



**Community Reinforcement and Family Training (CRAFT)**

Working with families of substance abusers

January 30, 31, 2018 8:30AM- 4:00PM  
February 1, 2018 8:30AM-11:30AM (2.5 days)

The Ware Center- Binns Room  
42 N. Prince St.  
Lancaster, PA 17603

Co-sponsored by: Project Lazarus Lancaster County & Millersville University School of Social Work

Supported by 20 years of peer-reviewed research, Community Reinforcement and Family Training (CRAFT) is a comprehensive behavioral program that teaches families to optimize their impact while avoiding confrontation or detachment. CRAFT methods are evidence-based and provide families with a hopeful, positive, and more effective alternative to addressing substance use problems than other intervention programs.

Become a CRAFT Interventionist and learn to teach your clients the following CRAFT skills:

- Employ effective positive communication
- Identify and use positive awards
- Develop a road map for understanding loved one's substance use and pattern
- Recognizing substance use
- Take domestic violence precautions
- Allow for the "natural consequences" of use
- Practice self-care without detachment
- Get a loved one into treatment

As a CRAFT interventionist you will learn how to help families identify practical and highly-effective ways to move their loved one into treatment, while simultaneously improving their own lives.

Project Lazarus Lancaster County is sponsored by SouthEast Lancaster Health Services

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## Book Descriptions:

# community reinforcement and family training craft manual

This adapted CRAFT manual is designed for Indigenous Health and Family Workers and other workers within Australian Indigenous community settings to support the families and friends of people who are at risk for alcohol related harm. It is likely that workers using this CRAFT 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 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. It includes a brief overview of some of the research evidence showing that CRAFT is particularly effective for supporting families who are dealing with alcohol related issues. It describes how CRAFT fits well with Indigenous health services and their holistic approach to health care provision, primary health care PHC and community development. The section concludes by describing the roles of individual and team health practitioners, families and the community in CRAFT. <http://www.poker.pt/images/users/carver-c2-preamp-manual.xml>

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CRAFT works to affect the loved one's behavior by changing the way the family interacts with him or her. It is designed to accomplish three goals 1. When a loved one is abusing substances and refusing to get help, CRAFT helps families move their loved one toward treatment. 2. CRAFT helps reduce the loved one's alcohol and drug use, whether or not the loved one has engaged in treatment yet. 3. CRAFT improves the lives of the concerned family and friends. Drs. Robert J. Meyers and Jane Ellen Smith of the University of New Mexico developed the CRAFT program to teach families how to impact their loved one while avoiding both detachment and confrontation, the respective strategies of AlAnon a 12Step based approach and traditional Johnson Institute style interventions in which the substance user is confronted by family members and friends during a surprise meeting. Read About How CRAFT Started CRAFT is a skillsbased program that impacts families in multiple areas of their lives, including selfcare, pleasurable activities, problem solving, and goal setting. At the same time, CRAFT addresses their loved one's resistance to change. CRAFT teaches families behavioral and motivational strategies for interacting with their loved one. Participants learn, for example, the power of positive reinforcement for positive behavior and of withdrawing it for unwanted behavior, and how to use positive communication skills to improve interactions and maximize their influence. Additionally, the skills remain essential over the long run for families in navigating and maintaining a positive trajectory for all family members. CRAFT is not a quick fix, but rather an approach that

can benefit both the substance user and the family in the short and long terms with a holistic plan of action and a more optimistic view. HBO profiled CRAFT in its ADDICTION series. <http://project-st.ru/userfiles/carver-c9-hologram-generator-manual.xml>

Results indicated that CRAFT was considerably more successful in getting the persons with substance abuse into treatment and reducing their alcohol consumption in comparison to the AlAnon group. Miller et al. 1999 conducted a controlled comparison of CRAFT, the Johnson Intervention, and AlAnon facilitation TSF that randomized 130 caregivers of problem drinkers to receive 12 hours of contact in one of the three conditions. CRAFT and TSF had better retention than the Johnson Intervention. Consistent with previous studies, participants tended to drop out of the latter intervention in order to avoid the family confrontation with the drinker. The CRAFT intervention also engaged substantially more drinkers into treatment 64% vs 23% Johnson and 13% TSF. Caregivers who were assigned to CRAFT attended more sessions than those in TSG and were more likely to complete a full course of counseling during which the persons abusing drugs were far more likely to enter treatment 64% vs 17%. Reductions in drug use occurred during the study, but there was no group x time interaction. Meyers et al. 2002 replicated and extended those findings with drug users with similar positive effects on engagement of the drug abusing family members in treatment. *Addiction*, 104, 4958. How could we improve this content. Meyers worked with Nathan Azrin in the early 1970s whilst he was developing his own community reinforcement approach CRA which uses operant conditioning also called contingency management techniques to help people learn to reduce the power of their addictions and enjoy healthy living. We bring in a family member, and what we do is we teach them how to interact differently with the drinker or the drug user. Instead of yelling and screaming when they're using drugs, we tell them to kind of just stay away from them, leave that person alone. But, then when they're sober—when they're not using drugs—we talk to them. So, at times, yes, you're going to be frustrated and put your hands up.

CRAFT stands for Community Reinforcement and Family Training. It's the community that we're really talking about. See disease theory of alcoholism for a full discussion. The diagnostic assessment of alcoholism in someone can include an assessment of comorbidity with conditions such as mental illness, and domestic violence. CRAFT combines CRA with family training, which equips the families and friends of addicts with supportive techniques to encourage their loved ones to begin and continue treatment and provides them with defences against addictions damaging effects on loved ones. Thus it was no surprise that, many years later, research discovered that substance use disorder treatments based on confrontation were largely ineffective in decreasing the use of alcohol and other substances Miller and Wilbourne 2002, Miller et al. 1998. Nate Azrin already was convinced of this back in the early 1970s, when he designed an innovative treatment for alcohol problems the Community Reinforcement Approach CRA. Azrin believed that it was necessary to alter the environment in which people with alcohol problems live so that they received strong reinforcement for sober behavior from their community, including family, work, and friends. In one study, clients treated with CRA and the disulfiram compliance component were abstinent an average of 97% of the days during the last month of the 6-month followup, whereas clients treated with a combination of a 12-step program and the CRA disulfiram compliance training were Meyers and the Treatment Research Institute TRI worked with Cadence Online to create a Parent CRAFT course where parents pay a one-off fee for a series of videos presenting the CRAFT process, aimed at teaching them skills to meet the risks of substance abuse in their adolescent children. Now, that's sort of not a fair comparison because AlAnon is not designed to get someone else to do something. And, the only reason to make those comparisons.

<http://eco-region31.ru/bosch-shu3036uc-service-manual>

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<https://domoticaaplicada.com/images/c-class-manual-pdf.pdf>

meet criteria for a substance use disorder SUD and less than 10% enter treatment each year SAMHSA, 2010 . Currently Available Help for Parents On a practical level, few resources are available to support parents whose adolescent have substance use problems before, during, or after their child's treatment entry. TwelveStep family support groups are freely available in the community and parents are welcome to join them. While these groups often include parents of older children, few are specifically for parents of adolescents and these parents may be uncomfortable with the groups since their issues differ somewhat from spouses, parents, or other loved ones of an adult with an addiction. Unfortunately, these 12step selfhelp groups are also typically the only thing that is readily available to support parents before and after the adolescent receives treatment. Although addictive disorders are increasingly accepted as a chronic, relapsing conditions, few treatment programs include continuing care for the adolescents or parents. Parental involvement during adolescent treatment After an adolescent enters a community treatment program, the extent to which parents are involved in their child's therapy during treatment varies widely from program to program. Sometimes parents are excluded most notably during the early days of their child's residential treatment with enforced periods where contact with the child is forbidden. Group Cognitive Behavioral Therapy was the only nonfamilybased intervention with good empirical support. The five empiricallysupported familybased treatments work with concerned family members to engage the entire family in treatment. The failure to involve parents meaningfully into their child's treatment is unfortunate for several reasons. Furthermore, parents may provide an active role in encouraging treatment retention, involvement in aftercare, and treatment reentry after relapse; activities that have been found to predict better longterm outcomes.

<https://www.nelsonrigg.com/images/c-24-manual.pdf>

Parents, however, often can more easily monitor their child and probably will receive greater benefits for doing so. They also are usually available to their child for decades into the future. Unfortunately, programs may be restricted in what they can offer due to limitations regarding the national addiction treatment system itself. In the meantime, parents desperately need skills to manage their child before, during, and after treatment and they are not receiving these skills through familybased interventions or family support programs in the adolescent treatment system.

The lack of practical resources for parents led us to consider interventions that could be delivered directly to parents, independent of community-based substance abuse treatment programs and independent of the adolescent's involvement. Parent and Family Treatments That Can Be Implemented Unilaterally Unlike many family treatments for substance abuse, unilateral treatments can be directly delivered to one concerned family member and do not require participation of the substance-using person they are concerned about. Although additional family members are welcome to participate, their participation is not always considered necessary unless they appear to be hindering progress. Why Select CRAFT We identified eight unilateral treatment programs for the family members of substance users Stanton, 2004 cf. Studies of the third strategy have established its efficacy in initiating treatment entry of the substance using person and in improving family member functioning. Community Reinforcement and Family Training CRAFT is probably the best known example of this approach. A family member or concerned significant other CSO is helped to identify antecedents and consequences that likely support the substance use of the person they are concerned about i.e., the person of concern or PC.

The CSO is then trained to provide more positive consequences for abstinence, avoid unintentionally delivering positive consequences for substance use, and identify opportunities where the PC may be more receptive to suggestions to consider treatment entry. In controlled studies conducted primarily with parents and spouses of adults with problematic substance use, CRAFT has consistently produced higher rates of treatment entry for the PCs and similar improvements in the CSO's psychological and social functioning relative to comparison conditions such as the Johnson Intervention JI and ANF. Comparison of approaches Miller et al. 1999 randomly assigned 130 CSOs of problem drinkers to receive JI, ANF, or CRAFT. Results indicated that more CSOs who received CRAFT and ANF were retained in the study in comparison to their JI counterparts. Consistent with previous studies, participants tended to drop out of JI, avoiding the confrontation with the drinker. CRAFT participants also engaged substantially more drinkers into treatment 64% than did JI 23% or ANF 13% participants. Two additional clinical trials Kirby et al., 1999; Meyers et al., 2002 randomly assigned CSOs of individuals using illicit drugs to receive CRAFT or ANF. Results were similar to those of Miller et al. 1999, with Kirby et al. 1999 and Meyers et al. 2002, respectively reporting 64% and 68% of the illicit substance users entering treatment in the group receiving CRAFT versus 17% and 29% in the ANF group. Parents of 42 treatment-resistant adolescents were offered 12 sessions of an intervention similar to CRAFT to facilitate treatment entry, support subsequent behavior change, and improve parent and family functioning. Thirty 71% of the adolescents were successfully engaged into treatment and significant reductions in their marijuana use and the parents' depression and anxiety were observed at six month followups. Furthermore, the improvements occurred regardless of adolescent treatment entry.

Unfortunately, the study did not include a comparison group of parents who did not receive the intervention, so it is impossible to know if the improvements were due to the CRAFT-style treatment. However, because the adolescent treatment entry rates were comparable to those achieved in adult CRAFT studies, we decided to adapt the CRAFT intervention in developing a unilateral treatment for parents of substance-using adolescents. Description of CRAFT Components CRAFT begins with 1 an introductory orientation session, which provides an overview of the intervention and builds motivation for CSO's compliance with the intervention by emphasizing the benefits to be gained. Next, the CSO is trained in eight basic behavior management strategies 2 functional analysis, where the CSO is taught to identify the triggers for substance use as well as the consequences; 3 positive reinforcement, which teaches the CSO to reinforce nonuse and other positive and prosocial behaviors; 4 competing reinforcing activities which trains the CSO to interfere with drug use; 5 planned ignoring, to encourage the CSO to extinguish drug use; 6 natural consequences, which trains the CSO to avoid interfering with the natural negative consequences of drug use; 7 communication skills training, which assists the CSO in ceasing ineffective negative communication

while simultaneously facilitating the delivery of appropriate consequences; 8 treatment entry training, which trains the CSO to recognize appropriate times to suggest treatment, ways to suggest it that are more likely to succeed and to have treatment options available for the drug user at the time the decision is made to enter a program; and 9 life enrichment, which focuses on helping the CSO increase their own reinforcing activities and decrease their focus on the PC.

In addition to training the CSO to implement these behavior management strategies, CRAFT therapists use behavioral training strategies during sessions including 10 role playing with feedback and 11 The therapist also evaluates family relationships to determine if 12 critical family members need to be included in some treatment sessions to ensure consistency with the behavioral strategies being used. CRAFT also provides 13 safety training, which teaches CSOs how to recognize and address situations with potential for physical violence. Finally, the CRAFT therapist conducts a 14 treatment termination session that summarizes critical skills learned and helps prepare the CSO to maintain the behaviors learned after treatment is completed. Adapting CRAFT to Better Address Parent Needs In order to adapt CRAFT for application with parents of substanceusing adolescents, we sought to identify related behavioral treatment components that could be combined with CRAFT components to make the intervention developmentally appropriate and to better meet parent needs. Because there was no research in parentfocused unilateral interventions for treating adolescent substance use disorders other than the single CRAFT study, we expanded our literature search to include those interventions that were shown to be effective in treating externalizing behavioral disorders, such as oppositional behavior and conductdisorder in younger children. Behavioral Parent Training Behavioral Parent Training BPT defines a broad class of parentoriented training interventions that are based on behavioral principles, similar to the foundation of CRAFT. A number of wellsupported manualdriven BPTs are implemented unilaterally with parents, for example Parent Management Training Oregon Model Patterson, 1975 ; Parent Management Training Kazdin, 2005 ; The Incredible Years Parent Training WebsterStratton, 2010 , and the TripleP Standard Individual Treatment Sanders, 2003 .

Although these parent training interventions vary in terms of methods of delivery and emphasis of particular components for the age and population of children they focus upon, they derive from and share the same foundation of behavioral principles and core components. According to Kazdin 2005 the term "Parent Management Training" PMT depicts the common core components of these unilateral BPT interventions. Indeed, as a behaviorallybased program, CRAFT shares many of the strategies inherent in PMT interventions. Comparison of PMT and CRAFT components Table 1 indicates the components of each intervention and the overlap between them. The 14 CRAFT components and implementation strategies are listed in rows and the core 12 common components of PMT Kazdin, 2005 in the columns. Table 1 indicates that CRAFT contains two components not found in PMT life enrichment and safety training. The purpose of the life enrichment component is to discourage the individual from completely focusing their attention on the family member's substance use and to enrich the life of the CSO. This component is probably not necessary in PMT because the primary focus of the intervention is to change the behavior of the child. Similarly, the safety training component is probably not necessary in PMT as it is most often used with parents of young children; therefore, the potential for physical violence is minimized. In CRAFT, some of the behavioral strategies CSOs learn and implement could produce increased conflict. For example, when implementing natural consequences, a parent may choose not to make excuses for his or her adult son's absence from work because the absence is related to drug use. As a result, the son may lose his job, producing conflict with the parent and increasing the potential for physical violence.

Conversely, the original CRAFT intervention includes most of the components found in PMT with the exception of a defining, observing, and recording behavior; b timeout from reinforcement; c lowrate behaviors; and d reprimands. While these strategies are contraindicated for use with spouses,

parents of adult children, and other adult relationships, they appear appropriate to add to a CRAFT intervention designed for parents of adolescents who use substances. The first strategy was titled Behavior Monitoring and was designed to have the parent define, observe, and record their adolescent's substance use and other problematic behavior. The second strategy was entitled Behavior Reducing Consequences that addressed appropriate discipline i.e., reprimands, negative consequences for behaviors such as rulebreaking and drug use. This component was to be implemented only when positive reinforcement, planned ignoring, scheduling competing activities, and natural consequences were being used but still were not sufficient to reduce dangerous behaviors. We did not incorporate the PMT components of low rates of behavior or timeout. The PMT component of timeout was not included because the basic principle behind timeout is to remove potentially reinforcing consequences for undesirable behavior and this seemed impractical for parents to use with adolescents because adolescents usually have at least two sources of reinforcement for their substance using behavior that parents cannot consistently control 1 peer attention, which is typically a powerful reinforcer for adolescents, and 2 the biological consequences of substance use itself i.e., the effects of the drug. After completing our revisions, we pilot tested the modified CRAFT intervention for parents of adolescents.

**Pilot Study Participants** Participants were recruited primarily through contacts with community adolescent treatment programs or through advertisements on local radio stations and in newspapers inviting parents concerned about their adolescent child's substance use to participate in a research study. The adolescent had to have a primary drug abuse problem involving alcohol or a psychoactive drug other than tobacco or caffeine, could not be receiving treatment, and could not have a significant cognitive impairment e.g., severe psychiatric disorder. Parents were excluded if they had a substance use disorder themselves during past two years determined via DSM-IV-TR criteria, significant cognitive impairment, a recent history of severe violence initiated by the adolescent, or were currently receiving treatment addressing the adolescent's substance use. Ineligible parents were offered referrals to more appropriate services. All procedures were approved by the Treatment Research Institute and Philadelphia Department of Public Health Institutional Review Boards prior to initiating study recruitment activities. Parents who telephoned the clinic were screened for initial eligibility and then scheduled for inperson screening to verify and finalize eligibility. Ten participants were assigned to one of two family specialists after providing informed consent. One participant became ineligible shortly after enrollment because her daughter was sent to a residential school precluding regular parent-child contact and one parent self-terminated from the study prior to engaging in any of the CRAFT sessions. Four participants were White, two were Black, two were of mixed race; and one was Hispanic. Procedures In the description of the intervention procedures below, the basic program structure and the treatment components are described. Additional procedural details regarding treatment entry procedures are also provided.

The CRAFT components listed in Table 1 plus the two PMT components added to modify the original CRAFT intervention are indicated in italics to show how all the components were integrated into the new CRAFT intervention for parents. Basic program structure All participants were encouraged to complete 12 individual training sessions within a 3-month period of time and could utilize up to six additional emergency sessions. The first session lasted 90 minutes and the remaining sessions lasted approximately 60 minutes. The content of the CRAFT sessions were delivered according to standard guidelines for behavioral skill training. When training a new skill, the family specialists would first teach the skill didactically, then model the skill, have the parent practice the skill in a roleplay with praise and corrective feedback provided regarding the parent's performance of the skill, and finally discuss how the parent would practice the skill at home, anticipating potential barriers and using problem-solving techniques to address them. The intervention was implemented according to a structured 11-module manual that contained clear specifications and guidelines for the delivery of the intervention. For each module, the manual specified the estimated completion time, the purpose,

specific behavioral goals for the parent and the family specialist, materials to be used, session content, homework, session evaluation, and decisionmaking guidelines e.g., if the parent's communications skills were sufficient to progress to treatment entry training, which relied heavily on communication skills. Although the CRAFT manual was highly structured, the family specialist was given considerable flexibility in selecting the appropriate module for a session, individualizing the content for each parent, and addressing the parent's concerns and crises as they arose.

**Description of the modules** The 11 modules included the 8 original behavior management strategies, and the two new PBT strategies that we added. Most of the modules focused on one of the 10 behavioral management strategies; however, one of the modules combined three strategies positive reinforcement, ignoring substance use, and arranging competing reinforcing activities were combined into one module training differential reinforcement. **Treatment entry procedures** As part of the treatment entry training module, parents were trained to invite their adolescent to enter treatment. Parents were given the option of inviting the adolescent to enter an adolescent treatment program directly or to invite the adolescent to come with him or her to a meeting at the clinic. Adolescents who attended a clinic meeting, were asked to discuss their own concerns and goals e.g., academic difficulties; family conflict as well as the concerns of the parent e.g., parent's concern about their academic difficulties or family conflict. Adolescents who agreed to consider receiving help were offered a wide variety of appropriate treatment options e.g., substance abuse treatment; family, mental health, school guidance, or pastoral counseling. When necessary, clinicians assisted the parent with issues related to treatment costs e.g., utilization of insurance, public assistance, etc.. **Measures** There were two main outcome measures for the pilot study; acceptability of the CRAFT intervention and adolescent treatment entry. We recorded the number of sessions parents completed as the primary measure of treatment acceptability. We defined adolescent treatment entry in two ways. First, we recorded entry to our treatment program if the parent was successful in bringing the adolescent to the CRAFT clinic to discuss parent and adolescent concerns.

<http://superbia.lgbt/flotaganis/1649391311>