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COMMUNITY REINFORCEMENT AND FAMILY TRAINING (CRAFT):  
AN EFFECTIVENESS STUDY

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Community Reinforcement and Family Training (CRAFT) is a cognitive-behavioral program designed to get treatment-refusing substance-abusing individuals to enter treatment by teaching family members how to support a clean/sober lifestyle. Additionally, CRAFT teaches family members how to improve their own lives, regardless of whether their loved one enters treatment. The Santa Fe County CRAFT Project examined whether CRAFT could be successfully transferred from a controlled research setting to a community treatment center. Although the liberal client selection procedures allowed for the recruitment of a heterogeneous sample of interested family members, engagement results obtained in this effectiveness study (55%-65% engaged) were roughly comparable to the controlled research findings. This study demonstrated that CRAFT could be successfully transferred to a community treatment agency.

Key words: CRAFT, cognitive-behavioral, substance abusers, engagement, treatment-refusing, unmotivated, family treatment

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Community Reinforcement and Family Training (CRAFT) is a cognitive-behavioral program designed to get treatment-refusing substance-abusers (Identified Patients: IPs) to voluntarily engage in treatment by teaching family members (Concerned Significant Others: CSOs) the necessary skills to successfully influence the IP (Meyers & Wolfe, 2004; Smith & Meyers, 2004; Smith, Meyers, & Austin, 2008). In addition, CRAFT teaches the family members skills to enhance their own lives, regardless of whether their IP enters treatment. The efficacy of CRAFT has been demonstrated in multiple research trials (e.g., Kirby, Marlowe, Festinger, Garvey, & LaMonaca, 1999; Meyers, Miller, Smith, & Tonigan, 2002; Miller, Meyers, & Tonigan, 1999; Sisson & Azrin, 1986). Importantly, the treatment engagement outcomes appear independent of both the type of relationship the CSO has with the IP (e.g., is the IP's spouse, mother), and the IP's drug of choice.

It has been recognized for years now that although highly controlled efficacy trials are critical starting points in the treatment outcome

field, community-based quasi-experimental effectiveness trials are essential as well (Chambless & Hollon, 1998; Garske & Anderson, 2003; Goldfried & Wolfe, 1998). Effectiveness trials are set up as a more naturalistic delivery of the empirically-based treatment, which typically implies less experimental control. The reduction in experimental rigor is the result of factors such as non-random treatment assignment, the inclusion of participants with comorbid disorders and/or involvement in other active treatments (e.g., psychotropic medication), and the reliance upon therapists with both limited ongoing supervision and with a training background that is sometimes vastly different from the treatment under study. The less-controlled design is considered a reasonable trade-off, however, in exchange for greatly improved external validity (Chambless & Hollon, 1998; Garske & Anderson, 2003; Morrison, Bradley, & Westen, 2003; Seligman, 1998). The ultimate goal is to solve the problem of empirically-supported treatments being rarely used in treatment settings (Carroll & Rounsaville, 2003).

The primary objective of the Santa Fe County CRAFT Project was to demonstrate that CRAFT procedures, already shown to be effective through years of university-level research, could be successfully implemented in a community mental health/substance abuse treatment center, and could achieve IP engagement rates comparable to the controlled studies. Additional goals (not addressed in this paper) included training local substance abuse treatment providers in the CRAFT approach, decreasing substance abuse in the treatment-resistant population, and developing modifications of the CRAFT approach to meet the specific local conditions and population.

This project was supported by a Targeted Capacity Expansion grant from the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. The grant was awarded to Santa Fe County Health and Human Services Department, and was implemented over approximately 3 ½ years. Clients were enrolled from the city of Santa Fe, New Mexico and from surrounding areas within an hour's drive. Recruitment procedures included newspaper advertising, flyers inserted in state employees' paychecks, booths at community fairs, and talks to professional organizations. Although some clients learned of the project through the legal system, all participation was voluntary. There was no charge to clients for services, and cash incentives were provided to encourage clients to provide follow-up data.

CRAFT services were provided by The Life Link, Inc., a community mental health/substance abuse treatment center that provides multiple ancillary services, including psychiatric, housing, family assistance, employment, psychosocial rehabilitation, and GED preparation in partnership with the local community college. Active in the Santa Fe community since 1987, The Life Link is a centrally located and well-established treatment provider, serving over 1,800 clients annually. Life Link staff were trained and supervised in CRAFT procedures by Robert J. Meyers, Ph.D., the originator of CRAFT (Meyers, Smith, & Lash, 2005; Meyers & Wolfe, 2004; Smith &

Meyers, 2004). Identified Patients who chose to enter treatment could access services paid for by the CRAFT Project at The Life Link, or at their own expense at other community agencies and with private practitioners. Since the project was designed primarily to determine whether CRAFT procedures were successful in encouraging IPs to enter treatment, rather than to determine if treatment was successful, IP engagement data were collected through interviews with the CSOs.

This paper reports on IP engagement and CSO outcomes for a CRAFT program implemented in a non-research setting. Although the paper does not focus on the challenges to conducting this community-based study, it should be noted that during the project there were various administrative and process issues that greatly affected staff and clients, and that may have had an impact on the outcomes. Among these were the terrorist attacks on the World Trade Center and the death of one of the female Life Link CRAFT therapists, who was married to another Life Link CRAFT therapist. While it is not possible to quantify what effect these events had on staff and clients, they appeared worth noting.

## Method

### *Participant Characteristics*

Given that CRAFT is designed to work with the CSOs of treatment-refusing IPs, the CSOs were both the main clients and the participants in this research project. In order for a CSO to be eligible for the project, the CSO had to:

- be concerned about and have direct knowledge of alcohol abuse (either with or without other substance abuse) of either a first degree relative (parent, child, or sibling) or a marital spouse or intimate partner (heterosexual or homosexual) who was not currently seeking treatment;
- have contact with the abuser at least 40% of the last 90 days, and to expect to maintain contact over the next 90 days;

- be at least 18 years of age;
- have evidence that the abuser met DSM-IV criteria for Alcohol Abuse
- show no signs of unremitted psychosis or other condition which could seriously impair the CSO's ability to understand and participate in treatment;
- be willing to participate in treatment;
- reside within approximately an hour's drive from Santa Fe, and have adequate transportation to get to CRAFT sessions.

In contrast to more tightly controlled research studies, we did not exclude CSOs who appeared to have a substance abuse problem themselves. The one exception was if there was current injectable drug abuse (for either the CSO or the IP), in which case they were excluded from this project and referred to a treatment agency specializing in that problem. As noted above, we also did not exclude CSOs who reported that their IP had multiple drugs of abuse or dependence.

Initially 114 CSOs were recruited into the CRAFT project at The Life Link. Seven of the CSOs never started CRAFT despite completing the assessment, and eight CSOs started but were excluded later upon discovering that the CSOs did not satisfy the eligibility criteria (e.g., insufficient contact with the IP). Therefore, 99 CSOs comprised the final data set.

Table 1 presents the demographic characteristics of the CSOs. Overall, CSOs tended to be married female Hispanics in their fifties with a high school education. They were employed full- or part- time. They primarily were concerned about alcohol abuse as opposed to drug abuse.

Approximately 90% resided in Santa Fe County and 88% resided in the city of Santa Fe.

Table 1  
*CSO Demographic Characteristics*

Mean Age in Years (n=98)	50.9 (SD = 12.5)
Mean Years in Education (n=96)	13.2 (SD = 2.9)
Marital Status (n=91)	n (%)
Married	48 (52.7%)
Divorced	22 (24.2%)
Single	16 (17.6%)
Separated	2 (2.2%)
Widowed	3 (3.3%)
Race (n=25)	n (%)
Other	18 (21.2%)
American Indian	2 (2.4%)
White	65 (76.5%)
Hispanic or Latino (n=93)	n (%)
Yes	55 (59.1%)
No	38 (40.9%)
Gender (n=99)	N (%)
Male	10 (10.1%)
Female	89 (89.9%)
Employment (n=95)	n (%)
Employed full time	46 (48.4%)
Employed part time	19 (20.0%)
Unemployed, looking for work	15 (15.8%)
Other (specify)	10 (10.5%)
Unemployed, retired	4 (4.2%)
Unemployed, disabled	1 (1.1%)
Relationship to Identified Patient (n=99)	
Mother	25 (25.3%)
Wife	24 (24.2%)
Significant Other	16 (16.2%)
Other	12 (12.1%)
Husband	7 (7.1%)
Other Relative	6 (6.1%)
Son	4 (4.0%)
Father	3 (3.0%)
Daughter	2 (2.0%)
Primary Drug of Concern (n=95)	n (%)
Alcohol	86 (90.5%)
Cocaine	7 (7.4%)
Heroin	1 (1.1%)
Methamphetamine	1 (1.1%)

### Measures

*Beck Depression Inventory (BDI-II;* Beck, Steer, & Brown, 1996). This 21-item measure examines symptoms of depression. Each item consists of four possible responses that are scored from 0 (no symptom present) to 3 (most extreme symptom presentation). Total scores on the BDI-II range from 0 to 63. The BDI-II demonstrates adequate test-retest reliability and convergent validity with other measures of depression (Beck et al., 1996).

*State-Trait Anger Inventory (STAXI;* Spielberger, 1996). The STAXI is a 44-item

self-report questionnaire which yields 5 subscales: State Anger, Trait Anger, Anger Outbursts, Anger Suppression, and Anger Control. Items are rated on a 4 point Likert scale. Higher scores indicate greater degrees of anger. This scale has demonstrated very good reliability and validity in both clinical and nonclinical groups.

*State-Trait Anxiety Inventory (STAI;* Spielberger, 1983). The STAI is composed of two 20-item self-report scales. One scale measures state anxiety; namely, how the participant is feeling "right now". The scale measuring trait anxiety reports on how the participant feels in general. Items are rated on a 4 point Likert scale. For the state anxiety scale items are rated from "not at all" to "very much so", while the trait anxiety items are rated from "almost never" to "almost always". This scale has excellent internal consistency, test-retest reliability, convergent and discriminant validity (Gros, Antony, Simms, & McCabe, 2007). Total scores for each subscale range from 20 to 80, with higher scores indicating greater anxiety.

*Relationship Happiness Scale* (Azrin, Naster, & Jones, 1973). This clinical instrument instructs individuals to rate their current happiness with their partner across 10 domains on a scale of 1 (Completely Unhappy) to 10 (Completely Happy). Representative domains include Drinking/Drug Use, Household Responsibilities, and Social Activities. The final rating is for "General Happiness". CSOs in the current study rated their happiness with their IP over the previous 30 days.

*Michigan Alcohol Screening Test (MAST;* Selzer, 1971). This 25-item measure screens for symptoms of alcohol dependence. Each item describes the symptoms or consequences of alcohol abuse (e.g., "Have you ever lost friends because of your drinking?") and requires a "yes" or "no" response. Each MAST item is weighted and total scores range from 0 to 53, with higher scores indicating increased symptomatology. Scores above the cutoff of 5 indicate the possible presence of an alcohol use disorder (Selzer, 1971). The MAST has

demonstrated concurrent validity with diagnoses based upon structured interviews (Watson et al., 1995).

## Results

### *CSO Baseline Measures*

Table 2 presents the baseline mental health measures for CSOs. On average, CSOs were experiencing mild to moderate depression (Beck, Steer, & Garbin, 1988), and elevated levels of anger compared to those reported in other CRAFT studies. In terms of anxiety, CSOs' mean state and trait anxiety fell at the 93rd percentile for normal adult females. If one examines norms for a treatment-seeking sample (i.e., general medical/surgical patients), state anxiety of the CSOs drops to the 61st percentile for females, and trait anxiety drops to the 57th percentile. On the Relationship Happiness Scale (Azrin et al., 1973), CSOs' average score on the "General Happiness" item indicated that they were feeling moderately happy with their relationship at the time that they started the study.

Table 2  
*Baseline CSO Mental Health Characteristics*

	Mean	Standard Deviation
Beck Depression Inventory (n=97)	15.4	12.1
State Anger (STAXI) (n=95)	22.2	10.2
Trait Anger (STAXI) (n=95)	17.3	5.9
State Anxiety (STAI) (n=96)	47.0	14.9
Trait Anxiety (STAI) (n=96)	43.3	13.3
General Happiness (n=83)	6.3	2.6

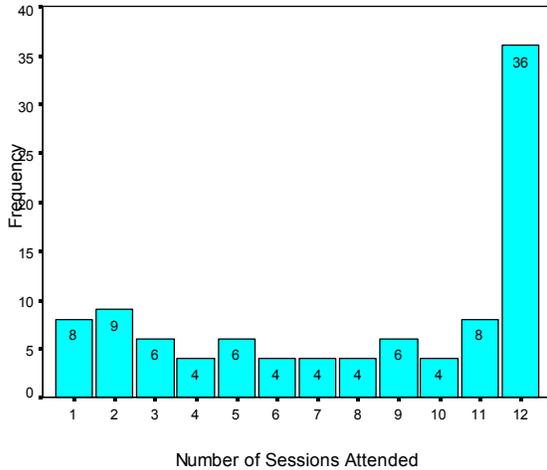
*Note.* STAXI = State-Trait Anger Inventory; STAI = State-Trait Anxiety Inventory; General Happiness = overall relationship happiness item from Relationship Happiness Scale.

### *CSO Attendance and Follow-Up*

Would CSOs receiving services in the community participate in CRAFT training as consistently as those in research settings? Figure 1 below shows the number of CRAFT sessions attended by CSOs. Of the 12 planned sessions

CSOs attended an average of 8.0 sessions; i.e., 67% of the possible 12 sessions.

Figure 1: Number of Sessions CSOs Attended



Given that we were dealing with a voluntary client population that was less highly selected than those in the university studies, and perhaps more geographically dispersed, follow-up presented significant challenges. The 12-month completion rate in our study is artificially low, as some of the clients started the project in the second half of Year 3 and consequently were not yet due for their 12 month interview when the project concluded. Follow-up completion rates were 52% (3 months), 57% (6 months), and 48% (12 months).

We checked for potential differences in measures assessed at baseline between CSOs who were assessed at 6 months versus those who were not. Of the 12 measures examined, the only difference reaching significance at  $\alpha = .05$  was that in the age of the CSO. CSOs who completed the 6-month follow-up were significantly older than those who were not assessed at 6 months (54 vs. 47 years old). Thus, one can be reasonably certain that the follow-up data are representative of all CSOs in the study.

*Treatment Engagement*

The major focus of this project was engagement of the treatment-refusing IPs into

treatment. Engagement was defined as completing the assessment process at the Life Link, or a CSO’s report that the IP had entered a treatment program at a facility other than Life Link within six months from the time the CSO began the CRAFT program. We calculated the engagement rates in three ways: (1) for all CSOs regardless of the number of sessions they attended, (2) for CSOs who attended at least four sessions, and (3) for CSOs who attended at least four sessions or who had an IP engage regardless of the number of sessions (see Table 3). The most conservative calculation gave an overall engagement rate of 55%. Dr. Meyers, developer of CRAFT, considers CSO attendance at a minimum of four sessions necessary for them to develop adequate skills to appropriately engage their IPs. Using this criterion, the engagement rate increased to 62%. The third method of calculating engagement included those CSOs who attended at least four sessions or who simply engaged their IP (regardless of the number of sessions attended). The third method resulted in an engagement rate of 65%.

Table 3  
*Treatment Engagement Rates*

<b>All CSOs</b>	
Total Number of IPs	99
Number of IPs Engaged	54
Percent of IPs Engaged	55%
<b>CSOs who attended 4 or more sessions</b>	
Total Number of IPs	76
Number of IPs Engaged	47
Percent of IPs Engaged	62%
<b>CSOs who attended 4 or more sessions or had an IP engage (regardless of number of sessions)</b>	
Total Number of IPs	83
Number of IPs Engaged	54
Percent of IPs Engaged	65%

We examined whether a particular category of relationship between the CSO and the IP predicted success in influencing the IP to enter treatment. Relationship categories were collapsed into spouse or significant other, parents, and all other relationship types. No one relationship type was found to be more successful for IP engagement. No difference in engagement rate of IPs was found when calculated by CSO:

- age (average for not engaged = 50 years; average for engaged = 52 years);
- educational level (13 years for both groups);
- gender (male CSOs tended to have a higher engagement rate compared to females, but the difference was not significant)

We next explored potential differences in substance use for the IPs who had been engaged and those who had not. Estimates of the severity of the IP’s drinking problem did not differ between CSOs who were able to engage their IPs and those who were not able to do so. As expected, alcohol was the primary drug for both the engaged IPs (90.9%) and the non-engaged IPs (89.4%).

One major question was whether we were reaching CSOs whose IPs had a level of alcohol intake that was cause for concern. The average MAST score for the subset of IPs who entered treatment was 26 (SD = 13), which suggested a relatively severe alcohol problem.

We also were interested in determining the number of sessions CSOs attended before their IP engaged in treatment. CSOs who engaged their IP took anywhere from 1-12 sessions (M = 3.9 sessions), with 30% of them engaging their IP after just one CSO session.

*CSO Functioning Over Time*

We used a repeated measures analysis to determine CSO improvement in functioning over time, regardless of whether the CSO had successfully engaged the IP in treatment. The results are presented in Table 4. For the main analysis we elected to run the analyses for the baseline, 3 and 6-months time points. We excluded the 12-month follow-up, in part because a fair number of the CSOs were not even due for their 12-month follow-up at the time the project ended. This contributed to the substantial number of missing 12-month interviews, which in turn severely impacted the sample size (i.e., from 38 down to 26). Nevertheless, when a secondary set of analyses was conducted using the subset of CSOs who had complete data for all time periods, the final

results in terms of which variables showed significant changes remained the same.

The Beck Depression Inventory (BDI) scores of the CSOs changed significantly over time, reflecting an overall reduction in depression,  $F(1,34) = 21.01, p<.001$ . State anger also decreased significantly over time,  $F(1,37) = 8.478, p<.01$ , but trait anger did not. Both state and trait anxiety significantly decreased over time,  $F(1,37)=16.09, p<.001$ , and  $F(1,37) = 10.94, p<.01$ . The Relationship Happiness Scale also significantly improved over time,  $F(1,27) = 4.81, p<.05$ .

Table 4  
Concerned Significant Other Functioning: Intake, 3months, 6months

Measure and Time	Mean	SD	Time Effect
Beck Depression Inventory (n=35)			***
Intake	16.1	11.8	
3 Months	11.5	10.9	
6 Months	8.8	10.4	
State Anger (STAXI) (n=38)			**
Intake	21.8	9.2	
3 Months	22.5	10.6	
6 Months	17.9	5.7	
Trait Anger (STAXI) (n=38)			ns
Intake	16.7	6.3	
3 Months	18.5	9.5	
6 Months	16.1	6.4	
State Anxiety (STAI) (n=38)			***
Intake	45.2	15.7	
3 Months	38.7	16.8	
6 Months	35.5	16.7	
Trait Anxiety (STAI) (n=38)			**
Intake	43.1	12.3	
3 Months	37.8	14.7	
6 Months	37.3	12.8	
General Happiness (n=28)			*
Intake	6.7	2.6	
3 Months	7.1	2.5	
6 Months	7.6	2.5	

Note. STAXI = State-Trait Anger Inventory; STAI = State-Trait Anxiety Inventory; General Happiness = overall relationship happiness item from Relationship Happiness Scale.  
\*p<.05, \*\*p<.01, \*\*\*p<.001

In order to determine whether CSOs with IPs who entered into treatment would improve in functioning more than those with IPs who had not entered treatment, we performed further analyses with baseline drinking as a covariate. There were no significant differences detected between CSOs whose IPs had entered treatment and CSOs whose IPs had not entered treatment; the CSOs experienced a similar benefit in mental health functioning. This is supported by the clinical interview data, as many

providers reported that even in the absence of the IP entering treatment, the overall functioning of the CSO was improved through participation in CRAFT.

### *Therapist Differences*

Therapists may differ in success rates in helping their CSO get their IP into treatment. We divided the therapists into those who worked with less than 10 CSOs and those who worked with 10 or more CSOs. The concern was that therapists with smaller caseloads might have unrepresentative rates and thus the reliability would be higher for therapists who treated at least 10 cases (Miller et al., 1999). Analyses determined that therapists with 10 or more cases had an engagement rate of 56% compared to 50% for those with less than 10 cases. This difference was not significant.

### Discussion

Our major outcome, IP engagement into treatment within 6 months, ranged from a high of 65% to a low of 55%, depending on which calculation was used. But it is also the case that some IPs likely entered treatment at other agencies without our awareness, thus artificially depressing our engagement rate. We know that 27% of the engaged IPs of which we were aware sought treatment at an agency other than the Life Link. And given the low follow-up rates, we did not have complete information from a fair number of CSOs; some of whom may have engaged their IPs and simply not informed us. Miller and colleagues (Miller et al., 1999) reported a 64% engagement rate for treatment-resistant alcohol abusers. The rates varied somewhat for studies that engaged illicit drug users: 64% (Kirby et al., 1999), 67% (Meyers et al., 2002) and 74% (Meyers, Miller, Hill & Tonigan, 1999).

A 55% - 65% range seems respectable given that this project used very few exclusion criteria for its CSOs, and the study was completed in a community-based setting with an agency's regular clinical staff. Although the therapists received ongoing supervision throughout the project, it was fairly common for

several of them to periodically resort back to divergent theoretical and practical treatment backgrounds. Conceivably the engagement rates would have been even higher if treatment fidelity had been optimal. Another potential influence on the engagement rate was the fact that several monolingual (Spanish speaking) CSOs (n = 7) were recruited into the study before some of the materials (forms, etc.) had been fully translated. Since the engagement rate for this subset was only 29%, one must wonder about unaddressed complications associated with the language or the culture. Finally, it is conceivable that the IPs were different in significant ways from the IPs of the earlier CRAFT studies, inasmuch as a substantial number of them appeared to have multiple substance abuse diagnoses. For example, secondary drug use reported by engaged IPs for the 30 days prior to treatment entry included cocaine (20% of IPs), marijuana (15%), and miscellaneous other drugs (6%).

Our finding of an average of 3.9 CSO CRAFT sessions before IP engagement was somewhat lower than the 4.7 found in the Miller et al. (1999) study. This was largely due to our study having 30% of the engaged IPs entering treatment after only one CSO session. Although the project advertised for the loved ones of substance abusers who were *unwilling* to enter treatment, conceivably the recruitment process was not sufficiently rigorous to screen out the adamant treatment-refusing IPs (Meyers et al., 1999; 2002; Miller et al., 1999) from the merely unmotivated IPs. It should be noted, however, that the IPs from whom we gathered self-report data indicated a lengthy duration of self-perceived problem drinking, with a mean of 12.9 years. Regardless of precisely *how* unwilling this subset of quick-responding IPs was to enter treatment, CSOs enrolled in a CRAFT program were the catalyst to treatment engagement for them.

It is also possible that the high percentage of IPs who sought treatment after just one CSO session was instead a reflection of the CSOs in the current study "jumping the gun" when it came to inviting their IPs to attend. CRAFT therapists routinely have to slow down

eager CSOs so that therapy time can be devoted to teaching them important relationship and self-care skills. One might wonder whether the abrupt entry of an IP into treatment somehow interfered with the CSO's development of self-care skills, and indirectly contributed to the higher than normal dropout rates of the CSOs in this study.

In terms of characteristics of the CSOs, we found that CSO baseline depression for the entire sample ( $M = 15.4$ ) was higher than the intake depression ( $M = 10.6$ ) reported in the main CRAFT alcohol study (Miller et al., 1999), but quite comparable to that reported in the Meyers et al. (1999) illicit drug study ( $M = 14.2$ ). It was also the case that our CSOs reported higher state anger at baseline ( $M = 22.2$ ) than did the CSOs in the Miller study ( $M = 13.0$ ) and the Meyers et al. (1999) study ( $M = 14.7$ ). Although anxiety measures were not used in the Miller study, our state and trait anxiety levels at baseline were just slightly lower than the levels reported in the Meyers et al. (1999) study. As far as relationship satisfaction, the CSOs in the current study rated it a 6.3 on a 10-point scale, whereas initial relationship satisfaction in other CRAFT studies was rated 4.9 (Miller et al., 1999) and 4.5 (Meyers et al., 1999). Thus, our CSOs entered the program with relatively higher levels of relationship satisfaction. In summary, the psychological profile of our CSOs at intake was one of somewhat more depression and anger than that of CSOs in previous studies, but with more satisfaction in their relationships. Conceivably we lost more CSOs earlier in treatment ( $M = 8$  sessions vs 10.7 in Miller et al., 1999) and from follow-up due to the combination of the CSOs' initial negative feelings being reduced (at least temporarily) early in treatment, and their already somewhat satisfying relationship with their IP from the onset.

With regard to average changes in CSO functioning by the time of the 6-month follow-up, the level of depression ( $M = 8.8$ ) had dropped to within the normal range, and was quite similar to the mean of the Miller et al. (1999) alcohol study ( $M = 7.0$ ) and the Meyers et al. (1999) drug study ( $M = 8.0$ ). Although

trait anger did not change significantly over time, state anger did. The 6-month state anger average for the current study ( $M = 17.9$ ) was markedly higher than the means reported for both the Miller study ( $M = 10.9$ ) and the Meyers study ( $M = 9.8$ ). State anxiety had decreased from the 93rd to the 69th percentile when using the norms for normal females, or from the 61st to the 46th percentile when using norms for a clinical sample. Trait anxiety dropped as well; from the 93rd to the 76th percentile for normal females, and from the 57th to the 47th percentile for a clinical sample. The 6-month state ( $M = 35.5$ ) and trait ( $M = 37.3$ ) anxiety averages for the current CSOs were comparable to the state ( $M = 35.0$ ) and trait ( $M = 35.0$ ) anxiety means for the Meyers et al. study. The "General Happiness" item on the Relationship Happiness Scale increased to 7.6 out of a possible 10 points, which was considerably higher than the 6-month average for both the Miller ( $M = 6.4$ ) and the Meyers ( $M = 5.9$ ) studies. Overall, CSOs in the current study, regardless of whether their IP entered treatment, showed noteworthy improvement across multiple indices of psychological functioning. With the exception of the current CSOs' state anger still being uniquely elevated at 6-months, the final levels of the remaining psychological constructs were at least comparable to those found in the earlier CRAFT studies.

The relatively large amount of missing data is problematic for this study. Although the original 99 CSOs was a respectable number, there were 48% and 43% missing surveys at the 3- and 6-month time points, respectively. The result is a reduction in the ability to detect change. Importantly, when the intake data were compared on CSOs for whom we did and did not have follow-up data, the only significant difference found was on CSO age. We believe this suggests that the available data are likely representative of the CSOs in general who started the study. Future effectiveness studies should consider offering more than a \$20 incentive for follow-ups, and having adequate staff assistance so that attempts to contact participants for follow-up appointments can be ongoing and persistent.

In conclusion, despite the challenges of providing CRAFT treatment by therapists who were tasked with changing over-learned treatment behaviors to follow a new protocol, with CSO and IP populations that were more inclusive (i.e., “complicated”) than those in the typical research study, and given the major disruptive events of 9/11 and the death of one therapist/spouse, we did achieve encouraging results:

- CSOs influenced their IPs to engage in treatment in up to 65% of the cases, and
- CSOs’ functioning improved over time

An additional, unexpected positive outcome of this project was the diffusion of the CRAFT approach into other venues. A major New Mexico health insurance provider now includes reimbursement for CRAFT treatment, and the San Juan County DWI Center now requires participation in CRAFT for DWI offender families. Further, The Life Link Training Institute was developed, and staff members now travel nationally and internationally to present CRAFT training.

In summary, this project demonstrates that, challenges notwithstanding, the CRAFT program can be successfully transferred to the community clinic treatment setting. CRAFT researchers might consider conducting future studies that are so-called “hybrid” models; designs which contain critical components of both efficacy and effectiveness research (Carroll & Rounsaville, 2003).

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