it clients will need skills that enable them to:

- determine a reasonable time to stay and leave
- communicate firmly their intention to leave
- plan ways how to reduce drinking cues while engaged in the situation

Role playing provides clients with the opportunity to practice these skills.

## **Activity**

Read the following scenario and use the 3 CRA ‘duration training’ skills listed above to suggest how Lauren should manage the situation.

### **Lauren’s Story**

Lauren’s best friend Annette is having an engagement party for her daughter on the weekend. Lauren and her family are all expected to attend the celebration which is being held on a Saturday night at the local club. Annette is also looking forward to the night out. Annette is a party girl and she and Lauren have had lots of fun drinking regularly together. Annette has been talking to Lauren about what alcohol they should get and how much to order. But now Lauren is feeling ashamed because she has not told Annette that she is giving up alcohol to improve her health. She is also worried about losing Annette as a friend if she does tell her. Lauren thinks she should try and get out of attending the party but also feels obliged to attend to support Annette and celebrate the engagement.

## **Independence training**

Skills that are learnt in independence training will equip clients to manage their own problems without having to rely on the support of Workers or others. These skills are not taught in any one session, but are incorporated throughout the client’s participation in CRA. Meyers and Smith (2004) describe independence training as consisting mainly of ‘behavioural rehearsal and feedback’ and give a number of examples of activities Workers can use with clients in both early and later CRA sessions. These are outlined below.

In early CRA sessions Workers can assist clients to develop independence by:

- temporarily leaving them in the room during the session to give them an opportunity to sort out a particular problem, and then re-entering the room to check how they are going to give feedback and positive reinforcement.
- setting up an early warning system so the client can monitor triggers to drinking and a possible high risk situations that could lead to a relapse. The system should include a response plan i.e. call a family/friend/ AOD counselor
- developing an alcohol free social and recreational plan that has a focus on non-drinking social and recreational activities of interest. These activities should be accessible and include non-drinking family/friends who can be role models linking clients up with available and appropriate support groups

In later CRA sessions Workers can:

- space sessions further apart so clients are provided with opportunities to practice increasing independence
- maintain an open door policy so clients know that if they need support it is there, thereby minimising a client's anxiety and supporting them to gain confidence and become independent
- arrange the final CRA session to review the client's progress, check their understanding of CRA procedures that will continue to support their nondrinking behaviour, reinforce achievements, ensure a support system is in place, discuss concerns and schedule monthly follow up appointments.

### **Social & Recreational Counselling**

Social and recreational counseling is introduced into the CRA sessions early because it is not easy for clients to change activities and friendships that have been associated with their alcohol use. This is particularly the case if their alcohol use has been longstanding and a key part of their lives. As with many of the CRA procedures, social and recreational counseling involves a number of steps for Workers to follow.

#### **Step 1**

Ask clients to describe the activities and friends that are usually associated with their drinking e.g. going to the pub with footy mates after training and after the game on Saturday. Then ask clients to describe the activities and friends that are usually associated with their non-drinking. The purpose of this step is to show clients the relationship between their drinking and their social life, so they can then make a commitment to try out new friendships and other non-drinking activities.

#### **Step 2**

Encourage the client to think about their interests and associated non-drinking fun/enjoyable non-drinking activities. As some clients may not be able to think of anything another option is to ask them to make a list of possible accessible, recreational activities and choose one to trial. Such activities might include for example: swimming/ other sport, watching TV, going to the movies, walking, catching up with a friend/s, community group activities. The support of a non-drinking family/friend to reinforce and share this activity will make it easier for clients to commit to giving it a go.

#### **Step 3**

Provide the client with information about easily accessible and available community activities and resources. Information should be based on the needs of individual clients and should include contact details, possible costs, availability etc. Workers should only recommend activities that are likely to give a positive experience.

#### **Step 4**

Reinforce the idea that clients do not have to make a long term commitment to an activity they may not be sure about. Instead they should be encouraged to sample or try out activities to see how much they enjoy them. This process is referred to as 'reinforcer sampling' (Meyers and Smith 2004 p142) As many clients may feel shy and hesitant about trying out new activities that may also take them into groups where they will meet new people it is best if Workers introduce 'reinforcer sampling' gradually.

## **Step 5**

Systematic Encouragement is the term used by Meyers and Smith (2004 p 141) to describe how Workers can assist clients to overcome any shyness or fear they may feel about trying out a new non-drinking activity or meeting new people. This is in recognition that the best laid plans may not be carried out. Workers who use ‘systematic encouragement’ assist clients by:

- Conducting role plays so clients can practice how they will contact an organisation to arrange the activity they have chosen;
- Being present and available to offer reinforcement when the client contacts the organisation to arrange their attendance/participation;
- Arrange for a contact person to assist the client and make them feel more relaxed with their first interaction with the organisation /activity
- Review the clients experience after they have participated in the organisation/activity and use a problem solving technique to manage any difficulties.

## **Reinforcer Access**

For some clients, achieving healthy non-drinking behaviour remains an unachievable goal because they do not have the resources they need. For example, people who are socially and physically isolated, unemployed and without any financial resources or who have other associated issues to deal with are often those most at risk. This is when ‘reinforcer access’ may be useful. Reinforcer access as described by Meyers and Smith (2004 p143) are those procedures used to supply the basics that clients may need to be able to take part in a non-drinking activities. For example a client who wants to try out a sporting activity may need special clothing, while an older person who spends time at home and has expressed an interest in gardening may need gardening tools and other equipment. In these circumstances it is worthwhile for Workers to try access such resources from charities and other community groups. This will enable them to reinforce client’s access as well as their interest and involvement in their chosen activity.

## **Response Priming**

This term describes a technique for Workers to motivate clients to try out a new behaviour. This technique recognizes that trying out a new activity or behaviour can be a threatening experience for some. In light of this, ‘response priming’ is based on the idea that clients can be ‘primed’ or prepared to try out a new activity behaviour and to experience it as successful so they will be more likely to want to try out another new activity/behaviour again on a different occasion. The role of Workers in this technique is to offer clients verbal prompts so they can practice being assertive and using their communication skills and to offer positive reinforcement and encouragement.

## **A Summary of CRA strategies and procedures**

This manual has outlined a range of CRA procedures that Workers can use to assist clients to think about their unhealthy use of alcohol and to change their behaviour towards it.

The manual began with a description of the *CRA Survey* conducted at intake when clients enter the CRA program. Next the *Functional Analysis of Drinking Behaviour* was explained. This analysis is a procedure to assess the way clients use alcohol in their day to day lives. The functional analysis has two phases. The first phase explores the triggers and short and long term consequences of the clients drinking, while the second phase explores the triggers for non-drinking and its short and long term consequences. The manual then described *Sobriety Sampling*, a procedure for supporting clients to give up drinking for a specific period of time and to develop a tailor made

plan to achieve this. This was followed by an outline of the *CRA Treatment Plan* and its two procedures: the *Happiness Scale* for assisting clients to think about their level of satisfaction in ten different areas of their lives and the *Goals for Counseling*, used with clients to address the problem areas in their lives.

Finally, the manual ended with *Skills Training*, a series of strategies that aim to identify, strengthen and extend the skills that individual clients may need to better manage their lives and stop their harmful alcohol use. *Relapse Prevention* was also described because it is a procedure that Workers may need to use with clients who give way to drinking even though they have been participating in the CRA program.

## **Section 4: Glossary**

This section includes useful technical terms and concepts commonly used to talk about alcohol and alcohol related harms. It also includes brief definitions of some of the terms used in this manual. Definitions are based on the two key references on which this manual is based. That is:

1. Smith JE and Meyers RJ (2004) Motivating Substance Abusers to Enter Treatment, Working with Family Members
2. Meyers R J, Smith J E (1995) Clinical Guide to Alcohol Treatment, The Community Reinforcement Approach

Terms are listed in alphabetical order.

### **Abstinence**

To not drink (abstain from) alcohol or take other types of drugs.

### **Alcohol Dependence**

When someone gives alcohol priority over and above other important things in their lives, for example looking after their family, going to work or school, taking care of their health. Alcohol dependence has biological, psychological and social elements and can range from mild to severe.

### **AUDIT**

This term stands for the Alcohol Use Disorders Identification Test. The term refers to a health assessment questionnaire that can be used to assess people's risk for hazardous and harmful alcohol consumption. The questionnaire includes ten questions that each get a score depending on the answer. When the scores are added together the total indicates the person's level of risk for alcohol. The questionnaire can be used by individuals interested in self checking their alcohol use or used by Workers with clients.

### **AUDIT C**

A similar but much shorter questionnaire used to assess risk of alcohol that includes only 3 questions. The questionnaire is therefore much quicker and therefore convenient and easier to use.

### **Brief Intervention**

A brief intervention is an activity that takes very little time and that can be done by health care practitioner as part of routine healthcare practice. It may consist of anything between 5 to 60 minutes of counseling and/or education, with usually no more than three to five sessions (Higgins-Biddle & Babor 1996:4). In some cases brief intervention might also be as brief as 30 seconds and delivered in one opportunistic session. What is done during a brief intervention depends on the client and their readiness to change their behaviour, the setting, and whether the client has been involved in previous interactions. It is recommended that brief interventions are used as early as possible with clients to prevent additional problems from developing.

Brief interventions for alcohol are 'those practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it'. Trials in a number of countries show '... clear evidence that well-designed brief intervention strategies are effective, low-cost and easy to administer (Babor, Higgins- Biddle 2001).

## **Cognitive-behavioural model**

The term cognitive refers to the process of knowing and, more specifically, the process of being aware, knowing, thinking, learning and judging. CRAFT is described as a cognitive-behavioural model. Very simply it focuses on changing the thinking and behaviour of individuals who misuse alcohol and of their families and relatives through the use of goal-oriented, systematic procedures.

## **CRAFT**

A structured but flexible approach to support people who are adversely affected by alcohol. This includes: people who are at risk of harm as a result of their unhealthy patterns of drinking, and family members, relatives or close friends. CRAFT has two parts. These are Community Reinforcement (CRA) for individuals who drink and Family Training (FT) for the families and friends of people who drink. CRAFT uses strategies that aim to achieve three goals:

1. remove positive rewards for drinking
2. strengthen positive rewards for abstinence
3. encourage the participation of family and relatives

### **CRA (Community Reinforcement Approach)**

Is the part of CRAFT for individuals whose alcohol use affects their health. CRA has two key goals. These are to:

1. Remove the positive reinforcements/rewards that maintain a person's alcohol use
2. Strengthen positive reinforcements/rewards that lead a person to reduce or cease their alcohol misuse

## **Evidence based**

This is a technical term used to describe the use of research to make decisions about the best health action for a given situation. CRAFT is an evidence based alcohol intervention. This means there is evidence to show it is an effective way to treat people affected by alcohol. Read more: Definition of Evidence Based Practice | eHow.com

[http://www.ehow.com/about\\_5048440\\_definition-evidence-based-practice.html#ixzz1D9PxuaqQ](http://www.ehow.com/about_5048440_definition-evidence-based-practice.html#ixzz1D9PxuaqQ)

## **FT (Family Training)**

Family Training is the part of CRAFT that is designed for the families, relatives and close friends of individuals who are alcohol dependent or whose alcohol consumption results in problems. FT has three main goals:

1. to assist families/ friends to get their alcohol dependent relative into treatment
2. to support families/ friends to provide their relative with social support to promote positive behaviour change and decrease their alcohol use
3. to promote health and wellbeing of families/ close friends through reducing the negative impact their relative's drinking is having on their health

## **Functional Analysis**

The functional analysis is an assessment framework used in CRAFT 'for understanding the factors that influence the occurrence of a particular behaviour' (Smith and Meyers 2004 p 40). There are a number of different CRAFT functional analyses. Although each functional analysis has a different purpose they are all based on the same general structure.

In CRA there are three functional analyses that are used to assess an individual client's drinking/non-drinking behaviour. These include:

1. functional analysis for drinking behaviour,

2. functional analysis for drinking behaviour (relapse version)
3. functional analysis non-drinking behaviour.

The CRA functional analysis for drinking and for relapse asks client's about the:

- internal and external triggers for drinking
- behaviour
- short term positive consequences of drinking
- long term negative consequences of drinking

The CRA functional analysis for non- drinking asks client's about the:

- internal and external triggers for non-drinking
- behaviour
- short term negative consequences of non-drinking
- long term positive consequences of non-drinking

In FT three functional analyses are used to assess families and/or friend's views/feelings/thoughts about their relative's alcohol related behaviour. This means families/friends respond to the functional analysis questions about their relative's alcohol use. Functional analyses include:

1. functional analysis of a relative's drinking behaviour
2. functional analysis of a relative's violent behaviour
3. functional analysis of a functional analysis of a relative's enjoyable healthy behaviour

### **Happiness Scale**

This instrument is used in both CRA and FT. In CRA the Happiness Scale is the first step in the development of the treatment plan. In this context it is used to assess a client's current level of happiness in ten different categories of life including: drinking/sobriety, job/education, money management, social life, personal habits, marriage/family relationships, legal issues, emotional life, communication, general happiness. In FT the instrument is referred to as the Relationship Happiness Scale. This scale measures family/friend's level of happiness with the relationship they have with their relative who drinks. Happiness in this context is also measured in ten different categories of life including: drinking/drug use, household responsibilities, raising the children, social activities, money management, communication, sex and affection, job/school, emotional support, general happiness.

### **Goals of Counselling**

This procedure is also used in both CRA and FT. In CRA it is used to assist clients who drink, whereas in FT it is used to assist the families/friends of a relative who drinks. In both cases the procedure is based on the completion of a form which asks people to:

- identify problem areas in their life using the same ten categories listed on the Happiness Scale
- set specific goals for each problem area
- list the intervention that they will use to change their unwanted behaviour
- identify a time frame in which to achieve the goal

### **Negative consequences**

Negative consequences maybe experienced by someone who misuses alcohol. They may result from a person's drinking or non-drinking. In the CRA functional analysis of drinking behaviour, a client is assisted to identify and consider the long term negative consequences of their drinking as it may impact on different areas of life including: interpersonal, physical, emotional, legal, job/study, money. Examples of the long-term negative consequences of drinking may include: loss of friends, unemployment, increased illness, risk of incarceration etc.

Clients may also experience short-term negative consequences of non-drinking. These are identified during the CRA functional analysis of non-drinking behaviour. Short-term negative consequences of non-drinking will depend on the client's non-drinking behaviour. For example a negative consequence such as feelings of loneliness may result if a client chooses to spend time alone at home to avoid going out with friends who drink.

In FT families/friends may also be assisted to identify and consider the long-term negative consequences of their relative's alcohol use. The use of the FT functional analysis of a relative's drinking behaviour and the FT functional analysis of a relative's violent behaviour will assist in this.

### **Patterns of drinking**

This words used in this term are sometimes used interchangeably, i.e. 'drinking patterns'. In either case the meaning of the term is the same. The term refers to the level of drinking, that is how much people drink, as well as to all of the other characteristics that are associated with the way people drink. This includes for example:

- when people drink (e.g. after work, at work, on the weekend) ;
- where people drink (e.g. club, home, pub, at the footy);
- who people drink with (e.g. with others, alone, late at night);
- the number of drinking occasions (e.g. daily, weekly);
- activities associated with drinking (e.g. sport, poker machines, smoking, parties);
- personal characteristics of the drinker and his/her friends (e.g. shy, withdrawn, extrovert, sociable);
- types of drinks (e.g. full/light strength beer, spirits, wine);
- drinking norms that contribute to a 'drinking culture' (for Indigenous people this might be influenced by pub bans, availability)

Other terms that are used to types of alcohol consumption are explained in Brief Interventions for Hazardous and Harmful Dinking, A Manual For Use in primary Care (2001 Babor, Biddle-Higgins). For example 'low risk' alcohol use generally refers to drinking that is unlikely to result in alcohol related problems. Whereas the term 'alcohol misuse' refers to any level of risk including hazardous drinking to alcohol dependence (Babor, Higgins-Little 2001 p ). A drinking pattern that is referred to as 'hazardous' is usually linked to a risk of harmful physical, mental or social consequences for the person who drinks as well as for their families and friends.

### **Reinforcer**

In CRA a reinforcer is anything (object, behaviour, comment, activity) that is likely to motivate a client to think about changing their unhealthy drinking behaviour and maintaining sobriety. Reinforcers may be positive or negative. A positive reinforcer is something pleasant or enjoyable that clients receive in return for not drinking. For example a client who wants to buy a **new car** maybe motivated to stop drinking and start saving. As savings start to add up clients may find that

they become more motivated and that the purchase of the new car becomes possible. A negative reinforcer is something unpleasant that a client wants to avoid and that reinforces their non-drinking. For example a client who plays football **feels guilty and ashamed** by letting their team down after a night's drinking may want to avoid those feelings and therefore becomes motivated to stop drinking.

When families and friends are thinking about which reinforcers might be likely to motivate their relatives to think about changing their drinking behaviour they should ensure the reinforcer is inexpensive, available to offer immediately, comfortable to deliver and will be enjoyable to their relative (Smith and Meyers 2004 p 138).

### **Risk**

The possible harm that might result to an individual as a consequence of their alcohol use. Although levels of risk associated with drinking alcohol are difficult to quantify they are often referred to as low risk drinking, risky and high risk drinking. More detailed descriptions of these terms can be found in the Alcohol Treatment Guidelines for Indigenous Australians (2007) and downloaded from the web at:

<http://www.health.gov.au/internet/alcohol/publishing.nsf/Content/AGI02>

### **Sobriety**

This term in the context of alcohol consumption refers to the state of being sober or not intoxicated or drunk.

### **Harm reduction**

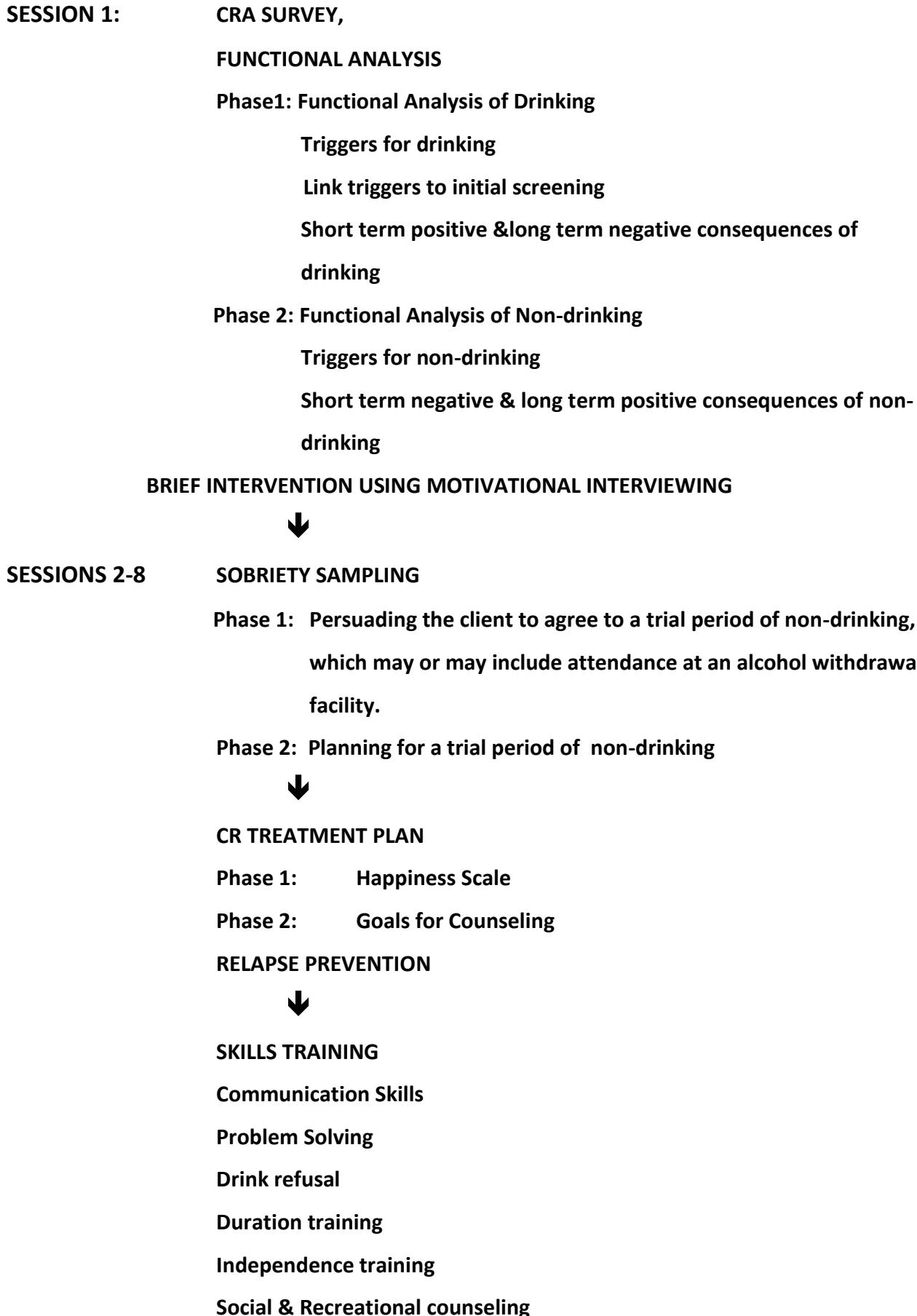
Harm reduction may be defined as those policies and interventions that focus on reducing the harms associated with drug/alcohol use, not the amount of drug/alcohol used (Ritter & Cameron 2005 p i). A brief intervention is one example of a harm reduction strategy. Other harm reduction strategies are those that minimize the total societal harm caused by the production, distribution, use and control of drugs/alcohol using whatever interventions are most effective (Caukins 2004 p1).

### **Motivational interviewing**

A technique Workers can use to assist people assess their own behaviour and desire to change. In CRAFT, Workers can use the technique to motivate or encourage people to make decisions about their alcohol use. Brief motivational interviewing involves Workers asking a person about their positive and negative experiences of alcohol. Workers then reflect this information back to the person enabling them to further explain their situation. Motivational interviewing is discussed in detail on pages ... of this manual.



## APPENDIX 1: SAMPLE CRA SESSION PLAN



## **Procedures Checklist**

The following checklist sets out the elements of each of the CRA procedures. They do not have to be done in order (except the overview and functional analysis) and several procedures may be done in one session depending on the client's situation. This checklist will be used for assessment if you are completing the CRA accreditation.

### **Overview of CRA:**

1. \_\_\_\_\_ Described basic objective (help find healthy, reinforcing lifestyle...)
2. \_\_\_\_\_ Outlined several procedures (communication skills, problem solving)
3. \_\_\_\_\_ Set positive expectations (describe scientific base)
4. \_\_\_\_\_ Described duration of treatment (time limited)
5. \_\_\_\_\_ Started to identify reinforcers

### **Functional Analysis of Substance Using Behavior:**

6. \_\_\_\_\_ Gave rationale
7. \_\_\_\_\_ Started by asking for description of common episode/behavior
8. \_\_\_\_\_ Outlined triggers (external; internal)
9. \_\_\_\_\_ Clarified the using (or non-using) behavior
10. \_\_\_\_\_ Outlined positive & negative consequences of the behavior
11. \_\_\_\_\_ Gave examples of how the information would be used

### **F.A. for Pro-Social Behavior:**

12. \_\_\_\_\_ Gave rationale
13. \_\_\_\_\_ Started by asking for description of common episode/behavior
14. \_\_\_\_\_ Outlined triggers (external; internal)
15. \_\_\_\_\_ Clarified the using (or non-using) behavior
16. \_\_\_\_\_ Outlined positive & negative consequences of the behavior
17. \_\_\_\_\_ Gave examples of how the information would be used

### **Sobriety Sampling/Tine out from drinking-using:**

18. \_\_\_\_\_ Explained the concept of sobriety sampling
19. \_\_\_\_\_ Gave rationale for sampling sobriety (e.g., forces use of other coping strategies)
20. \_\_\_\_\_ Negotiated a reasonable period of sobriety
21. \_\_\_\_\_ Developed a specific plan for maintaining sobriety at least until next session
22. \_\_\_\_\_ Developed a back-up plan as well
23. \_\_\_\_\_ Reminded client of reinforcers for sobriety

### **Disulfiram or Naltrexone [or Psychotropic Medication] Administration Program:**

24. \_\_\_\_\_ Educated about disulfiram/naltrexone
25. \_\_\_\_\_ Presented advantages of the medication (e.g., builds family trust)
26. \_\_\_\_\_ Set up monitor/compliance protocol
27. \_\_\_\_\_ Role-played administration of the medication (with monitor)

### **Happiness Scale:**

28. \_\_\_\_\_ Provided rationale category
29. \_\_\_\_\_ Gave instructions specific)
30. \_\_\_\_\_ Reviewed some ratings

### **Treatment Plan/Goals of Counseling:**

31. \_\_\_\_\_ Used Happ. Scale to select goal
32. \_\_\_\_\_ Set goal using guidelines (e.g.,
33. \_\_\_\_\_ Checked on progress of goals

**Communication Skills: [NOTE: You have a choice between this and Drink/Drug Refusal Skills]**

- 34. \_\_\_\_\_ Discussed why positive communication is important
- 35. \_\_\_\_\_ Described/reviewed the 7 positive communication elements (or an appropriate subset)
- 36. \_\_\_\_\_ Gave examples of poor & good communications/conversations
- 37. \_\_\_\_\_ Role-played (reinforced, gave specific feedback, repeated)
- 38. \_\_\_\_\_ Did a reverse role-play

**Drink/Drug Refusal Skills: [NOTE: You have a choice between this & Communication Skills]**

- 39. \_\_\_\_\_ Enlisted social support
- 40. \_\_\_\_\_ Reviewed high-risk situations
- 41. \_\_\_\_\_ Presented/reviewed options for assertive refusal (e.g., changed subject)
- 42. \_\_\_\_\_ Role-played (kept brief, reinforced, gave specific feedback, repeated)

**Problem Solving Skills:**

- 43. \_\_\_\_\_ Described/reviewed steps of the procedure
- 44. \_\_\_\_\_ Conducted CRA problem solving procedure (e.g., defined the problem, brainstormed)

**Social/Recreational Counseling:**

- 45. \_\_\_\_\_ Discussed importance of satisfying social life
- 46. \_\_\_\_\_ Identified area to add (e.g., thru problem-solving or F.A. for Pro-social Behavior)
- 47. \_\_\_\_\_ Discussed & planned the sampling of a new enjoyable behavior/activity

**Job Counseling:**

- |  |                                     |
|--|-------------------------------------|
| 48. _____ Discussed high-risk jobs                                 | 52. _____ Completed applications    |
| 49. _____ Developed a resume                                       | 53. _____ Rehearsed interviews      |
| 50. _____ Generated/followed-up job leads                          | 54. _____ Discussed/planned for job |
| 51. _____ Rehearsed & made phone calls<br>maintenance/satisfaction |                                     |

**Systematic Encouragement:**

- 55. \_\_\_\_\_ Identified need & took 1<sup>st</sup> step in session (e.g., locate contact person, make a call)
- 56. \_\_\_\_\_ Reviewed the experience in next session

**Relationship Therapy: [NOTE: Required only if you work with couples]**

- 57. \_\_\_\_\_ Explained & gave Relationship Happiness Scale
- 58. \_\_\_\_\_ Explained & gave Perfect Relationship Scale
- 59. \_\_\_\_\_ Developed goals & strategies following guidelines
- 60. \_\_\_\_\_ Gave instructions for Daily Reminder to Be Nice
- 61. \_\_\_\_\_ Practiced relationship communication skills

**Relapse Prevention:**

- 62. \_\_\_\_\_ Administered Functional Analysis for Relapse
- 63. \_\_\_\_\_ Discussed behavioral chain of events
- 64. \_\_\_\_\_ Described & set up early warning system

**Miscellaneous:**

- 65. \_\_\_\_\_ Looked for/Tied in Reinforcers
- 66. \_\_\_\_\_ Monitored Trigger Contact
- 67. \_\_\_\_\_ Checked for Skills Generalizing
- 68. \_\_\_\_\_ Assigned Homework (made specific, anticipated obstacles)
- 69. \_\_\_\_\_ Reviewed Homework (assessed outcome; modified plan if necessary; reinforced)
- 70. \_\_\_\_\_ Role-Played (kept brief, reinforced, gave specific feedback, repeated)
- 71. \_\_\_\_\_ **Overall:** stayed within CRA protocol (as far as philosophy & objectives)
- 72. \_\_\_\_\_ **Overall:** introduced CRA procedures at appropriate times

**General Clinical Skills**

- 1. \_\_\_\_\_ Warm                    3. \_\_\_\_\_ Non-judgmental                    5. \_\_\_\_\_ Maintains session focus
- 2. \_\_\_\_\_ Understanding            4. \_\_\_\_\_ Appropriately active            6. \_\_\_\_\_ Behaves professionally

## **Section 5: Some Useful Resources and Contacts**

### **Government Guidelines, Plans, Reports, Strategies**

National Health and Medical Research Council (NHMRC) Australian Alcohol Guidelines to Reduce Health Risk from Drinking Alcohol (2009). Available at:

<http://www.nhmrc.gov.au/publications/synopses/ds10syn.htm>

National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009. Australian Government Department of Health and Ageing (reprinted May 2006).

Available at:

<http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/indigenous-drug-strategy-ip>

National Drug Strategy: Aboriginal and Torres Strait Islander Peoples, Complementary Action Plan 2003-2009: Background Paper

Canberra: Ministerial Council on Drug Strategy. Available at: see above

The Alcohol Treatment Guidelines for Indigenous Australian (2007)

Alcohol and other drug treatment services in Australia 2006–07: Findings from the National Minimum Data Set Canberra: Australian Institute of Health and Welfare  
Australian Institute of Health and Welfare (2007)

The National Drug Strategy 2010-2015. Canberra: Australian Government

Ministerial Council on Drug Strategy (2011). Available at:

<http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/nds2015>

Australian Institute of Health and Welfare (2011) *Substance use among Aboriginal and Torres Strait Islander people*. Canberra: Australian Institute of Health and Welfare. Available at:

<http://www.aihw.gov.au/publication-detail/?id=10737418268>

### **Other**

Talking about alcohol with Aboriginal and Torres Strait Islander patients - revised edition – flipchart

Brady M. The Grog Book: Strengthening Indigenous community action on alcohol (2005). Department of Health and Ageing, Canberra

### **DVDs**

Alcohol DVD - Strong Spirit Strong Mind - what our people need to know about alcohol.

## **Web Sites**

<http://www.healthinfonet.ecu.edu.au> Healthinfonet

<http://www.adca.org.au/> Alcohol and Other Drugs Council of Australia (ADCA)

<http://www.adf.org.au/> Australian Drug Foundation

<http://www.ancd.org.au/> Australian National Council on Drugs

<http://www.health.nsw.gov.au/public-health/dpb/about.htm> Centre for Drugs and Alcohol

<http://ndri.curtin.edu.au/> National Drug Research Institute

<http://www.nidac.org.au/> National Indigenous Drug and Alcohol Committee

<http://ndarc.med.unsw.edu.au/> National Drug and Alcohol Research Centre

<http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/home> National Drug Strategy

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