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▶ Community reinforcement approach (CRA) for cocaine dependence in the Spanish public health system: 1 year outcome.

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Emerging from its US home, the community reinforcement approach aiming to rearrange a patient's life outside the clinic to reinforce abstinence has been trialled for cocaine users at a Spanish drug treatment centre. Though therapeutic contact was equalised, patients did better than in standard treatment based on cognitive-behavioural principles.

Summary Often trialled in combination, contingency management approaches, which systematically apply incentives and sanctions, and the community reinforcement approach are recommended psychological interventions for addiction to cocaine and other stimulants.

Community reinforcement involves behavioural skills sessions intended to rearrange personal and community resources and develop alternative social activities to reinforce recovery from substance use problems. Though supported by research, there are questions over cost and feasibility in usual community contexts, especially outside the USA.

The featured study assessed the approach in a Spanish city at a public outpatient facility specialising in substance use problems, following up patients for a year after the intervention started. Patients selected for the study were adults without severe psychopathology who were seeking treatment for their dependence on cocaine. Nearly 9 in 10 of the 82 who joined the study were men. They averaged 31 years of age, had used cocaine for on average 10 years, and about three quarters were in full-time employment.

They were assigned at random to standard treatment or the community reinforcement approach, both offered for six months and with the same weekly frequency of sessions

and total amount of therapeutic time. Following no set protocol, standard treatment included family sessions as appropriate and was based on cognitive-behavioural, relapse prevention principles. In contrast, community reinforcement was applied in line with a structured protocol setting the content for each session plus written 'homework' assignments, and therapists (different staff from in the standard treatment) had been intensively trained and were supervised weekly.

A year after treatment started, 34 patients (41% of the initial sample and 85% of those who completed treatment) could be reassessed, including 37% of those assigned to standard treatment and 44% community reinforcement.

Main findings

Though not always to a statistically significant or large degree, in general community reinforcement patients fared better than those offered standard treatment in terms of retention and cocaine use and their wider problems, especially in family-social and drinking domains.

Treatment was completed by 55% of community reinforcement patients but 40% in standard treatment. Abstinence from cocaine was assessed at one year for the 34 patients who could be reassessed. Of the 21 who had been offered community reinforcement, 95% were no longer using cocaine compared to 69% of the 13 reassessed after standard treatment, a statistically significant difference. On the assumption that those not followed up were still using cocaine, the gap was 43% versus 26%, no longer statistically significant. Continuous abstinence throughout the follow-up year was attained by 27% versus 21%.

Substance-related and other life problems generally improved more after community reinforcement and to a statistically significant degree in the family-social and alcohol domains.

The authors' conclusions

Cocaine use abstinence and life in general improved more among patients offered the same amount of therapy but following a community reinforcement protocol. Notably this protocol included modules lacking from standard treatment on relationships and other substance use, the areas where (apart from cocaine use) community reinforcement patients improved significantly more. Based on these results, community reinforcement can be considered a promising programme which can be adapted to community contexts with good results.

That there were not clearer or greater gains from community reinforcement may have been due to the comparison treatment sharing some of the same cognitive–behavioural therapeutic principles, and to the omission of contingency management elements from the protocol.

FINDINGS The authors' "promising" verdict seems about right given a small sample, most of whom could not be followed up. Less promising was the major relevant UK trial, which incorporated community reinforcement elements in its social behaviour and network therapy option for alcohol dependent patients. Like community reinforcement, this was intended to bolster the incentives for sobriety in the patient's social life outside

the clinic. Though offered and on average delivered over more sessions, this option did not improve on a brief therapy based on motivational interviewing principles. However, both were just part of the treatment patients were given, not the sole inputs, perhaps masking any benefits of community reinforcement.

In Spain and applied largely to employed male cocaine users, community reinforcement led to at least 43% of patients no longer using cocaine a year later, and probably more. This creditable result again shows that cocaine addiction can effectively be managed and overcome through generic psychosocial therapies, even though there is no specific psychological or pharmacological option such as methadone for heroin dependence.

In the featured study it may have been relevant that the therapist(s) assigned to community reinforcement had recently been specially trained in this new approach and then supervised weekly. The optimism of a new scientific approach, extra support, and clearer structure afforded to community reinforcement therapists may in itself have accounted for the somewhat better outcomes, regardless of the content of the therapy.

For more run a search on the Findings site for all our analyses of family and social network therapies. The results include this review of community reinforcement studies.

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