Blanchardstown Local Drugs Task Force

CRA

(Community Reinforcement Approach)

Implementation of CRA – an Evidence based Treatment approach across addiction services in Blanchardstown (and other regions)

Brid Walsh, BLDTF, Nov 2011

Presentation Overview

- Local Drugs Task Forces (LDTF's)
- Implementation of Evidence based approach (rationale)
- CRA (overview & accreditation process)
- BLDTF CRA Implementation process
- Key factors/challenges
- Early outcomes

Local Drugs Task Forces

Set up in 1997 to develop and implement effective strategies to respond to areas experiencing the highest levels of drug use, particularly opiates (Heroin)

14 in Ireland – 12 in Dublin, 1 in Cork, 1 in Wicklow

Original Objectives

- **Prevention**: Reduce number of people turning to drugs in the first place
- **Treatment & Rehab**: develop & support effective services for existing drug users
- **Justice & supply**: Develop mechanisms to tackle drug related crime
- **Research**: To ensure access to research/information to inform local planning

Local Drugs Task Forces can achieve this through building the capacity of:

- **Policy makers**
- **Frontline workers**
- **Agencies/services**
- **Local Community**
- **Problem substance users**
- **Substance users families**

Why use Evidence based approaches in addiction?

- ***To ensure the best outcomes for service users***

- **Ethically we have a responsibility to use the most up to date scientifically proven approaches**
- **Using untested or unproven methods would not be tolerated in medicine or other fields. The same standards should apply in addiction**
- **As funders we are using Public expenditure which means greater accountability which means using methods with proven outcomes**
- **As a funder, in a time of restricted resources, agencies that are using proven methods will get priority. Using Evidence based approaches gives agencies credibility**

Some examples of evidence based approaches in the addiction field

- Motivational Interviewing (used in Ireland)
- Cognitive Behaviour Therapy (used in Ireland)
- Strengthening Families programme –manualised whole family programme (used in Ireland)
- CRA, ACRA & CRAFT (in process of implementation)

Why CRA

- **It has been proven to work**! CRA (ACRA &CRAFT) has shown significant positive outcomes in over 30 years of clinical trials. **In meta analyses** when compared against other well established approaches still comes out on top
- Package of tools- not just one technique - includes a range of different procedures
- **Soon to be launched Nat Substance Misuse strategy** – CRA has shown excellent results across the board with various substance use including alcohol
- **Interagency collaboration**– CRA accreditation is not exclusive to a particular discipline or sector -it has excellent applicability across disciplines/agencies. Clinicians & project workers can use same model
- It complements other existing approaches rather than replacing them
- **The new National Drug Strategy** (NDS) reference it as an evidence based approach that should be used and its introduction is a key action in our local drugs strategy

Why Isn't CRA Used More?

- Limited accessibility to training – up to 2011 no trainers in Ireland (Nor is it linked to a 3rd level institution here)
- Funding: training, coding & supervision are expensive
- accreditation process requires high level of practical support & co-ordination
- Traditional treatment models can be easier and its 'It's hard to teach an old dog new tricks'
- "We already do that"
- Therapist drift post training
- 'CRA isn't sexy' (structured, methodical approach, taping

Community Reinforcement Approach (CRA) brief background

- initially developed in the US in the early 1970's(Azrin, Godfrey and Dr Bob Meyers) for heavy drinkers
- It had Unprecedented positive outcomes for heavy drinkers initially both on an in-patient and then on other trials with out-patients
- The approach was refined further in subsequent years and demonstrated similar effectiveness with other drug users, adolescents (ACRA) & families of substance users (CRAFT)

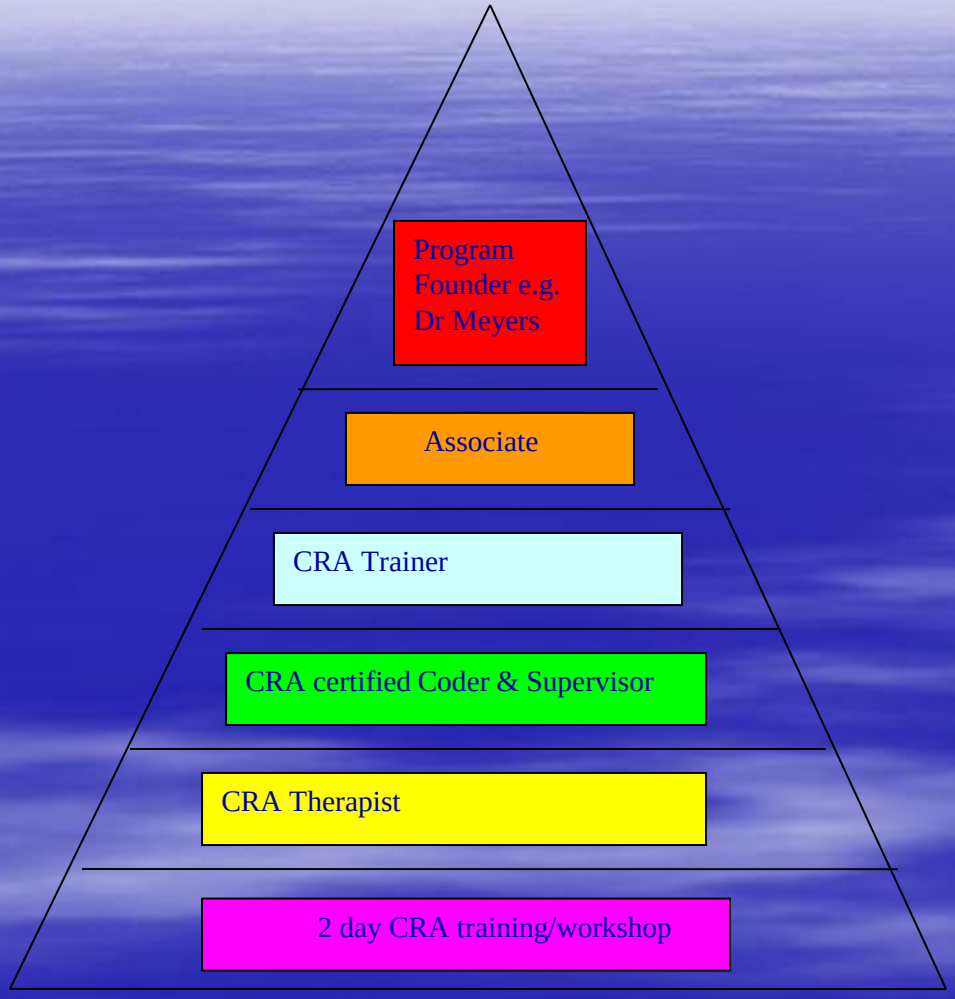
CRA Tools/Protocols

Basically teaching new skills to deal with old problems – behavioural approach that uses clients own rein forcers to make a drug free lifestyle more rewarding than a using one. the areas covered are:

- Overview of CRA
- Functional analysis for using/non using/relapse behaviour
- Happiness/contentment scales
- goals of counselling
- Communication skills
- Drink/drug refusal skills
- Problem solving skills
- sobriety sampling
- Social/recreational training
- Relapse prevention
- Anger management
- Domestic violence counselling
- Relationship counselling
- Care giver sessions
- Jobs counselling
- Systematic encouragement
- Identifying positive reinforcers

To achieve accreditation therapists must submit taped sessions to accredited CRA coders and receive mark of 3 or above on the protocols submitted (competencies in 8 or more must be achieved to become therapist)

Accreditation process



Accreditation process

CRA Therapists

- 2 full days Training with accredited CRA Trainer
- Upload taped real therapy sessions to accredited CRA coder
- attend supervision (Skype) with accredited supervisor
- Coders' scores must pass trainee on 8 or more CRA protocols to become therapist

CRA Coder/Supervisor

- Must be CRA therapist first but needs to pass all protocols in the modality
- using Dr Myers' coding criteria trainee must listen to tapes and get 80% agreement with accredited coder for 5 tapes consecutively (inter-rater reliability)
- Trainee must Submit taped supervision sessions of CRA therapists to be reviewed by Dr Meyers & team – must demonstrate reinforcement of competent use of CRA constructive feedback, use of CRA language & philosophy – 4 tapes approved to certify

Trainer

- Complete all of the above processes and co-train with Dr Meyers who will sign off on competency

BLDTF CRA Plan objectives

- **Ultimately the main objective is to provide better outcomes for people who wish to move from problematic drug and alcohol use**

- Match the expectation of standards of care in mainstream medical/primary healthcare with those in addiction field
- Introduce in Ireland value for money treatment that is scientifically proven to work and move away from investment in approaches that have no evidence base to support them
- Develop standard level of competencies in evidence based treatment for nearly 200 addiction practitioners in Ireland across a wide range of sectors, disciplines & projects
- Evaluate the process of the implementation of CRA as an evidence based treatment to inform future planning & development
- Establish a panel of Irish CRA/ACRA/CRAFT coders/supervisors & trainers to sustain the model here in Ireland

BLDTF CRA Plan Milestones

- **Between March and December 2010** we commissioned Dr Meyers to train nearly 200 frontline workers & case managers in level 1 CRA, CRAFT and ACRA

- **Sept 2010 –** we sought and secured funding from Social Inclusion unit for implementation
- **Jan 2011-** we secured capital funding for equipment (recorders, web cams etc)

- **Jan 2011 –**we set up a structure with 13 chairs to support groups of 10 trainees (approx) each and form the Steering group chaired by BLDTF to drive implementation process

- **Jan 2011-** Dr Myers appointed an accredited CRA coder to each group

- **Jan 2011-** met with NACD to agree process for evaluation and hired Prof Mark Morgan to carry out implementation research in June

- **June 2011 –** invited 1st 15 people who got accredited as therapists to form additional group to work towards accreditation as coders/supervisors under Dr Meyers teams supervision chaired by BLDTF
- **Oct 2011** –DR Meyers presented 70 people with Practitioner certs who have become accredited with us through this process
- **October 2011-** process began again with 80 more trainees in CRA & ACRA

CRA Steering group

Chaired by Brid Walsh (BLDTF)

- **James Kelly- Manager Coolmine lodge & Ashleigh house**
- **Kevin Ducray- Drug Treatment Board (Young persons programme)**
- **Gerry Ryan- Manager, Tolka River**
- **Brendan Mc Kiernan- Manager, Keltoi (HSE group)**
- **Sean Foy- HSE substance misuse team**
- **Gemma Collins- Manager, Crinan Youth Project**
- **Brian Fitzsimons – Blanchardstown Foroige (Drug prevention programme)**
- **Brian Foley- Ballymun Youth Action Project**
- **David Madden- Coolmine (chaired both coolmine & external group)**
- **Yvonne Booth- Coolmine**

New groups

- **Sue White & Catherine Meleady – (internal Coolmine grps), Nora martin (internal Genesis grp)**

BLDTF CRA PLAN – Accreditation Groups

ACRA (ADOLESCENT VERSION)

Group 1-Chair :Kevin Ducray (DTCB) HSE SASSI & YPP team, YODA, HALO, Ciall Project, Crinan Youth Project, St Patricks Dual Diagnosis & HSE including Dr Bobby Smyth, Dr Gerry McCarney

Group2- chair: Brian Fitzsimons (Foroige), Blanchardstown Youth Service, WEB, MBYI, ORB

Group3-Chair: Brian Foley (BYAP), HHCDT, MBCDT, Genesis family Psychotherapy, HSE nurse, STAR

CRA (ADULT)

Group1: Chair: Gerry Ryan (TRP) – Tolka River project, MCCDT, HHCDT,MBCDT, Probation

Group2: Chair: Brendan McKiernan (HSE) – HSE Clinical including, RIS, Keltoi, Counselling, consultant psychiatrist Dr Rooney

Group3: chair Sean Foy (HSE), MCCDT,MBCDT,HHCDT,STAR, Crinan, Simon Com, St Patricks Dual Diagnosis

Group4: chair: **Dave madden (Coolmine),** Ballymun STAR, YAP, De Paul Centre, Genesis Family Psychotherapy centre, CASP (also managed small internal coolmine group)

Group 5: chair: **James Kelly** (Coolmine staff)

Group 6a &b: Chairs: Catherine Meleady & Sue white (new internal Coolmine grps) –

CRAFT (FAMILY VERSION)

Group1: chair: Gerry Ryan (TRP)-Tolka, MBCDT, MCCDT, BJC, HHCDT, STAR, YAP

Group2: chair: Nora Martin (Genesis internal group)

Group3: chair: Gemma Collins(Crinan) – Crinan, St pats dual diagnosis, HSE regional, CASP, STAR, Tabor Lodge, Simon

Group4: chair: Brendan McKiernan(HSE) – Keltoi, RIS, Consultant Psychiatrist, Counsellors

Group 5: chair: Yvonne booth (Coolmine internal)

Challenges with BLDTF implementation of CRA

- **Selling the model: Getting buy in from funders, projects, services & Task Force**
- **Champions**: Ensuring that the appropriate people were targeted -having 'champions' to promote the model and endorse it's effectiveness (Shane Butler, Paul Conlon, Gerry Ryan) & dedicated and committed chairs/steering group
- **Funding**: cost of training from the USA, coding of tapes, purchase of equipment, development of training manuals, training DVD, hourly rates for supervision from the USA (SKYPE)
- **Co-ordination –**a central structure to manage communication, troubleshooting, support and liaison with nearly **200 trainees from different disciplines, sectors, agencies, geographical areas. This plan involved a wide range of agencies not just one centre**
- **Practical barriers**: equipment & logistics of broad spread of trainees, difficulties with uploading of tapes
- **Capacity of coders:** given huge volume of tapes which increased dramatically close to upload deadline which meant a 'panic' on submission and longer waiting time for feedback from coders on tapes

Challenges for CRA implementation (continued)

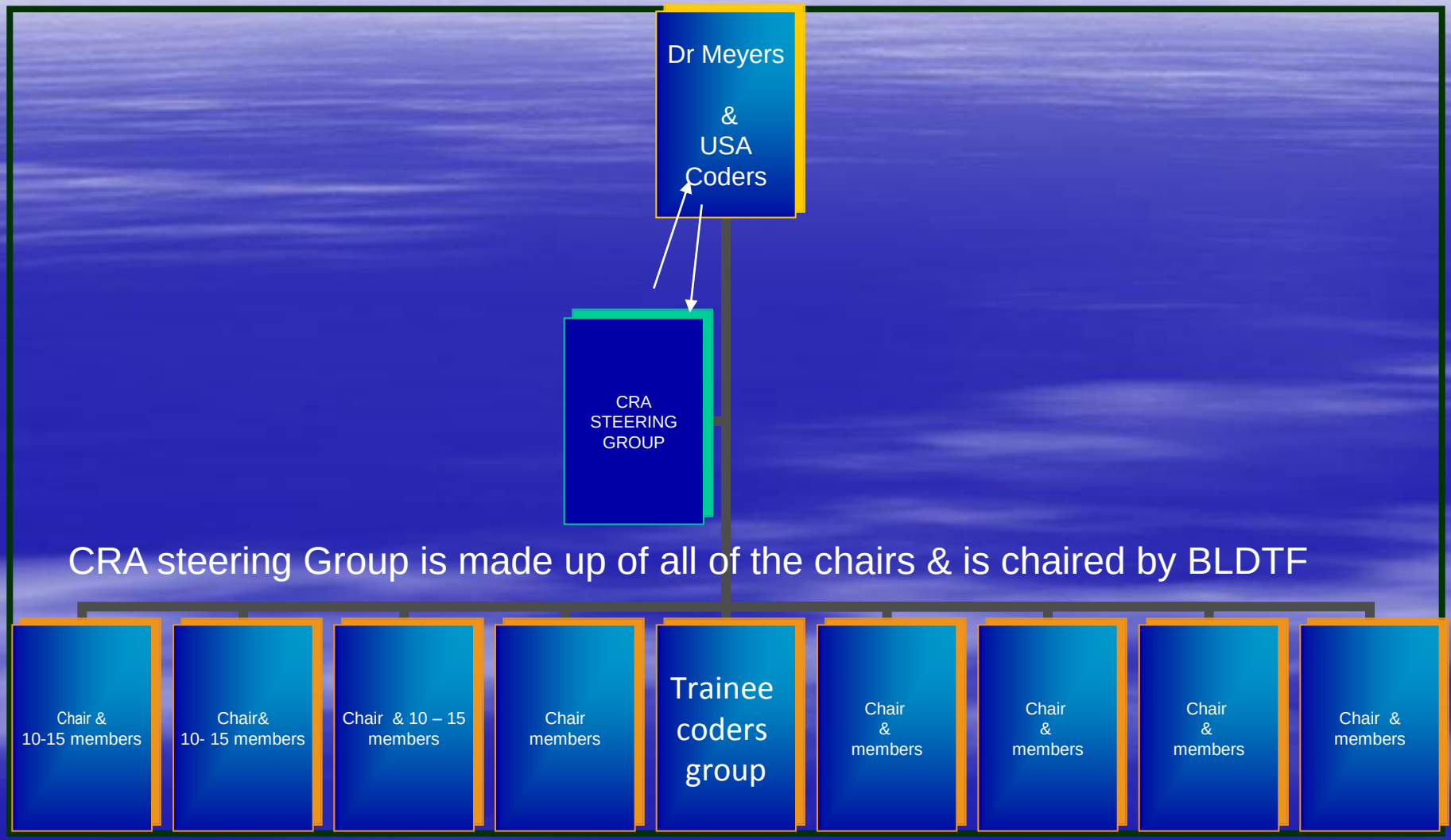
- **IT security** – particularly statutory group – still trying to deal with security restrictions on staff PCs which has meant no one from that group has been in a position to progress with accreditation

- **Realistic expectations**: Creating awareness that 2 days training does not a therapist make. Also accredited CRA practitioners are only accredited to practise CRA (it does not qualify you as an addiction counsellor nor can it replace formal 3rd level training in clinical practise)

- **Agency Culture**: Imbedding the approach in agencies policies & procedures so it is fully integrated into the ethos/case management of the agency . **Management support**: It is very structured -agencies used to working in a less formal way need management support & guidance to implement & monitor standards- quality control

- **Sustaining the model post accreditation** (ideas include online CRA community, 6monthly peer groups, annual skills workshops etc)

Communication & Support Process



BLDTF CRA Plan Benefits/Outcomes

- **We now have over 80 accredited CRA practitioners (1st ever in Ireland) – Dr Meyers informs us that this is more than any other country in the world including the USA!**
- **We have 1 accredited coder/supervisor (James Kelly) with another small group nearly there**
- **Although very early to record with accuracy - Anecdotally there are reported noticeable positive outcomes for clients**
- **Anecdotally many workers report increased competence & confidence in their work because of the structured nature of the model**
- **Because of the structures that we had to put in place there has been a huge increase in interagency activity between participating services**
- **Already CRA is becoming a 'common' language among services with some using 'goals of counselling' and happiness scales' etc as part of their care plans**
- **The 'critical mass' of trainees who have engaged in this process from across regions has meant that other areas are now looking at implementing the approach too and before long it will be nationwide – local & regional CRA communities which will provide opportunities for shared learning events**

Possible Future Steps for CRA Implementation & Sustainability

- Establish panel of Irish Coders/Supervisors/Irish Trainer (s)
- Develop online ‘CRA support community’
- Develop CRA Boot camps/ workshops
- Support for projects with sustainability (integration into case management processes, induction for new staff, CRA audits, twining projects??
- Secure National support for sustainability through NATP?

For more information

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SOME A/CRA/FT CLINICAL TRIALS

Hunt & Azrin, '73 (inpatient alcohol dependent)
Azrin, '76 (inpatient alcohol dependent)
Azrin et al., '82 (outpatient alcoholic)
Higgins et al., '91 (cocaine)
Budney et al., '91 (cocaine)
Higgins et al., '93 (cocaine)
Smith et al., '98 (homeless alcoholics)
Abbott et al., '98 (methadone/heroin addicts)
Roozen et al., '00 (opioid dependent individuals)
Schottenfeld et al., '00 (opioid & cocaine dependent individuals)
Meyers & Miller., '01 (outpatient alcoholics)
Godley, et al., '02 (Adolescent aftercare mj & alc)
Azrin, '04 (outpatient adolescent patients)
Roozen et al., '06 (nicotine dependent individuals)
Slesnick, et al., '07 (homeless, street living youth)
De Jong et al., '07 (opioid dependent individuals)
DeFuentes-Merillas, & De Jong '08 (opioid & cocaine dependent individuals)
Miller et al (2005), (meta analysis of evidence based treatements)