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The Adolescent Community Reinforcement Approach: Effectiveness in our Multi-Cultural Nation

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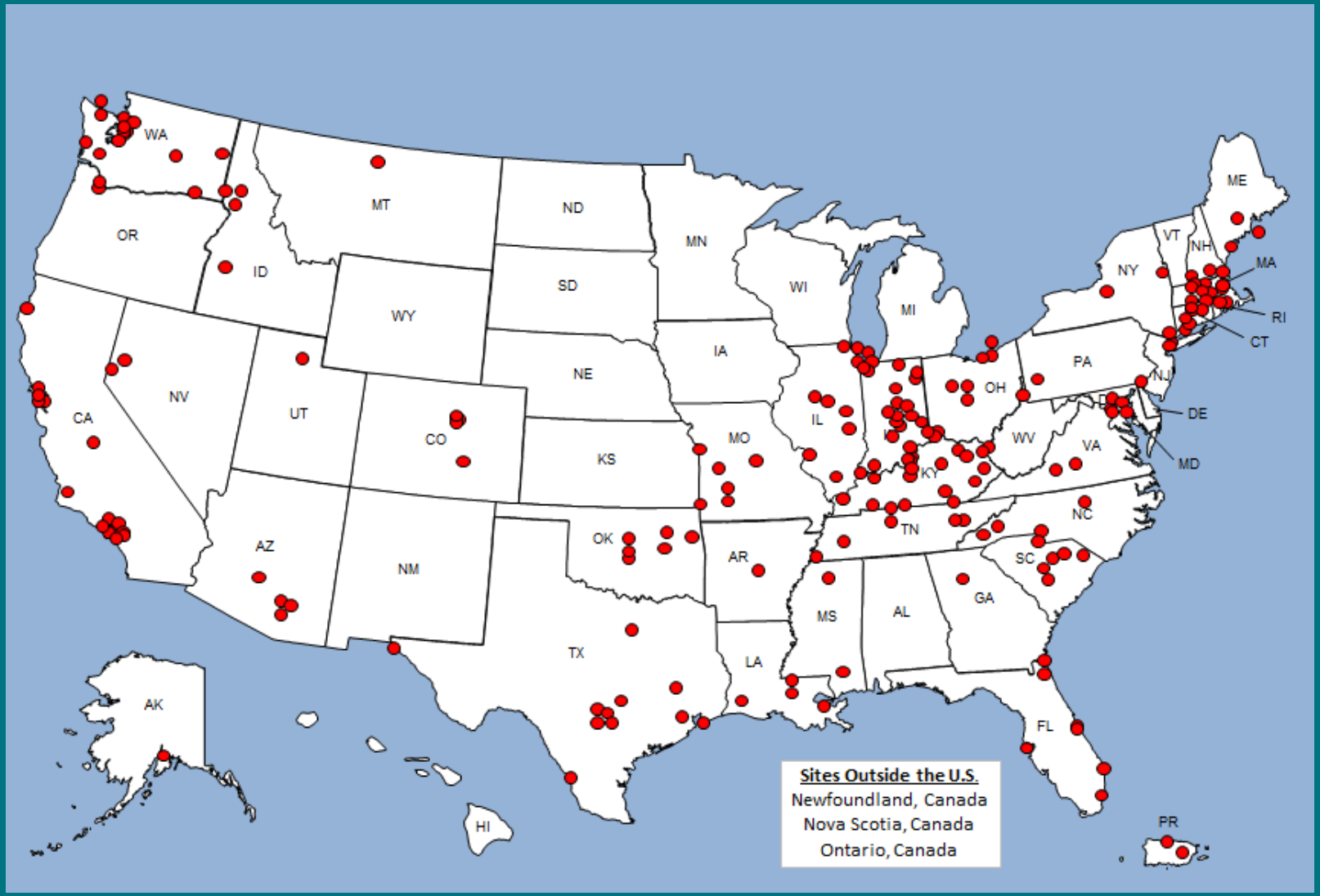
Presentation Goals

- Overview of the A-CRA model
- Effectiveness of the model across race/ethnic groups and gender
- Family involvement in A-CRA
- Recommendations

Who is A-CRA/ACC serving …

- urban youth
- rural youth
- girls and boys
- Native American youth
- Latino youth from different Latin American countries
- African Americans/Blacks born in the U.S. and elsewhere
- GLBT youth
- Caucasian youth
- youth with different levels of acculturation
- Youth from different Asian Countries
- youth who live in colonias (southwest TX border neighborhoods)
- youth in Appalachia

Locations of Sites



A-CRA Implementation by the Numbers

- 295 provider sites in the U.S., Canada, and abroad
- 17,866 adolescents and young adults served
- 157,195 A-CRA sessions have been documented in the EBTx.org database
- 72,441 audio recorded sessions uploaded to EBTx.org
- 18,839 audio-recorded sessions reviewed by A-CRA experts with fidelity feedback provided to clinicians

What is the CRA Theory of Change?

. . .to rearrange the vocational, family, and social reinforcers of… [clients] such that time-out from these reinforcers would occur if… [they use substances]. (Hunt & Azrin, 1973)

- A-CRA clinicians help youth and their parents or other caregivers improve their relationships, and find rewarding pro-social activities and relationships in their community that compete with and eventually replace substance use.

What is the Community Reinforcement Approach (CRA) and A-CRA?

- Focus is on helping make life worthwhile and fun without alcohol and drugs
- Comments from 15 year-old female in A-CRA: "I learned a lot about myself. I learned a lot of skills that can help me in life in general. It's not just about not using drugs; it's about changing your life for the better."
- Reasons clinicians tell us why they like A-CRA
  - Flexible menu of procedures to choose from
    - WHEN procedures are used and for WHICH clinical issues
  - Client-driven
  - Strengths-based approach

A-CRA's Clinical Procedures

- Assessment and Planning Procedures
  - Functional Analysis of Substance Use and Pro-Social Behaviors, Happiness Scale, Goals of Counseling
- Behavioral Skills Training
  - Communication, Problem Solving, Job Finding, Social and Recreational, Relapse Prevention, Anger Management, Job Finding, Homework
- Other
  - Use of individualized reinforcers
  - Caregiver support through improved communication and parenting practices/relationship counseling
  - Systematic Encouragement
  - Medication adherence

Cultural Responsiveness Challenges Confronting EBTs

- Model fidelity versus cultural responsive needs
- Inadequate inclusion of gender, ethnic & cultural groups in studies to understand effectiveness
- Lack of analyses on the impact of ethnic, linguistic, or cultural factors
- Limited resources devoted to research on culturally specific practices

A-CRA Model & Cultural Responsiveness

- A-CRA therapists are respectful, nonjudgmental, accept youth as they are – including working on goals youth tell us are important
- Individual sessions working with each participants community/culture
- Flexibility - Procedures create the entire toolbox, but the clinician chooses when and how to use
- Clinician's ethnic and cultural background, individual style and skills are needed to be responsive to cultural needs

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Gender and Racial Differences in Treatment Process and Outcome Among Participants in the Adolescent Community Reinforcement Approach

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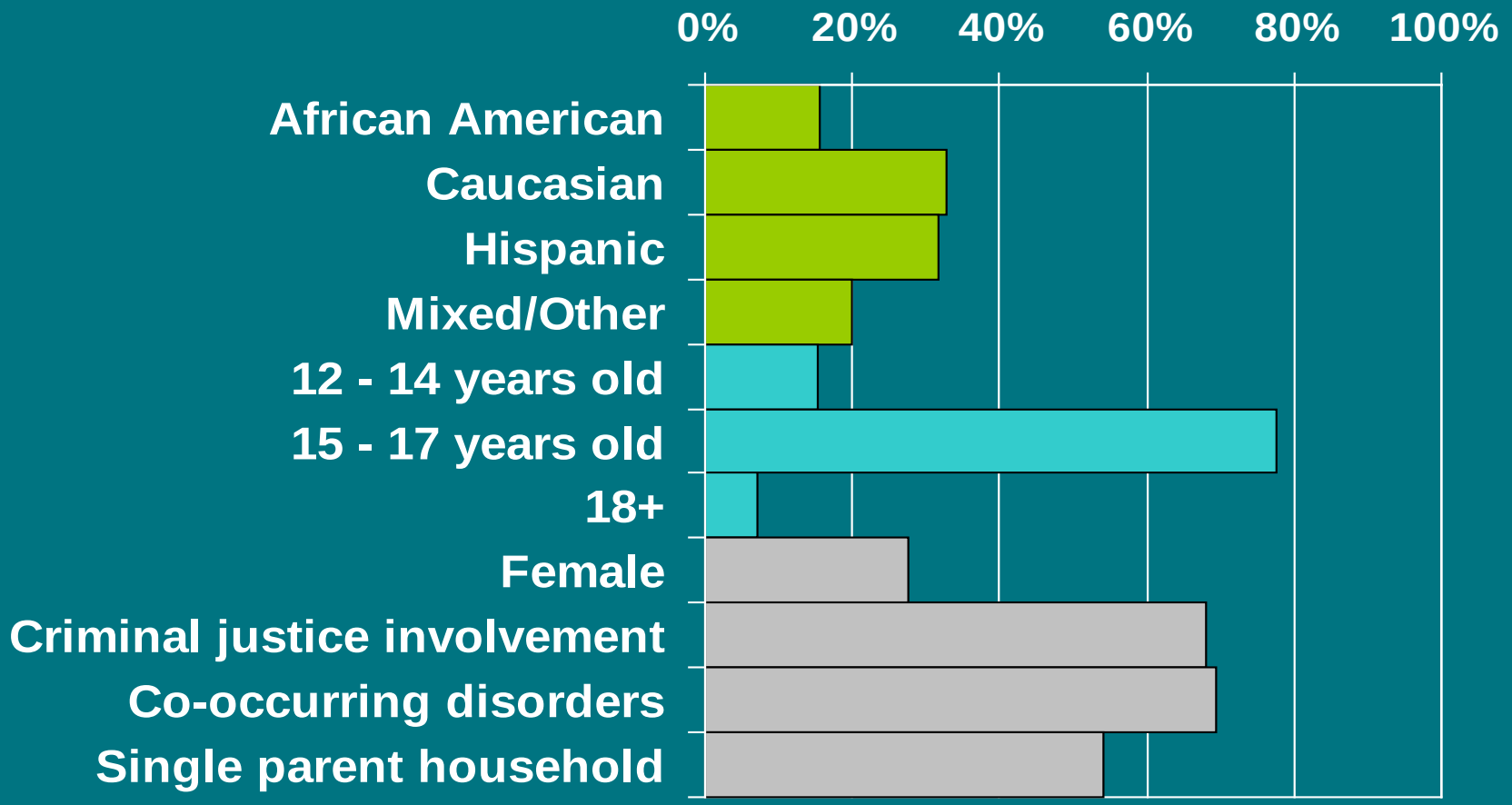
Increasingly, evidence-based treatments are being implemented by community treatment providers, and it is important to understand whether they can be implemented with similar quality and equivalent effectiveness across gender and racial groups. This study examined whether initiation, engagement, dosage, treatment satisfaction, or outcomes for adolescents who received the Adolescent Community Reinforcement Approach (A-CRA) in a large implementation effort were equivalent by gender or racial group. Analyses of data from 2,141 adolescents representing 33 sites across the United States revealed no significant differences for initiation, engagement, or retention by gender or race. Ninety-six percent of the sample reported being satisfied with treatment; however, male adolescents had significantly higher rates of treatment satisfaction than female adolescents, and African American adolescents had significantly higher rates of treatment satisfaction than Caucasian adolescents. A subset of the initial sample ($n = 1,819$) was used to investigate outcomes. All racial groups had significant increases in days abstinent from alcohol and other drugs and in the percentage in recovery across the measurement period but did not differ from one another at the six-month follow-up. Female adolescents had a higher percentage of days abstinent from alcohol and other drugs and were more likely to be in recovery at the six-month follow-up than male adolescents. Overall, process indicators suggest the intervention was well implemented across gender and racial groups and equally effective across racial groups, with males having equivalent gains in abstinence and recovery compared with females despite males having greater intake severity and differential outcomes at six months.

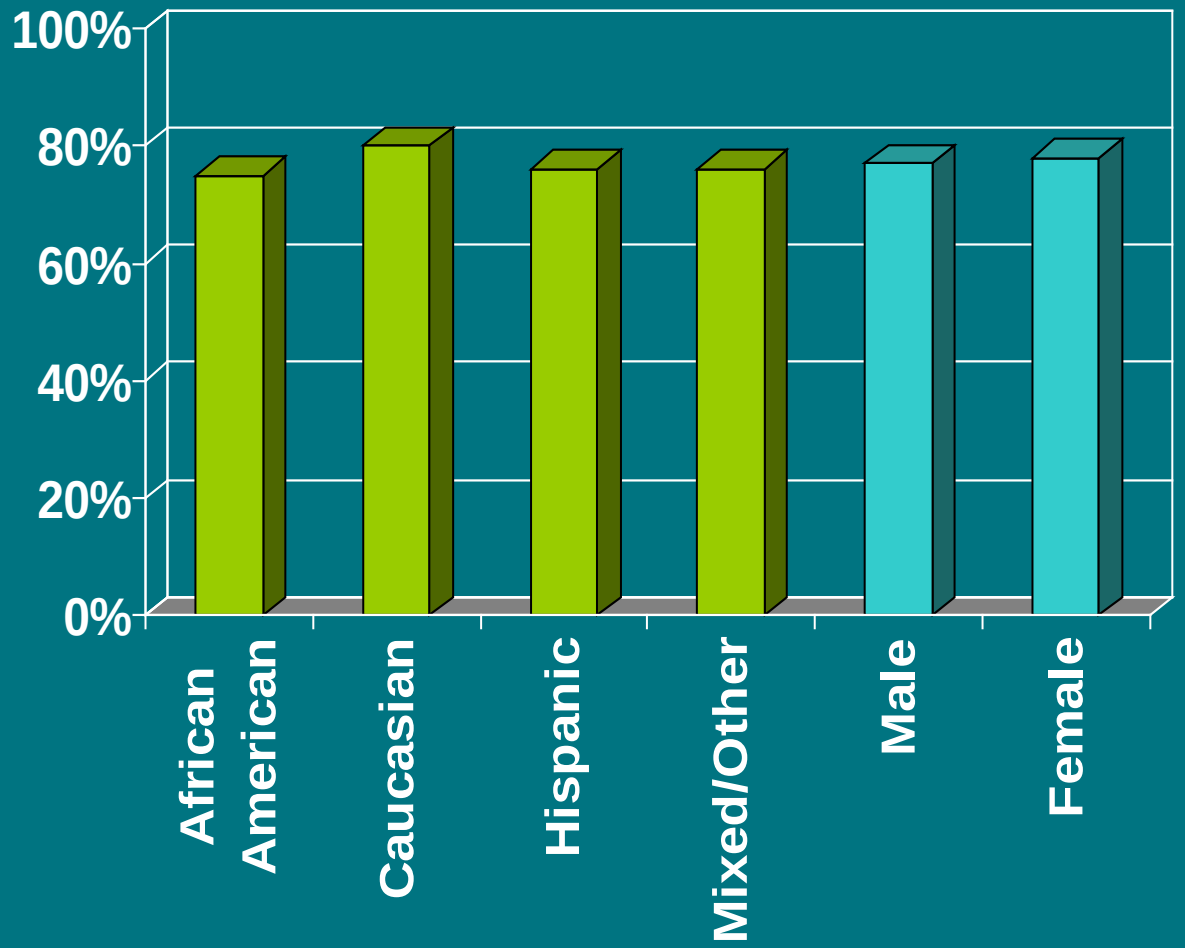
Keywords: evidence-based treatment, gender, race, cultural competence, implementation

In 2008, 1.9 million adolescents living in the United States needed treatment for an illicit drug or alcohol use problem (Substance Abuse and Mental Health Services Administration, 2009). The 141,682 youth aged 12 to 17 who entered substance abuse treatment were very diverse: 30% were female, 20% were African American, 24% were Hispanic, and 56% were White (United States Department of Health and Human Services, 2008). Increasingly, funders are requiring that substance use treatment providers use evidence-based treatments (EBTs) that have been found effective in randomized clinical trials (Garner, 2009; Gotham, 2006). However, concerns have been raised about the widespread implementation of these models because of the growing diversity among those presenting for treatment and the unknown generalizability of EBTs that were not specifically developed for or tested with different cultural groups (Bernal & Scharron-del-rio, 2001; Hwang, 2006; Lau, 2006; Santisteban, Vega, & Suarez-Morales, 2006). Others have suggested that the assumptions and methods that support EBT development might have negative ramifications

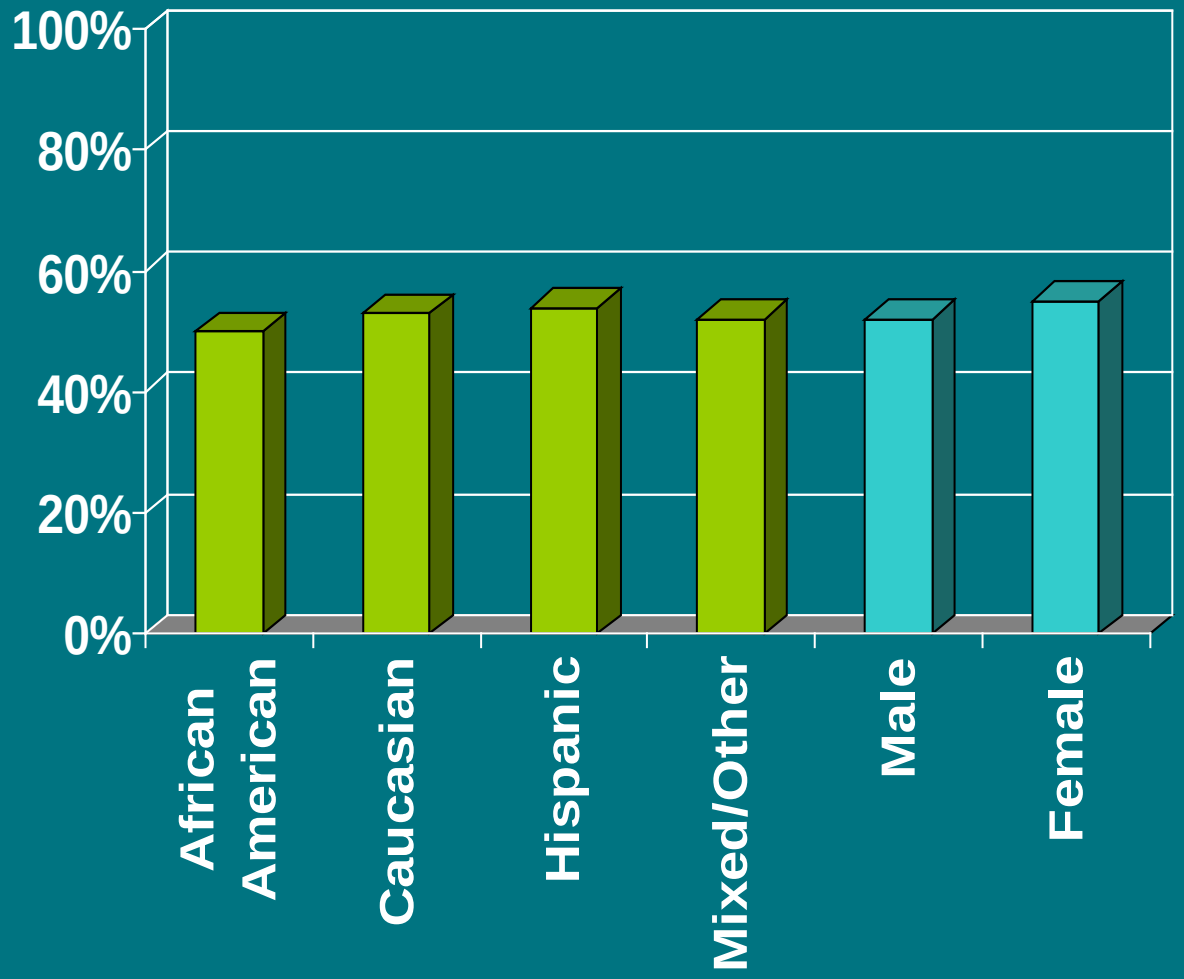
Adolescent Intake Characteristics (N=2,141)



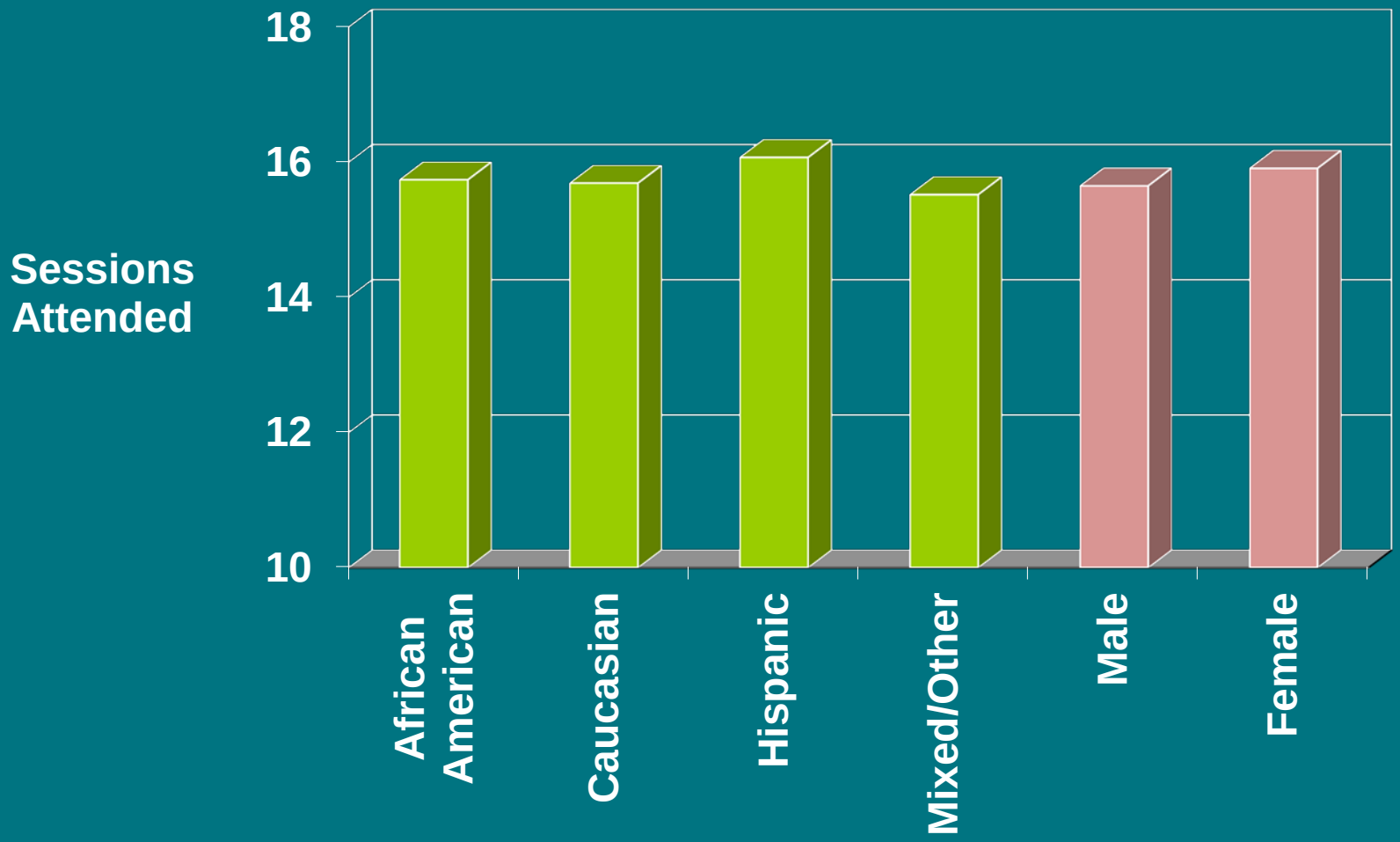
Rates of Initiation



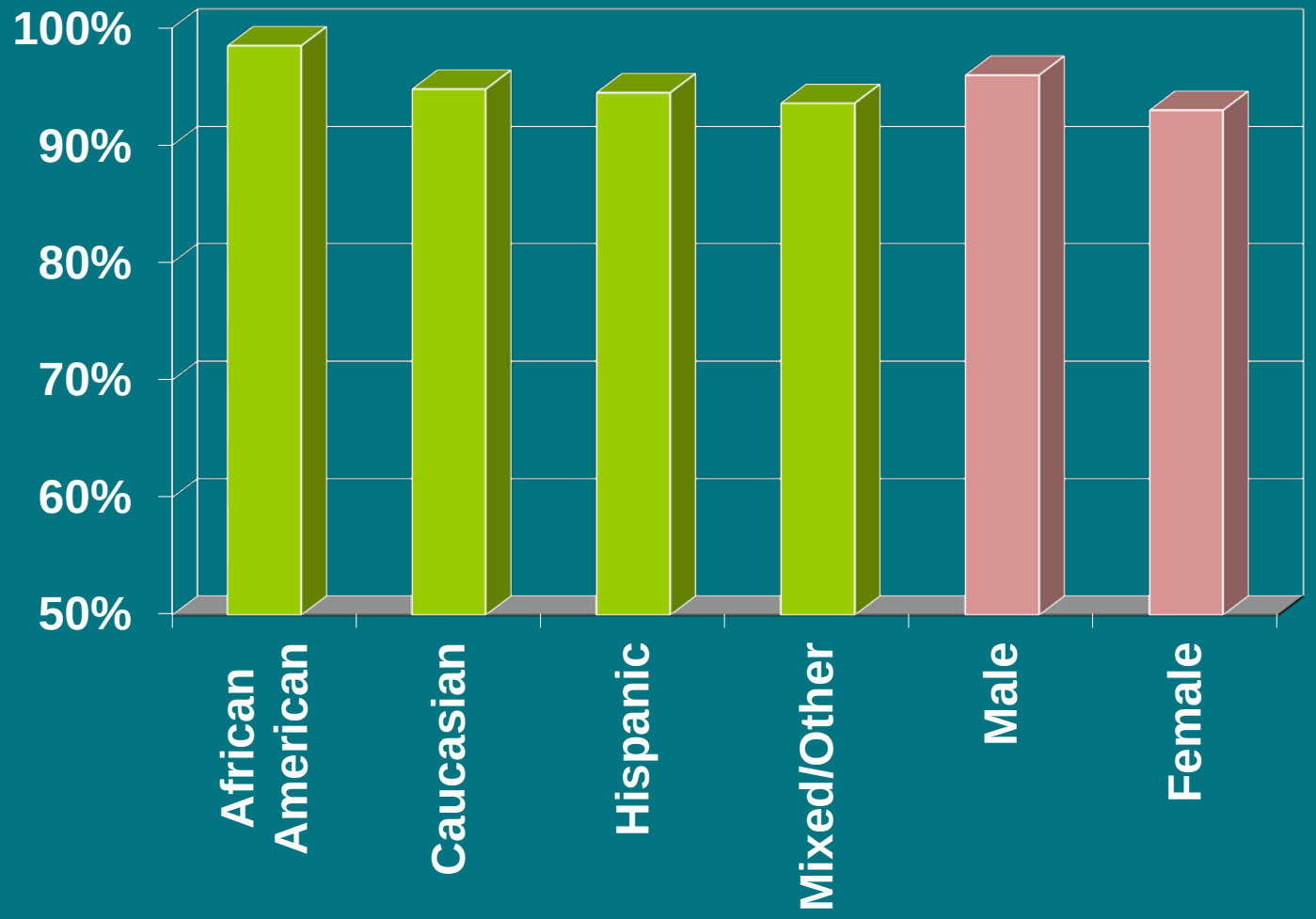
Rates of Engagement



A-CRA Treatment over 6 months

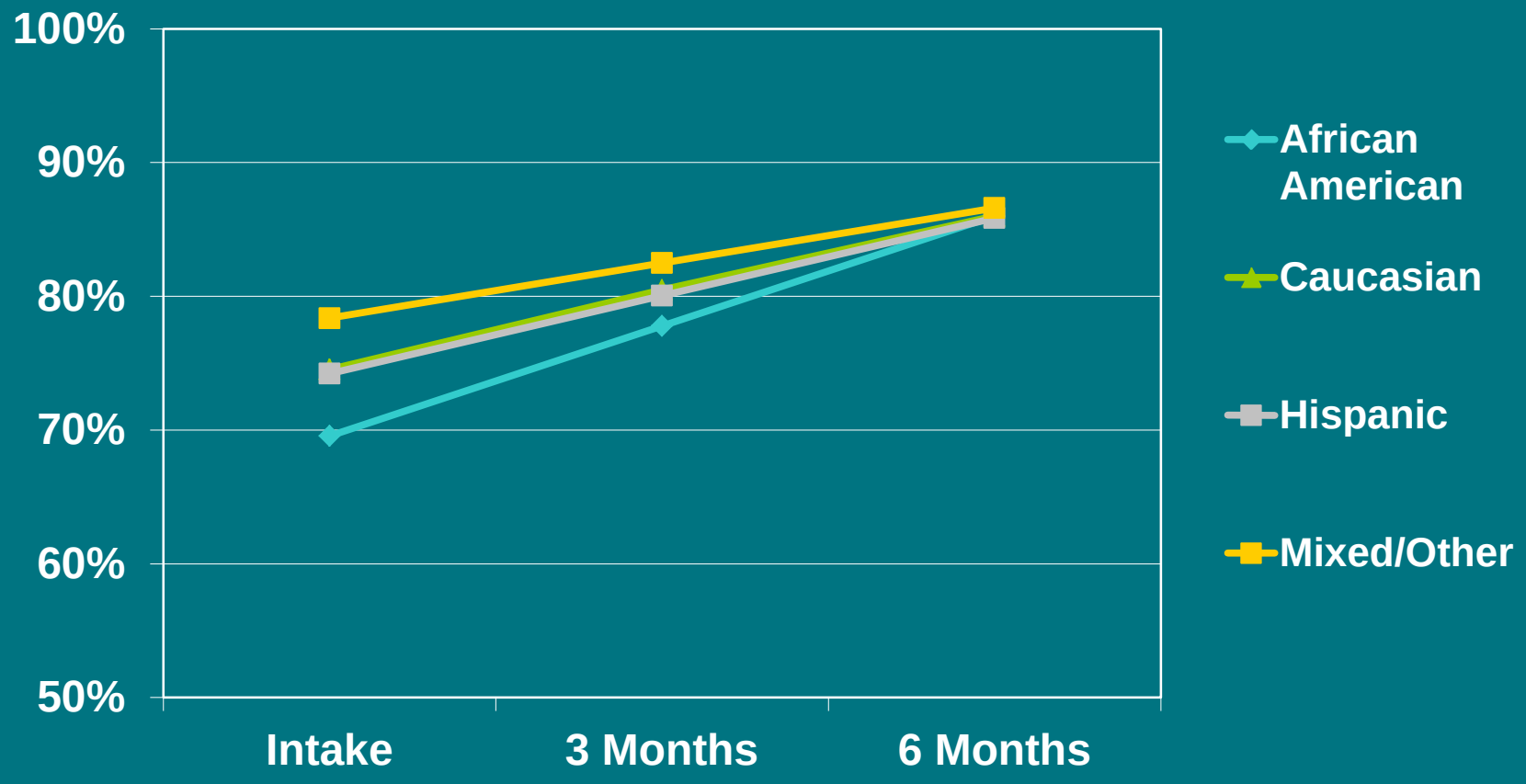


Treatment Satisfaction



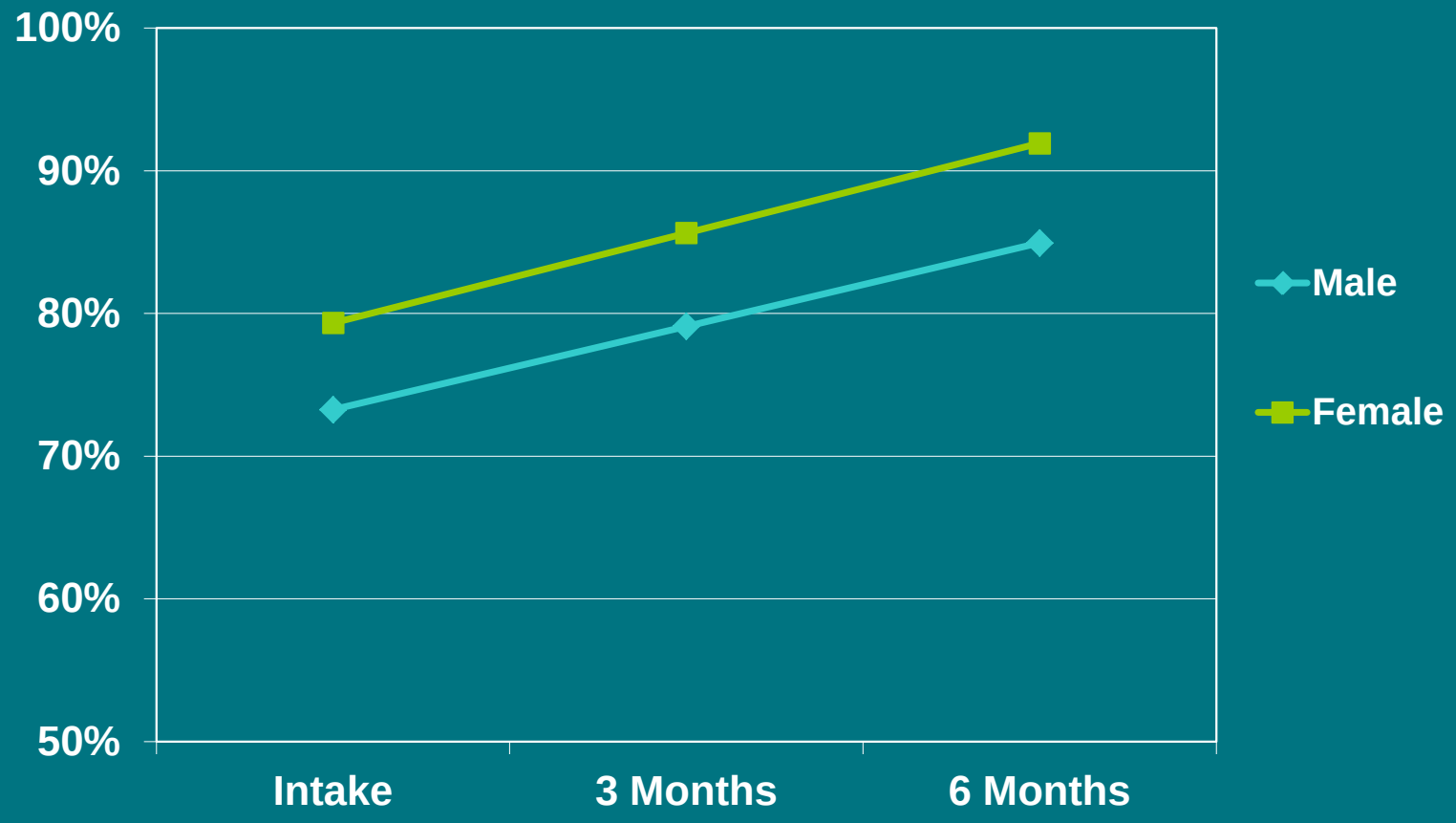
Treatment Satisfaction Scale includes items that measure satisfaction with services and staff, including cultural sensitivity of staff.

Days Abstinent from AOD by Race



Note: **African American, Caucasian, Hispanic, and Mixed/Other adolescents were equivalent over the 6 month follow-up (Godley et al., 2011)**

Days Abstinent from AOD by Gender



Note: d = .33 (Godley et al., 2011)

Engaging Parents/Caregivers:

- Understand context (culture, single parent, etc)
- If parent doesn't come to initial appointment
  - Call
  - Listen for what would motivate them to attend
  - Briefly describe their A-CRA and their participation as an important part of the model. (time limited)
- Parent or other caregiver? (substance problems may emerge)
- Use flexible scheduling
  - Community location
  - Gas gift card/bus tokens (if available)
  - Telephone session (last resort)

Engaging Parent/Caregivers

- Feels helpless
  - Validate feelings, offer hope show how A-CRA can address concerns
  - Discuss some positive parenting practices
- Anger/tried treatment already
  - What are their motivators (e.g., love and want their child to have a better life)
  - Offer to meet w/ them alone 1-2 time to learn more and share more about the model.
  - Offer hope – earlier failed treatment doesn't mean this one will fail – describe how it has helped many other families.

Recommendations for future A-CRA research

- Additional race/ethnic groups
  - Native Americans, Asians
- LGBT adolescents
- Testing model improvements to engage and maintain parental involvement
- Further research on the importance of community visits