Capstone Paper: Community Reinforcement Approach (CRA)

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Abstract

Community Reinforcement Approach (CRA) was developed and researched in the 1970s by behavioral psychologist, Dr. Nathan Azrin. The goal of CRA is to replace substance use with healthy and rewarding non-using behaviors and activities, called pro-social behaviors. CRA was initially developed and studied for adults with alcohol use disorders. Dr. Azrin's colleagues and successors, including Dr. Mark Godley and Dr. Robert Meyers, adapted CRA to work with other substance use disorders, such as stimulant use disorders and opioid use disorders. These researchers adapted CRA to work with a variety of populations, including transition age youth, adolescents, and homeless adults. I review theoretical underpinnings of CRA, the assessment and case conceptualization process, and diagnostic formulation. Finally, I discuss the course of CRA treatment, including discharge and aftercare planning. I highlight a case study of a young adult who received CRA treatment to address her opioid use disorder.

Keywords: evidence-based treatment, substance use disorders, pro-social behavior

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When I initially learned of my agency's federal grant award to implement Adolescent Community Reinforcement Approach (A-CRA) in 2005, I was curious about this treatment model. I knew little, if anything, about A-CRA or CRA. Our outpatient department recently completed another federal grant on Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT). We were tying up loose ends on this grant when we learned of our new grant award.

As part of our implementation of A-CRA, I had multiple consultations with one of the model developers of CRA and A-CRA, Dr. Mark Godley. We reviewed training and certification requirements and covered the logistical aspects of the training. Dr. Robert Meyers, another model developer, was our lead trainer. Dr. Meyers is a dynamic and engaging speaker. His clinical acumen was quite evident as he shared case examples to illustrate teaching points in the treatment model.

At that time I did not fully appreciate the depth of the research base of CRA and A-CRA. Furthermore, I was not aware of how Dr. Godley and Dr. Meyers contributed to shaping how our field provides treatment for substance use disorders. Their vast research and publications on CRA guide how many substance use counselors provide effective and ethical treatment. Dr. Godley and Dr. Meyers were collaborators with the founder of CRA, Dr. Nathan Azrin.

In my fifteen years of learning, implementing, and supervising this treatment model, I saw firsthand the effectiveness of CRA. In the beginning, there were anecdotal results demonstrating positive outcomes. Nonetheless, there is no greater joy as a counselor to see the improved relationships between your client and their loved ones; to hear your client recall with

pride that they had refused drugs; to hear their probation officer enthusiastically state that your client was released from probation because he met his court requirements.

These anecdotal results were quantified through our external grant evaluation with the University of Virginia when our treatment results were published. Our program notched the following results: two-thirds of youth decreased substance use, improved school attendance, and reduced their legal involvement. We served 180 youth during through this three-year reporting period (McGarvey, Leon-Verdin, Bloomfield, Wood, Winters, & Smith, 2012).

Notwithstanding our agency's contribution to the literature on effective substance use treatment, I immersed myself in this treatment model. The model is positive and uplifting. It focuses on the strengths of our clients rather than a sheer focus on their deficit areas. CRA's concept is straightforward: replace substance use with healthy and positive activities and behaviors that are more rewarding or reinforcing than substance using behavior. Throughout this replacement, a focus on improving skills and relationships is addressed, highlighting Bandura's social learning theory (Bandura & Walters, 1963).

As I continued to gravitate toward this treatment model, I was offered opportunities to enhance my professional development. I was invited to be an assistant trainer to Dr. Meyers. Later, I became a lead trainer and was afforded the opportunity to travel across the country training clinicians and supervisors in CRA and A-CRA. I serve as a session rater, consultant, and coach on supervisory conference calls with trainees across the county. This work led to speaking engagements at conferences and seminars.

Although many of these opportunities were fortuitous, I grasped each opportunity and I am grateful, as these opportunities have shaped my professional growth. Community Reinforcement Approach is the bastion of my identity as a counselor and supervisor. I proudly

champion this model in my evolving role as an emerging scholar. As I seek to grow in my professional development in the areas of research, advocacy, and leadership, I do so with CRA by my side.

Commented [SLS(fC&FS1]: A scholarly introduction Jennifer.

As you move toward taking your QE, remember that your theoretical model must be comprehensive enough to treat presenting problems across the diagnostic spectrum (i.e., non-substance related). Therefore, it will be important to expand your model. Counselor educators must supervise and teach counselors in training working in diverse settings. Based on CACREP standards, CES leadership are, therefore, responsible to assess doctoral student's ability to apply a flexible enough model to the variety of presenting concerns. Let me know if you have questions about this.

Comprehensive Theoretically Grounded Model of Clinical Counseling

Evidence based theories I apply in counseling

Community Reinforcement Approach (CRA) draws heavily on behavioral therapy. When counselors think of behavioral therapy, BF Skinner is likely a name that comes to mind. In his 1939 landmark publication, *The Behavior of Organisms*, he disseminates information from his research at Harvard University. The basic tenets of his approach are as follows: to understand behavior we must look at the cause of the action and the related consequence. This is referred to as operant conditioning. Skinner introduced the concept of reinforcement. Behavior that is reinforced continues to be repeated, and behavior that is not reinforced will become extinct. Operant conditioning may be described as changing the behavior by use of the reinforcer which is provided after the desired behavior occurs (Skinner, 1939).

Many parents use a Skinnerian approach with raising children. My children are not allowed to use their electronic devices during the school week. They may earn time on their devices on the weekends if they exhibit desired behavior during the school week as evidenced by being respectful to their parents, completing their work as required, and being respectful with each other. This is an example of operant conditioning. Their undesirable behavior (back talking parents) is extinguished because they will not earn time on their electronic devices if they exhibit this behavior.

Operant conditioning influences the principles of CRA. In order for our client to choose the non-using behavior over the using behavior, the non-using behavior must be more rewarding

or reinforcing than the substance using behavior. Thus, time-out from the reinforcers will occur if the client begins to drink or use drugs again (Hunt & Azrin, 1973). For example, a client's reinforcer for sobriety may be to get off of probation. If the client continues to use drugs, he or she may test positive on a drug screen. A positive test may result in increased court sanctions. The reinforcer of court involvement serves to curtail the substance use. However, the reinforcer alone may not be sufficient to eliminate use.

Of paramount importance is to identify the positive consequences of the using behavior. A target of treatment is to assist the client in finding healthier ways to access the positive consequences associated with substance use. A functional analysis of substance using behavior outlines both positive and negative consequences of the using behavior (Meyers & Smith, 1995).

CRA was developed by behavioral psychologists Dr. Nathan Azrin and Dr. George Hunt based on B.F. Skinner's operant conditioning. However, these researchers recognized that reliance solely on operant behavioral principles may not take into account the role of inherited and cognitive factors. Furthermore, the importance of learning through observation is not addressed with operant conditioning (Hunt & Azrin, 1973).

Commented [SLS(fC&FS2]: Important points

Azrin and Hunt incorporated components of Albert Bandura's social learning theory into CRA. The theory addresses the importance of learning through observing the behaviors of others and imitating these behaviors. Social learning theory brings the cognitive processes to the forefront which the pure behaviorists did not address (Bandura & Walters, 1963).

Social learning theory is incorporated in CRA through the use of the community as positive reinforcement. More specifically, the importance of sober supports and non-using activities is emphasized in CRA. These non-using behaviors are modeled for our clients by non-using peers and supports in their community. This modeling can occur through one-to-one

activities between the client and a non-using peer such as attending a movie or going bowling. The modeling may also occur during group activities, including attending a church group or AA meeting (Azrin, 1976).

Several procedures in CRA underscore Bandura's theory. In the drink and drug refusal skills procedure, the counselor assists the client in identifying a non-using social support to assist with the client's goal of reducing or eliminating substance using behavior. A plan is developed in session on how to contact the identified social support and ask for support. A goal is developed to engage in alternative activities through modeling positive behavior with the identified support (Meyers, Villanueva, & Smith, 2005).

My comprehensive method of bio-psycho-social/multi-systemic-cultural/spiritual assessment

After a referral is made for substance use treatment, the face to face assessment is scheduled. The Global Appraisal of Individual Need (GAIN) is a reliable and valid bio-psycho-socio-spiritual assessment that provides a comprehensive and holistic framework to gather information. The GAIN is a semi-structured assessment that takes about one to two hours to complete. The GAIN has been normed on ages twelve and above (Dennis, 2003).

The GAIN is organized into separate sections that address different domains the client's life. The client uses timeframe anchors to respond to questions, along with yes or no responses, and verbatim responses. Sections of the GAIN include referral information, substance use, mental and emotional health, physical health, environmental/living situation, legal status, and vocational or school status. The GAIN assesses for issues of race, culture, or gender that may influence treatment (Dennis, 2003).

The GAIN is a self-report assessment that includes collateral information from other sources, such as a probation officer or significant other, and urine drug screening results. This

information is synthesized in a narrative clinical summary that serves as the case report. The case report is the foundation for the case conceptualization process. The GAIN is utilized across a variety of treatment settings for clinical and research purposes due to its strong psychometric properties (Dennis, Rourke, Lennox, Campbell, & Caddell, 1995).

The GAIN assesses from a biological perspective by exploring medical and psychological conditions of the client's blood relatives. There are questions about the substance use, mental health, and physical health of these relatives. Psychological history and functioning is assessed by the section on emotional and behavioral health. Past and current history of symptoms and treatment is outlined. The instrument assesses for issues of risk, including past or current suicidal or homicidal ideation. The environment and living situation sections probe for the client's supports, strengths, and nature of the living situation with regard to drug and alcohol use.

Cultural issues that may affect treatment are queried, including the client's identified culture, religion, race, and gender. The assessment recognizes the client's sexual orientation. Furthermore, the assessment identifies the client's spiritual beliefs and how these beliefs play a role in the client's life (Dennis, 2003). Although the GAIN provides a basis for outlining cultural issues that may affect treatment, the clinician must practice within a framework of cultural competence to address multicultural considerations identified during the assessment process.

A main benefit of this assessment tool is consistency across assessors. As the GAIN is a semi-structured assessment, each clinician who administers the GAIN provides a thorough assessment focusing on all aspects of the client's functioning. The GAIN ensures that all

dimensions are probed equally, thereby reducing the possibility of an inaccurate diagnosis or incomplete assessment (Dennis, 2003).

Commented [SLS(fC&FS3]: Appropriately scholarly and insightfully presented sections Jennifer.

The case report is a narrative document that is entered into the client's electronic health record. This report guides treatment and provides documentation for third-party payors who require medical necessity as a prerequisite for authorizing treatment. The case report begins with referral information and general background information on the client. The case report is divided into narrative sections that align with the respective sections on the GAIN assessment.

The report maps to American Society of Addiction Medicine (ASAM) criteria. ASAM is a dimensional assessment that is required for all forty community service boards in Virginia to determine appropriate placement for individuals with substance use disorders (Hays, 2006). While some agencies use a separate ASAM assessment and bio-psycho-socio-spiritual assessment, the GAIN embeds ASAM criteria throughout the assessment (Dennis, 2003).

The case report includes narrative information on the client's frequency, duration, and length of substance use along with any functional impairments that the substances may have caused. The report includes details on the client's endorsement of mental or emotional problems, current or past treatment, and use of medications. The document outlines the current and past history of physical health issues for the client and family of origin. This includes current or past medication. The report documents history of trauma, neglect, or abuse. The narrative addresses issues of risk, such as suicidal ideation, homicidal ideation, or self-harming behavior, both current and by history. The document details the client's environment and living situation, vocational status, and school status.

The case report details the client's strengths, treatment preferences, cultural preferences, and spirituality. Included in this document is collateral information from other sources,

including caregivers, significant others, referral agencies, and urine drug screening results. The case report aligns with the CRA model in that the document outlines the client's reasons or motivators to reduce or stop using drugs or alcohol. This report serves as the cornerstone of the case conceptualization process and guides the development of the treatment plan.

Commented [SLS(fC&FS4]: Fortunately, a lot of what you are doing applies across the diagnostic spectrum Jennifer.

How I synthesize assessment data into an accurate case conceptualization, diagnosis, and measureable treatment plan (including the maintenance plan)

The case conceptualization process is a synthesis of the information gathered in the referral and assessment process. This process serves as a road map to guide treatment planning and delivery of services. The counselor reviews the referral information, assessment information, collateral information, mental status presentation, client history, and drug screening results to formulate a plan of care that is consistent with the client's desired goals and outcomes of treatment (Sperry, 2005).

As part of the GAIN assessment, a risk assessment is conducted. The results of the risk assessment inform the case conceptualization process. The case conceptualization process aligns with CRA as the model is strength-based, client-focused, and collaborative in nature. The case conceptualization process is linked to the GAIN assessment. The GAIN embeds ASAM criteria (Dennis, Chan, & Funk, 2006). The ASAM assessment drives client placement into the appropriate level of care for substance use treatment. The levels of care range from level .5 prevention to level 5 inpatient treatment (Hays, 2006).

As part of my case conceptualization process, a referral is made to a primary care provider for a medical evaluation. A medical evaluation ensures that differential diagnoses are assessed. If a client is currently under the care of a primary care physician, a release of information is obtained. The counselor requests a copy of the client's medical records. Moreover, in keeping with a holistic approach toward care, clients are encouraged to receive

annual dental and vision examinations. The counselor or case manager assists with linkage to community resources if barriers are identified.

Commented [SLS(fC&FS5]: Excellent!

A DSM-5 diagnosis is determined through the assessment process. The assessment process consists of several steps. First, I obtain referral information and schedule a face-to-face assessment. A Global Appraisal of Individual Need (GAIN) assessment drives the determination of a diagnosis and begins the process of case conceptualization. I gather collateral information once a release of information is signed by the client. Collateral sources of information may include information from a significant other, information from the referral source, department of social services, court service unit, and previous treatment records, if applicable.

Commented [SLS(fC&FS6]: Excellent

I incorporate urine drug screening results in the collateral information. These results guide the determination of a diagnosis. A client mandated for substance use treatment may not be forthcoming in sharing information about the frequency, length, and duration of his or her substance use. Collateral information from drug screening results and referral sources provides a comprehensive set of data to make a diagnostic determination.

Commented [SLS(fC&FS7]: It takes courage and kindness to do this Jennifer.

The effort, energy, and thoughtfulness that goes into this holistic treatment is huge. Yet it really is what is needed to provide ethical and effective comprehensive intervention with this population.

Consequently, the DSM-5 diagnosis develops after completion of the comprehensive assessment and data collection. Supervision and consultation may be used to determine an accurate diagnosis. As a clinical supervisor, I am consulted by clinicians that I supervise if they seek further guidance or input into the selection of an appropriate diagnosis.

As counselors, we must practice within the scope of our training and competence. We may refer our client for further assessment with a trained provider if an area is identified that requires further assessment before a diagnosis can be made. For example, counselors do not typically diagnose neurocognitive disorders and sleep-wake disorders. Referral for neurodevelopmental testing may be indicated in these cases.

Furthermore, counselors will not typically diagnose schizophrenia spectrum disorders. Counselors may use the DSM-5 to identify symptomology and make a preliminary diagnosis. However, a psychiatrist or a licensed clinical psychologist should confirm the presence of a schizophrenia spectrum disorder.

CRA uses a client-centered process for developing goals and a treatment plan. This process begins with two CRA procedures, the happiness scale and goals of counseling. The happiness scale procedure invites the client to rate his or her level of satisfaction or happiness in 16 life areas on a likard scale from 1 to 10. This scale is used to identify client strengths, set treatment goals, and monitor progress toward goals set in treatment. Happiness scales are conducted throughout the course of treatment to highlight progress and edit or add goals, as identified by the client.

The goals of counseling procedure develops from the client's happiness scale. There are 16 goal areas that correspond with the happiness scale categories. The clinician guides the client's selection of one to two mid-rated categories from their happiness scale that he or she would like to work on in treatment. The clinician suggests mid-rated categories because these categories would not be too easy or too hard to work on.

After a category selection is made, the clinician helps the client develop a 30 day goal statement. For example, if the client rates a "4" in the area of money management and selects this category, the client is asked what he or she would like to happen to improve this area from a 4 to a 5 in the next 30 days. The clinician helps shape the goal statement into a positive, measurable, specific, and straightforward statement that is under the client's control. "I would like to save $100 out of my paycheck in the next month" is an example of a goal statement. A weekly strategy or intervention is developed from the goal statement. For example: "I will

deposit $25 weekly into my savings account every Friday at 4:30 pm at the bank after I get paid."

CRA emphasizes the importance of anticipating and addressing obstacles toward completion of a goal or strategy. If the client identifies forgetting to make the deposit as an obstacle, strategies are brainstormed with the client. The client may identify a solution to set a phone reminder.

The weekly strategy or intervention becomes the client's homework assignment. Weekly homework is assigned at the end of each session. Homework is positive, specific, measurable, and under the client's control. Homework is based, at least in part, on the client's input.

Community Reinforcement Approach focuses on replacing substance using behavior with healthy and positive non-using behaviors and activities (Hunt & Azrin, 1973). This overarching goal guides every session. CRA focuses on what the client would like to gain from treatment. The client's strengths, preferences, and desired outcomes are gathered at intake and reviewed each session. These areas serve to build the client's reinforcers for sobriety.

While CRA is an abstinence-based model, it can be adapted to clients who want to reduce their use. This adaptation includes the use of a harm reduction approach. CRA is a flexible model that is delivered in offices, homes, schools, jails, hospitals, or other confidential settings. There is no minimum or maximum duration for each session. The duration is guided by the clinician's judgment. Typically, sessions last about an hour. The general frequency is weekly; however, the frequency may be dictated by the treatment setting. In residential facilities, CRA is delivered more often than weekly. With a home-based model, the therapist usually delivers CRA twice a week (Smith, Meyers, & Miller, 2001).

CRA demonstrates effectiveness with a variety of populations. CRA was proven to be effective when introduced with homeless individuals in a day treatment setting (Tolomiczenko, 1999). Moreover, studies demonstrate successful outcomes in treatment of opioid use disorders and stimulant use disorders (Schottenfeld, 2000). Meta-analyses rank CRA among the top treatment models for substance use disorders (Roozen, Boulogne, van Tulder, van den Brink, De Jong, & Kerkhof, 2004).

Commented [SLS(fC&FS8]: Effective and strategic presentation of your model throughout Jennifer.

There are 21 procedures in the CRA model. Clinicians use their clinical judgment, dictated by the client's stated preferences, to decide which procedures to introduce. During the first session, the overview of CRA procedure is provided to the client. CRA is a transparent and straightforward approach. We believe that sharing information on the purpose of treatment and length of treatment is important so that our clients guide the treatment process. In the overview of CRA, we set positive expectations by describing the research base of the model. We begin to identify reinforcers for sobriety and discuss why these reinforcers are important in treatment (Palinkas, 2000).

Following the overview, there are several assessment-based procedures completed in the first one to three sessions. The happiness scale and goals of counseling procedures are used to develop a collaborative treatment plan. CRA facilitates two types of functional analyses: functional analysis (FA) for a problem behavior (substance using behavior) and functional analysis (FA) for a healthy behavior or pro-social behavior (Meyers & Smith, 1995).

The goal of the FA for substance using behavior is to decrease or eliminate the behavior. The goal of the FA for pro-social behavior is to increase the behavior. The functional analysis is a road map that outlines the antecedents and consequences of the identified behavior. The

information collected on the functional analysis informs the treatment plan (Smith, Meyers, & Miller, 2001).

After a treatment plan and goals of counseling are operationalized, the clinician selects procedures to introduce from the CRA menu of procedures. Two foundational procedures in CRA are communication skills and problem solving skills. These skills are introduced and reviewed throughout the course of treatment to ensure skill generalization.

CRA employs the use of role-play to assist clients with skill generalization. Each procedure begins with a rationale or purpose of the procedure. The rationale is tied to the client's treatment goals or reinforcers for sobriety to maximize the client's engagement. Positive and constructive feedback is provided to the client at the end of the role-play. The client is encouraged to offer feedback at the end of the role-play. Procedures that include role-plays in CRA are communication skills, anger management skills, job-seeking skills, and drug refusal skills (Meyers & Smith, 1995).

A unique aspect of CRA is the inclusion of job-seeking skills in the treatment model. This is a multi-layered procedure that includes the following: helping the client develop a list of job interests, discussing risk of substance use with regard to job areas of interest, developing a list of job contacts, setting up a job tracking system, job application skills, and job interview preparatory points and interviewing skills. In addition, clients are taught steps to make a job inquiry and these skills are role-played in the session. Clients are encouraged to make the first contact for a potential job during the session. This contact is an example of a procedure called systematic encouragement (Meyers & Smith, 1995).

CRA sessions are structured to begin with a homework review. Following the review, a CRA procedure is introduced. Finally, the session ends with a homework assignment. The CRA

therapist must exhibit flexibility in the selection of procedures to be introduced. For example, the therapist may plan to introduce drink and drug refusal skills; however, the client may arrive for the session upset about an argument that she had with her significant other. In this instance, it is clinically appropriate to table the procedure on refusal skills and introduce communication or problem solving skills (Palinkas, 2000).

CRA is a time-limited approach. CRA has a definitive start and end point. The initial research was based on 12-14 weekly outpatient sessions lasting about an hour. Development of a termination plan begins at treatment inception. The termination plan is reviewed throughout the course of treatment (Meyers & Smith, 1995).

Clients receive an overview of CRA in the first CRA session. The therapist explains that treatment is time-limited and outlines the duration of treatment. A discharge goal and objective are included on the client's treatment plan. This plan is developed collaboratively with the client. As part of termination, a final happiness scale is conducted to review the client's progress throughout the course of treatment. This review serves as an opportunity to highlight the client's progress and discuss any unmet needs. The tool provides visual reinforcement for the client to see the improvements that he or she made during the course of therapy.

The review of the final happiness scale assists with development of an aftercare plan. The client and clinician discuss any unmet goals. This discussion fosters the development of the aftercare plan. For example, if a client's goal is to find two non-using friends to engage in pro-social activities and only one friend was identified, a plan to identify and engage with another non-using friend may be part of the aftercare plan. Another example may include attendance in Alcoholics Anonymous/Narcotics Anonymous (AA/NA), Celebrate Recovery, or other support group.

The focus of the aftercare plan is to continue facilitation of the client's wellness and sustain treatment gains. As CRA focuses on the client's community engagement in healthy, non-using activities, aftercare plans rely heavily on community-based interventions and activities. Some of these activities may include: linkage to non-using community activities, like church groups, book clubs, and recreation centers.

Aftercare or maintenance plans include names and contact information for support people. As part of the termination of treatment, the clinician assists the client in development of a relapse prevention plan. This plan outlines triggers and high risk situations and delineates specific actions that the client can take when a trigger or high-risk situation is encountered. The relapse prevention plan is included as part of aftercare planning.

An intentional focus on aftercare is a crucial aspect of recovery from a substance use disorder. Many of the evidence based treatment models focus only on the initial treatment episode. Aftercare planning can assist with reducing the likelihood of relapse and multiple treatment episodes. Viewing recovery through the lens of the medical model with a focus on longer-term aftercare provides optimal ethical care for clients with a substance use disorder (DuPont, Compton, & McLellan, 2015).

Commented [SLS(fC&FS9]: Scholarly, well-organized, and comprehensive presentation of your model Jennifer. I am delighted with the ethical and effective treatment you and your teams provide!

Case Study

Kelly is a 25 year-old single Caucasian female residing in central Virginia. Kelly was referred for a substance use assessment by her probation officer after she tested positive for opiates on three separate occasions in a one month time span. Kelly is on probation for larceny associated with stealing over $2,000 from her employer during a six month time span. Kelly has a 5 year-old daughter. Kelly and her daughter live with Kelly's mother. As a requirement of

probation, Kelly must have a job in order to pay restitution and court-related costs. Kelly is currently unemployed.

The GAIN assessment revealed that Kelly met criteria for opioid use disorder, moderate. Her urine drug screen on the date of the assessment was negative. Kelly reported no history of trauma or abuse. She was raised by a single mother and is the eldest of two daughters. She has a high school education and worked for a doctor's office as an administrative assistant following high school. She was prescribed oxycontin after a knee injury two years ago. After her oxycontin was discontinued, she found ways to subvert this medication, including visits with multiple doctors to obtain prescriptions.

The GAIN assessment highlighted that oxycontin helped Kelly forget about feelings of stress related to raising her daughter and financial concerns. She reported: "It made me feel numb. It just took away all of my feelings. When I ran out, a flood of stress overcame me and I had to get more pills." At the height of her oxycontin use she was taking 80 mg per day. Her longest period of abstinence was one week. The GAIN identified her primary motivators for sobriety were to be released from probation and retain custody of her daughter.

Kelly's case report highlighted a number of strengths, including her faith. Kelly identified as a Christian and reported that she had been a member of a local church since childhood. Additional strengths included Kelly's work history. Prior to her arrest, she maintained an excellent employment record. Over the years, she received accolades from her supervisor and co-workers on her interpersonal skills and organizational skills.

Kelly's treatment preference was outpatient treatment. There were no cultural factors identified that affected treatment; however, Kelly shared with the counselor that she identified as bisexual, although she has not come out to her family and most friends.

Kelly was reported to be in good physical health. She had no history of serious injuries, surgeries, or hospitalizations. She attended annual well visits and received dental examinations twice a year. She was not on any prescription medication and reported no allergies.

Collateral information from Kelly's case report included referral information from her probation officer. This information included Kelly's legal history and current legal status, social and family history, and substance use history. The information documented drug screening results.

Kelly signed a release of information in order for the counselor to obtain collateral information from her mother. Kelly's mother highlighted concern about Kelly's use of opiates. Her mother reported concern for Kelly's welfare and the welfare of Kelly's five year-old daughter. Kelly's mother added that she thought about calling social services with her concern; however, she feared that this would cause strife in her relationship with Kelly.

Kelly's case conceptualization included synthesis from the following sources of information: collateral and referral information from her probation officer, collateral with her mother, GAIN assessment, urine drug screening results, risk assessment, and mental status examination. Based on a review of the information collected and face-to-face observation with Kelly, the counselor recommended ASAM level 1 outpatient treatment consisting of weekly individual sessions with Kelly. Treatment included random urine drug screening. The focus of the individual sessions was to address Kelly's opioid use as well as her other identified problem areas (relationship with her mother, loss of her job).

The treatment duration was 12 weeks followed by continuing care or aftercare. Kelly's feedback and goals for treatment helped guide the case conceptualization process. When asked

what she would like to get out of treatment, Kelly replied: “I want to get off of probation, get a job, and get along better with my mother.”

In keeping with the Community Reinforcement Approach, Kelly’s treatment plan was based on her reinforcers for sobriety (release from probation, improve relationship with her mother, obtain a job). Collaboratively, the counselor used CRA procedures, including the happiness scale, goals of counseling, and functional analysis of substance using behavior, to develop Kelly’s treatment plan. After these assessment based procedures were completed, the counselor introduced CRA procedures to address Kelly’s identified goal areas.

Since Kelly reported getting a job as a goal, the counselor included the job-seeking skills procedure on Kelly’s treatment plan. Throughout the course of treatment, the counselor assessed Kelly’s satisfaction with treatment and progress toward her treatment goals. Her goals were edited, modified, and changed as deemed necessary by Kelly and her counselor. The overarching focus was to help Kelly replace opioid use with healthy and positive behaviors and activities that were more rewarding than her opioid use. A focus on identifying and increasing pro-social recreation was woven in throughout the course of treatment. Kelly’s full treatment plan is found in Appendix B.

The focus of Kelly’s treatment centered around her reinforcers for sobriety. Each procedure linked to her stated reinforcers, including release from probation. Kelly met with her counselor for weekly individual sessions lasting about an hour. The counselor conducted conjoint sessions with Kelly’s mother, who Kelly identified as a sober support. The conjoint sessions focused on a plan to assist Kelly with drug refusal skills and development of a relapse prevention plan, using her mother as part of her early warning system to avert a relapse.

Furthermore, the conjoint sessions focused on improving the relationship between Kelly and her mother.

Kelly received random urine drug screens, designed to evaluate and inform the treatment process. If Kelly submitted a negative drug screen, verbal reinforcement and praise was provided. If there was a positive drug screen, the counselor chose from a variety of procedures, including a functional analysis of relapse or a behavior chain of events.

Kelly's termination plan was developed at the beginning of treatment and explored throughout the course of treatment. CRA is a time-limited approach. Her aftercare plan consisted of attending her church services weekly and the church life group. Both of these activities were identified as support for Kelly. She was referred to a weekly one hour continuing care group following the completion of her outpatient CRA treatment.

Continuing care group assisted Kelly in monitoring triggers and high-risk situations. The group counseling provided reinforcement of skills learned in CRA, including communication skills and problem solving skills. An emphasis on pro-social activities highlighted the continuing care focus. This highlighted area served to keep the importance of healthy, non-using activities to address triggers such as boredom, in the forefront of Kelly's maintenance plan.

Following three months of weekly CRA treatment and an additional three months of continuing care group, Kelly stepped down into community supports to maintain her recovery. She was released from probation as she submitted negative drug screens to her probation officer. She gained employment at the time of discharge from treatment. She began attending Celebrate Recovery, a faith-based recovery support program. She continued to live with her mother and reported improved relationships and overall better communication.

Commented [SLS(fC&FS10]: Engaging case study congruent with your model. Very effective presentation Jennifer!

Conclusion

In the forty-six years since Hunt and Azrin's landmark research on Community Reinforcement Approach was published, many challenges and opportunities have abounded in the field of substance use treatment. Hunt and Azrin's inceptive work was conducted on adults with alcohol use disorders. In the decades that ensued, CRA has been replicated, adapted, and modified to work with a variety of populations, genders, cultures, and diagnoses. CRA is heavily rooted in behavioral principles and social learning theory.

Early studies demonstrated the efficacy of using CRA with disulfiram for treatment of alcohol use disorders (Azrin, Sisson, Meyers, & Godley, 1982). Later studies documented CRA's outcomes with stimulant use disorders, opioid use disorders, and cannabis use disorders, with the adolescent adaption, Adolescent Community Reinforcement Approach (A-CRA). CRA is shown to be effective in treating traditionally challenging populations, including homeless adults and adolescents with co-occurring mental disorders and substance use disorders (Smith, Meyers, & Miller, 2001).

With a variety of national initiatives and focus on evidence-based treatment across behavioral healthcare, CRA is well-suited to maintain its place among the pillar of evidence-based treatment models for many years to come. In the past several years, federal funding has been earmarked to states to deliver opioid-specific trainings. A handful of states, including Oklahoma, Kentucky, and the District of Columbia, chose CRA as their designated treatment model to address the challenges of opioid use disorders. With the challenge of treating opioid use disorders and the resurgence of stimulant use disorders, CRA will once again be called on to lead the collective charge to provide empirically based treatment for those who suffer with a substance use disorder.

Commented [SLS(fC&FS11]: Appropriately academic set of references. Robust citations to the literature throughout your document.

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Appendix A

Case Conceptualization

Kelly is a single 25 year-old Caucasian female living in central Virginia. She has a five year-old daughter. Kelly and her daughter live with Kelly's mother. Kelly has a high school education and worked in a doctor's office as an administrative assistant for six years before losing her job due to stealing from her employer. She was charged with larceny eight months ago and placed on probation.

Kelly is court mandated to receive substance use treatment after she was charged and convicted of larceny for stealing $2,000 from her employer to purchase oxycontin from a drug dealer. While in court she tested positive for opioids. Kelly has no previous substance use or mental health treatment history. She briefly received counseling in elementary school when her parents divorced. Kelly notes remorse for her legal charge and subsequent placement on probation. She states that she will attend treatment "to get off of probation" but denies that she has a substance abuse problem. Kelly denies suicidal or assaultive ideation. Her urine drug screen upon intake was negative.

In order for Kelly to reach her stated goal of "getting off of probation" she is required to pass a drug screen and to get a job to pay restitution to the court. Kelly's GAIN assessment revealed several reinforcers for sobriety: release from probation, improved relationship with her mother, obtaining a job, and being a good parent for her five year-old daughter. CRA begins with identification of reinforcers for sobriety. These reinforcers help shape the case conceptualization and treatment planning processes. Kelly's treatment plan consisted of identifying the external and internal triggers that led to her opioid use. In addition, outlining the positive and negative consequences of use were areas of focus.

Case conceptualization consists of helping Kelly find healthier ways to access the positive consequences associated with her use. Furthermore, a focus on identifying healthy and rewarding non-using behaviors to replace using behavior is a part of CRA's conceptualization of the problem. A focus on improved relationships is addressed throughout treatment with the introduction of communication and problem solving skills. Ultimately, Kelly will use coping skills and strategies to disrupt patterns that led to her opioid use.

Kelly was referred to her primary care physician for an evaluation. A consult was conducted with a physician specializing in addiction medicine to determine if Kelly was a candidate for Medication Assisted Treatment (MAT), such as suboxone. Clients with a moderate or severe opioid use disorder may benefit from MAT in conjunction with counseling or therapy (Saxon, & McCance-Katz, 2016). Upon completion of the initial dosage of CRA, she was referred to a continuing care group that met weekly at the same treatment facility where Kelly received outpatient counseling.

Section B.1.c of the American Counseling Association (ACA) 2014 Code of Ethics is considered when working with court mandated clients. This section notes that information should be disclosed with appropriate signed release of information (ACA, 2014). Upon entry into treatment, Kelly received informed consent, including the relevant limits and privileges of confidentiality. She signed a release of information in order for her probation officer to be kept abreast of her treatment compliance.

Section B.2.e is reviewed as the counselor provides minimal disclosure to the probation officer (ACA, 2014). The details of Kelly's therapy sessions were not disclosed. An overall update on Kelly's attendance and compliance with treatment were provided to the probation officer.

Finally, section B.3.e is considered as the probation officer and court require written updates of Kelly's progress. Section B.3.e addresses the transmission of confidential information. Confidentiality must be maintained during any transmission (ACA, 2014). The counselor sent treatment updates that were through an encrypted electronic mail exchange to ensure that Kelly's protected health information was not compromised.

Kelly's mental status was considered as part of the case conceptualization process. Kelly presents as a neatly dressed and groomed individual appearing approximately her stated age of 25. She is pleasant and maintains appropriate eye contact with the counselor. There were no unusual mannerisms noted and her speech rhythm and pace were within normal limits. Her mood was euthymic. Her affect was congruent with her mood. Her thought processes were intact. There were no perceptual deficits noted. Her attitude was cooperative and insight fair to poor. She appeared to be of average intelligence. Her recent and remote memory appeared to be good.

Kelly's assessment informed the case conceptualization process. Kelly completed a Global Appraisal of Individual Need (GAIN) assessment to determine her treatment needs.
A urine drug screen was obtained as part of the assessment. Kelly's screen was negative. Kelly's ASAM level of care is determined to be 1.0 Outpatient treatment.

Kelly met diagnostic criteria for F 11.20 opioid use disorder, moderate, as evidenced by the following: a problematic pattern of opioid use (oxycontin) that led to clinically significant impairment. The impairment occurs within a 12-month period and is manifested by the following: oxycontin is often taken in larger amounts or over a longer time than was intended, there is a persistent desire or unsuccessful efforts to cut down or control oxycontin use, a great deal of time is spent in activities necessary to obtain oxycontin, a strong desire to use oxycontin,

recurrent oxycontin use resulting in failure to fulfill major role obligations at work and home. The specifier of moderate was added as Kelly endorsed five symptoms.

Her use of oxycontin caused problems at work including tardieness, missing work altogether, and stealing from her employer to purchase oxycontin. Kelly spent much of her time, from one to six hours a day, trying to acquire oxycontin. Eventually she began buying oxycontin from the "street" once her medical doctors would no longer prescribe the medication.

Differential diagnoses considered included opioid-induced mental disorders and other substance intoxication. However, Kelly's GAIN assessment did not reveal evidence of a co-occurring mental disorder. Thus, this diagnosis was rejected in favor of an opioid use disorder. Other substance use disorders were considered; however, there was no evidence from Kelly, her probation officer, or her urine drug screening results, that she was using other substances. Thus, this diagnosis was also rejected in favor of an opioid use disorder. Additional diagnosis included Z65.3 Problems related to other legal circumstances and Z56.0 unemployment.

Based on the synthesis of information gathered, Community Reinforcement Approach is indicated as the treatment modality to achieve Kelly's stated goals of release from probation, finding a job, and improved familial relationships. It is anticipated that the initial course of treatment will be 12-14 weeks followed by aftercare to ensure a long-term plan for maintenance of sobriety. CRA will target Kelly's reinforcers for sobriety by increasing pro-social recreation, improving communication and problem solving skills, and addressing triggers that led to her opioid use.

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Appendix B

Commented [SLS(fC&FS14]: Comprehensive plan that aligns with both your model and the case.

Your clients and supervisees are very fortunate to work with you and your team Jennifer!

Evidence Based Treatment Plan

Problem or Concern	**Measurable Treatment Goal**	**Treatment Interventions**	**Expected Number of Sessions Devoted to Reaching This Goal**	**Measurable Means of Evaluating and Monitoring Progress Toward Treatment Goal**	**Aftercare Plan/Follow-Up**
Kelly's use of opioids (oxycontin) has resulted in the following consequences: placement on probation and loss of her job. She is at risk of incarceration as a result of stealing from her employer to support her oxycontin use.	Kelly will abstain from using oxycontin as evidenced by self-report, collateral report, urine drug screening results.	Counselor will administer assessment based CRA procedures to identify Kelly's triggers and consequences of oxycontin use. Counselor will administer the functional analysis of substance using behavior. Counselor will assign weekly homework. Intervention: Community Reinforcement Approach Frequency: weekly	14	Urine drug screening results, client report, clinical observation collateral report, Happiness Scale	Transition/discharge plan: Kelly will be discharged from outpatient therapy upon completion of 14 weekly sessions of Community Reinforcement Approach
Kelly's oxycontin use has caused	Kelly will use positive communicat	Counselor will teach the three elements	14	Relationship happiness scale, client report,	Counselor will complete a final happiness scale to review and highlight

Problem or Concern	Measurable Treatment Goal	Treatment Interventions	Expected Number of Sessions Devoted to Reaching This Goal	Measurable Means of Evaluating and Monitoring Progress Toward Treatment Goal	Aftercare Plan/Follow-Up
problems in her family relationship as evidenced by strife with her mother and concern that she may lose custody of her five year-old daughter if she continues to use.	ion skills with her mother and will set goal areas and develop strategies to improve their relationship as evidenced by client report, collateral report, and clinical observation.	of positive communication to Kelly (understanding statement, partial responsibility statement, offer to help). Counselor will engage Kelly in role-play and reverse role-play to practice and receive feedback to help shape Kelly's behavior. Homework will be assigned to practice skills in Kelly's natural environment Intervention: Community Reinforcement Approach Frequency: weekly		collateral report, clinical observation	progress and discuss a plan to address any unmet goals
Kelly lost her job due to drug-related behaviors of stealing	Kelly will apply for at least two jobs per	Counselor will introduce Community Reinforcemen	8-10	Client report, clinical observation, happiness scale, collateral report	Counselor will assist Kelly with development of a plan for job maintenance

Problem or Concern	Measurable Treatment Goal	Treatment Interventions	Expected Number of Sessions Devoted to Reaching This Goal	Measurable Means of Evaluating and Monitoring Progress Toward Treatment Goal	Aftercare Plan/Follow-Up
money from her employer to purchase opioids. She is required to gain employment as a condition of probation.	week and will learn and practice job inquiry skills, interviewing skills, and learn how to complete a job application	t Approach's job seeking skills procedure which includes: describing and setting up a job tracking system, making a list of job contacts, practicing making job inquires and interviewing through role-play, and developing a plan for job maintenance Intervention: CRA Frequency: weekly			
Kelly spends her time (1-6 hours per day) using or attempting to obtain oxycontin	Kelly will increase pro-social behavior to replace substance using behavior through completion of the leisure	Counselor will administer the FA for pro-social behavior, the leisure questionnaire and 2 by 2 checklist to identify pro-social	10-14	Client report, collateral report, clinical observation, happiness scale, review of homework assignments designed to increase pro-social behavior	Counselor will assist Kelly with completion of a relapse prevention plan to include list of sober activities and contacts and development of a schedule of weekly pro-social activities as well as a list of triggers and high-risk situations to avoid

Problem or Concern	**Measurable Treatment Goal**	**Treatment Interventions**	**Expected Number of Sessions Devoted to Reaching This Goal**	**Measurable Means of Evaluating and Monitoring Progress Toward Treatment Goal**	**Aftercare Plan/Follow-Up**
	questionnaire, functional analysis for pro-social behavior and 2 by 2 checklist of pro-social activities.	activities that Kelly would like to sample and increase Intervention: CRA Frequency: weekly			
Kelly experiences maladaptive problem solving skills resulting in legal involvement and placement on probation	Kelly will learn the 8 steps of problem solving and apply CRA's problem solving model to life's problems through completion of weekly homework assignments	Counselor will teach Kelly the 8 steps of problem solving and assist Kelly with applying these steps to a relevant problem area as identified on her happiness scale Intervention: CRA Frequency: weekly	8-14	Happiness scale, homework review, client report, clinician observation, collateral report	As part of Kelly's discharge plan, Kelly will identify at least three sober supports in her family and community that she can contact if she encounters triggers or high-risk situations through problem solving skills
Kelly has been unable to maintain abstinence from oxycontin for longer than one week since she began using two years ago	Kelly will engage in sobriety sampling by establishing time-limited durations of sobriety where a primary	Counselor will introduce CRA's sobriety sampling procedure to engage Kelly in setting short, time-limited	10-14	Happiness scale, client report, collateral report, clinician observation, urine drug screening results	Kelly will transition from weekly CRA sessions to weekly continuing care group. Counselor will complete referral for group and introduce Kelly to group facilitator prior to transition from outpatient therapy to continuing care group

Problem or Concern	Measurable Treatment Goal	Treatment Interventions	Expected Number of Sessions Devoted to Reaching This Goal	Measurable Means of Evaluating and Monitoring Progress Toward Treatment Goal	Aftercare Plan/Follow-Up
	back-up plan are developed to ensure that she can achieve this outcome. She will identify and address high-risk situations and triggers that may impact her ability to maintain sobriety.	amounts of sobriety in order to implement coping skills and replace use with pro-social activities			

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Overall, your paper is clear, consistently insightful, reasoned, and creative Jennifer. Moreover, it exemplifies a depth of research, employment of excellent sources, and an abundance of critical, detailed examples. Likewise, it is sophisticated in its organization and structure on all levels, making it appropriately scholarly.

Outside of expanding your general model to incorporate diverse conditions, you are all set to prepare for the Qualifying Examination Jennifer. If you need or want to discuss how you might do this, please let me know.

What a joy to meet you and have you in class this term! May you continue to flourish in every way as your doctoral journey continues!