ENABLING DEPENDENT DRUG USERS: A COGNITIVE BEHAVIOURAL ASSESSMENT

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Based upon six years social work practice with dependent drug users in Merseyside, the author introduces the broad principles of a cognitive behavioural approach, and then integrates this theoretical understanding to a highly specific area of practice, - assessing dependent drug users. Assessment is discussed in detail and using examples the article provides a much needed model of good practice. The approach is based upon a risk reduction philosophy and is underpinned by cognitive behavioural principles. The article offers a comprehensive outline from which a practitioner could follow and conduct an assessment. Importantly, the process seeks to empower clients, redressing the balance by returning to them responsibility for their future, thus enabling them to set their own targets and plans without coercion from the worker.

This paper briefly outlines the emergence of cognitive behavioural therapy from within behaviourist theory and then, using examples, relates it to dependent behaviour. Based upon six years social work practice with dependent drug users, the paper provides a detailed framework of an established cognitive behavioural assessment which has been developed and refined through practice.

THE EMERGENCE OF A COGNITIVE BEHAVIOURAL APPROACH.

In the 1970s behaviourist theory, supported with strong empirical research, was built around the work of Pavlov, Skinner and Bandura. The Pavlovian contribution of 'classical' conditioning saw individuals mainly as passive, with behaviour being triggered, either instinctively or conditionally. Raising one's hands to protect ones head in the sight of a falling object would be an example of instinctive behaviour triggered by unconditional stimuli, whereas an example of conditional or learnt behaviour would be the lighting of a cigarette in response to the conditional stimuli of drinking coffee. Skinner further introduced the concept of operant conditioning, and explored the link between behaviour and the environment.

Operant conditioning is described as behaviour which operates upon

the environment, reinforced by either positive or negative rewards. For example, if a child crying in the supermarket is given a bag of sweets, the next time the child visits the supermarket, there may be a further episode of crying with the expectation that this behaviour will be positively reinforced by another bag of sweets. Albert Bandura (1977) introduced a more cognitive understanding of behaviourist theory alongside social learning theory, recognising that individuals model themselves upon people they observe, although their behaviour will depend upon what they perceive and understand to be happening. The mind and its thought processes are then seen as a crucial mediator in this process, between the environment and behaviour.

Cognitive theory was firmly established through the work of Beck, Meichenbaum and Ellis. A cognitive behavioural approach combines behaviourist and cognitive theory. Like behaviourist theory, it cannot be identified as a specific technique or understanding. Georg Eifert described it more broadly as:

...neither one identifiable therapy, technique or treatment package nor has it one unifying underlying theory. It is rather a conceptual orientation towards defining clinical problems in a specific way and designing intervention strategies based on these conceptualisations (Eifert, 1984, p. 174).

In particular, cognitive behavioural therapy focuses upon the way experiences are organised and structured by the mind. This is seen as a crucial factor in determining behaviour. For example, a person you know well walks past without speaking. You then structure that experience, linking it with an apparently inoffensive discussion you had with that person a few days ago. You may conclude your friend walked past deliberately because they were offended by your previous comments. Your cognitive interpretation and structuring of that experience may then hinder your future behaviour and interaction. For example, in any future discussions or debates with friends you may feel less confident to disagree and more likely to assume a submissive role, fearing further rejection. If the friend had simply walked past because they had failed to notice you, then these changes in behaviour would be the result of a cognitive misinterpretation of the environment. Obviously, there are a whole range of perfectly plausible explanations to any scenario. What the example illustrates is the interplay between cognition and behaviour. It is, therefore, easy to see how cognitive dysfunctions can hinder therapeutic

progress.

For example, a heroin user who finds it hard not to spend all her/his money on drugs may say to themselves' I can't help myself, I've got no choice, I must have a bag of heroin'. In reality they can help themselves, do have a choice, and do not have to have a bag of heroin. It would be more accurate for them to say they want heroin. Such distorted cognitions sustain and justify behaviour by removing individual responsibility. A cognitive behavioural approach, therefore, should involve the education and training of the client, passing on relevant skills and understandings within a sympathetic, non-judgmental relationship. Joan Kirk emphasised this role:

A cognitive-behavioural assessment also has a general educational role and focuses the patient on internal and external variables which may not have been seen as relevant to the problem. The patient is asked about situations, physiological states, cognitions, interpersonal factors, as well as overt behaviour, and how each of these groups of variables relates to the problem (Kirk, 1989, p. 14).

COGNITIVE BEHAVIOURAL THERAPY AND DRUG DEPENDENCE.

In the early 1980s, much of cognitive behavioural therapy concentrated upon the treatment of depression. The broad conceptualisations have since been applied to a whole range of social and emotional problems including smoking, drinking, child behaviour problems and other emotional disorders (for example, Scott, 1989). In this paper 1 shall detail a cognitive behavioural assessment which uses a structured approach, to move drug dependent individuals towards a more rational, planned and long term treatment plan. The assessment attempts to centre upon the following cognitive behavioural insights:

1. To use a deliberate and structured approach.

2. To see the assessment as an educative and empowering process s opposed to a curative experience.

3. To encourage the client to take an active role, as a responsible individual, moving towards self management and self control.

4. To challenge expectations or goals which have been imposed by outside professionals or individuals, and to seek to help the client

establish their own realistic and measurable targets.

5. To focus primarily upon the present social situation rather than begin by exploring the past. Previous social history is only discussed when existing behaviour or cognitions necessitate further exploration.

6. To appreciate and explore the clients' cognitive representations of their environment, rather than assume any understanding per se.

7. To use corrective feedback and modelling, to challenge and restructure cognitive dysfunctions such as `faulty thinking' or `self blame'.

8. To accept that the best therapist is one who possesses a very broad range of skills and understandings, and has the flexibility and insight to introduce them when appropriate.

Unfortunately, it seems that when faced with a dependent drug user practitioners have too often assumed they know what the client wants to do (get off heroin), and how it should be done (dry out and go to a rehabilitation centre). Van Billion and Van Emst poignantly highlighted the problem many dependent drug users faced: 'Heroin addiction seems to elicit from the therapist so much concern, that there is nothing left for the client!' (1989, p.37). Basic social work principles, which have so often been neglected when working with dependent drug users, should form the foundation of any assessment.

Remaining non-judgmental isn't easy when working with dependent drug users, but clients must feel understood and accepted. The worker needs to accept and support clients who have no intention of giving up drugs, but simply want help to curb associated lifestyle difficulties. Listening is crucial, but may be inhibited if the worker has preconceived ideas of what the client ought to be saying. This may then lead to jointly agreed goals which reflect more the workers' expectations than any desires of the clients. Change is unlikely to occur without the full support of the client, and the worker may be guilty of setting the client up to fail.

Encouraging independence and individual responsibility in the client is particularly important, but workers may feel tempted to abandon these principles to 'save' the client from the 'evils' of illegal drugs. Clients may collude by assuming the role of victim, and become

heavily dependent upon the worker and then when relapse occurs, as it is always likely to, the client is likely to feel a personal disappointment to the worker. Instead, the worker should go at the clients' pace, despite the fact that the worker may find this personally frustrating. On occasions this could cause conflict with other requirements, such as the expectations of the court in relation to offending, or in relation to standards of parental care. However, little could be achieved by coercing the client to take action to which they are not committed. Indeed coercion is more likely to lead to a less helpful and potentially more risky game playing situation (Berne, 1964), in which the client superficially presents the behaviour the agency requires of them.

A STRUCTURED COGNITIVE BEHAVIOURAL ASSESSMENT.

The aim of a cognitive behavioural assessment is to utilise a structured process to provide clients with the freedom to be honest about what is happening, to help explore what they want to do, when they want to do it, and how. The role of the worker is to enable and encourage a trusting environment, to give the client responsibility for their behaviour, to be reflective, provocative, and flexible. When faced with a dependent drug user, it is often tempting to respond immediately, seeing the interview as a possible last or only chance, perhaps fearing the client's motivation may change.

Realistically, people cannot be rushed when trying to unravel habitual behaviour patterns to regain control. A coffee and short informal chat with the client, listening to why they have come, explaining the philosophy of the agency and nature of the cognitive behavioural assessment, would be more productive at this stage. An appointment for assessment should be arranged as early as possible - provided this is what the client wants. It can be explained that an hour will be set aside to give the client the time they need. This delay before the assessment may help the client to ponder and reflect upon their situation. It also provides some useful protection to the worker (and the client) from a potentially unhelpful panic response. Resources are then less likely to be wasted upon those not really wanting change.

Some agencies or individuals strongly favour particular treatment options, and clients may, for example, find that hospital detoxification is continually suggested as the only appropriate and effective treatment option. Another problem for clients is that some

agencies do not offer a full range of services, and may even refuse to have any involvement with those that do. Occasionally this occurs in relation to the prescribing of injectable drugs. If clients are aware the practitioner has access to the full range of drug services without prejudice, then they are more likely to return.

During this initial contact a good rapport needs to be established. The assessment process should, ideally, be seen by the client as a structured framework within which they can be helped to understand and explore their situation before they consider what action, if any, to take. Occasionally some clients may think the worker is being awkward. However, working in the local drug scene, clients soon develop well formed opinions about the credibility of any agency or individual. Good or bad practice as experienced by the clients, is quickly communicated through the drug users' 'grapevine'. In my experience this assessment process is accepted and respected by the drug dependent community.

Sometimes it comes as a shock to clients, who have previously been met with a frantic panic response, to be faced with a cognitive behavioural approach. Emotional manipulation may be used by clients, who claim that your failure to respond immediately is forcing them back on the streets to commit crime and take drugs. However, this cognitive distortion is unhelpful, and should be confronted. It attempts to put the client in a dependant role by placing responsibility for change with others. It wrongly assumes that long term lifestyle problems may be changed dramatically overnight - if only the worker would give some immediate help. Even after assessment, neither the worker nor the client should expect any immediate substantial change in lifestyle. Regaining self-control, relearning and re-establishing behaviour patterns will take a considerable amount of time and effort.

Starting the assessment

On the day of assessment, undue lateness should be met with a rearranged appointment, unless the client had good reason and, more importantly, the worker still had at least an hour available. This is not designed to be punitive but effective. Workers who try hard to be extremely accommodating are easily exploited by the drug dependent population, who have, by necessity, learnt to become adept at manipulation. Such workers often unintentionally provide a poor service. They keep clients waiting, while accommodating others. They

find their time consumed by talkative clients who make frequent visits. They rarely take coffee breaks and may work lunch hours. They work under considerable pressure and stress. In these circumstances they are less able to communicate, understand, or analyse and the likelihood of worker `burnout' increases.

Co-working when conducting assessments reduces pressure and isolation. It can assist and enhance communication between the client and worker, while keeping the interview structured and focused upon the important issues, comments, and feelings. When working with women clients, at least one woman worker should be present and assume an active role in the assessment. Interviews should start in a relaxed manner with coffee and easy conversation. Ideally, the environment should be comfortable and pleasant. The client should feel valued and respected, as they too often experience prejudice and discrimination. This can partly be communicated by insisting that you have no interruptions for the next hour. Generally, given the secret lifestyle of a dependent drug user, it is better to see such clients alone, without relatives or friends, in order to provide space and freedom to talk.

The interview begins by reminding the client of the structure and purpose of the assessment. There should be absolutely no obligation upon the worker to persuade the client to become abstinent. The ultimate goal is to give whatever help or service the client wants, provided it attempts to reduce some identifiable risk, to the client, relatives and/or wider society. 'Me worker should, as far as possible, have no hidden agendas.

Drug services must be prepared to help one client give up drugs entirely whilst advising the next client on how to minimise the risks of continued drug use (HMSO, 1989, p.37).

So it is a perfectly acceptable target simply to help a client reduce their daily intake of heroin, if that was what they felt committed to achieve. This knowledge is usually liberating for the client, and leads to a more honest and productive dialogue.

Exploring the drug habit

A full drug history should then be taken preferably using a set questionnaire (Appendix 1). This will help the client to review and reflect upon their drug taking, particularly when, why and how

changes occurred. It obviously also provides the workers with a real insight into the nature and depth of the drug habit. The way in which drugs are taken, and their frequency, can help the worker to understand what the client is able to achieve. For example, a client who daily injects virtually any drug they can obtain is likely to find a stable and controlled lifestyle more difficult to achieve than a client who rarely injects and uses mainly cannabis.

When gathering detailed information, real names and places may need to be avoided, as this can cause unnecessary anxiety in the client, and ultimately may lead to conflicting responsibilities for the worker. For example, it may be important to know that the client purchases amphetamine from a house which they must pass every day. This is relevant to the therapeutic relationship. The knowledge would enable strategic and practical intervention towards reducing the impact of a likely `trigger' situation. However, to ascertain the name or address of the person supplying amphetamine would raise suspicion in the client, and could cause a conflict of responsibility for the worker. Given such detailed information the worker may feel a responsibility to inform the Police, but at the same time a commitment to remain silent to protect the client's confidentiality and physical safety. Such specific information is best avoided as it is likely to hinder the work of the agency.

Begin by asking the client which drugs s/he has ever taken, and at what age they began. It is usually easier for the client to discuss past drug taking, rather than their current intake of drugs. Alcohol, tobacco, analgesics and caffeine should be included on the questionnaire as they are drugs. These socially acceptable drugs can be used to illustrate to the client that virtually everyone in society is a drug user. It is something common to all of us and not isolated to them. Indeed, at various levels most people do experience some associated difficulty or problem, with the recreational use of legal drugs, such as headaches with caffeine, aggression with alcohol, cancer with tobacco, and psychological dependence upon analgesics. Chaotic use of legal drugs can be particularly dangerous. The dependent illegal drug user then is not seen as different, especially dangerous or unique. Illegal drugs are certainly no more harmful than their legal counterparts, although it is important to ensure that the client is properly aware of the physical risks of their drug habit, particularly if injecting. Ironically though, it can be the illegal status of certain drugs which causes the clients most problems. These insights should be reflected to the client so

they can appreciate that their drug problem neither makes them special nor particularly different from others in society.

The next stage is to discuss drugs which have been taken during the past month e.g. how regularly, taken alone or with friends, what quantities and, particularly in relation to HIV and hepatitis, whether injected. At this point it is crucial the client feels the worker can be trusted. Having previously discussed drugs which they have taken in the past, provided the client did not feel any negative or judgmental responses, they are now more likely to speak openly in relation to the drugs they are taking at present. It is inappropriate for the worker to express any feelings of disappointment, disapproval or shock in relation to the client's lifestyle. The way in which questions are asked may also reveal unconscious prejudices. Rather than ask: 'You haven't started injecting have you?' It is better to give the client an easy route so they can admit to something they may be ashamed of, or believe the worker to disapprove of. This could be achieved by asking: 'How would you normally take this drug?. If the answer is smoke it, the follow up question would be: How often would you inject it?' This is more likely to elicit an honest and accurate dialogue. Knowledge of drugs, how they are taken, how they are obtained and how accessible they are will enhance communication, enabling the client to feel the worker is in touch. Using more open questions when exploring their drug habit allows the client freedom to discuss and reflect on significant events as they perceive them. Closed questions are then possible such as: 'How come you started taking diconal before taking heroin?

Asking the client to identify which drug is the major problem removes supposition from the worker. The period of control or abstinence in relation to this identified problem drug gives some indication of past motivation. Although, using paradox (Miller, 1983, pp-147-172), it is sometimes more illuminating to ask why did they ever bother to give up this enjoyable drug. Often it is a half hearted attempt to relieve pressure from family or the court. It is worth clarifying whether giving up the drug was what they themselves really wanted to do. It can then be stressed that change rarely occurs unless the individual is ready and committed. Where they have been for help, what they felt was useful, and why they felt their period of self control came to end will all provide important indicators for future helping strategies.

Understanding the client's present experiences.

A large board can then be used to explore wider concerns as determined by the client. Presenting information visually upon a blackboard, flip chart or white board can have quite a powerful impact. It enables the client to analyse and reflect upon their own situation. However, when presenting the information, it is worth reading it aloud to the client, not only does this help to sharpen understandings, but also avoids unnecessary embarrassment with those clients who may have difficulty in reading.

The aim of this part of the assessment is to give the client the opportunity to determine the issues that are pertinent to them by using 'open' questions. Dividing the board into two sections, ask the client to list three areas of their life which they feel good about, stressing there are no right or wrong answers. This technique encourages the client to discuss the world as they see and experience it, as opposed to being asked an overwhelming number of possibly irrelevant questions relating to childhood, family, education, health, employment etc. Concentrating on one item at a time, it is sometimes difficult for clients to identify areas of their life they enjoy. Silences while conducting this part of the assessment are often an important process. Clients should not feel rushed, nor should they be prompted towards any particular explanation.

It is not unusual for a client to list heroin or some other drug as one of the three things in life they currently enjoy. As with any answers, the worker should not assume s/he understands until answers have been more fully explored. This is vital to the assessment. For example: 'You have said you feel good about heroin ... Tell me, what is it about heroin that makes you feel good? You say it takes away the pain in your life,...could you say a bit more about the pains in your life that you are glad to take away?' Each explanation should be briefly recorded on the board, giving more context and understanding to the initial statement. This provides a closer appreciation of the client's life. For example, on one occasion a client said he enjoyed being with his parents' dog. Deeper exploration revealed that he felt angry and rejected by his alcoholic father and ineffectual mother, yet he desperately wanted to be reconciled with them. When asked to clarify what he liked about the dog, the client articulated a sense of companionship, warmth, and acceptance. Feelings which he could not share with his parents. This illustrated that, on a superficial level, a range of understandings may have initially been assumed, without pursuing a more accurate appreciation of what the client was

actually saying. Sometimes clients themselves find that exploring their present situation visually on a large board provides them with new insights.

The process continues using the bottom half of the board, listing three things that `get them down'. Clients seem more easily to identify unhappy aspects of their life. Again, one must use their words and interpretations to understand their experience. This provides insight into their cognitive interpretations of the environment, as opposed to the environment per se (Mahoney, 1977, p.7). At this point the client may feel contradictions occur in their life. For example, they may have previously said crime made them feel good, gave them a sense of achievement and success, and yet they now list crime as a real problem in their life. Van Billion and Van Emst identified it as a task of the drug counsellor to:

... stimulate the client to start an internal re-evaluation of his position in such a way, that it leads to a 'wise' all pros and cons considered decision (Van Billion and Van Emst, 1989, p.29).

Any internal conflict should be accepted and encouraged as it produces stress necessary for contemplating and making important decisions (Jarvis, 83, pp.143-160). It also enables the client to understand their own inner turmoil, with the realisation that either alternative is likely to involve risk. For example, if the client wanted to give up committing crime because they resented the frequent visits to prison, steps would need to be taken to replace the positive aspects of committing crime. The final part of the assessment involves reflecting to the client their situation as you have understood it, all the time seeking the client's verification or redefinition. This often illustrates that the drugs themselves are not the main or sole problem but instead there are other factors. The question is then what does the client want to do, and indeed what are they able to do, given their circumstances. A whole range of options available should be thoroughly explored, speculating the likely pitfalls and benefits for that particular client. Ultimately it must be the client who decides which option to pursue - if any. The worker's task is to give the client independence and responsibility, and enable them to make rational and informed decisions, based upon all the available knowledge. Targets should be realistic and achievable, working towards a long term strategy. The worker should encourage the client to break down long term goals into short term attainable targets which can easily be measured and identified. This

is more likely to assist the client to regain self-confidence, as well as avoiding the danger of 'setting the client up to fail'. For example, if a chaotic heroin user, who occasionally injects temazepam, decided they wanted to give up illegal drugs altogether and spend more time with their family the first attainable targets could possibly be:

1. For the client to arrange an early appointment with a clinician who can prescribe a legal substitute.

2. In the meantime, while waiting for the clean legal supply of prescribed drugs, which will enable further stabilisation and greater self-control of lifestyle, the client can attempt to abstain from injecting.

3. To begin to have more involvement with the family, the client could arrange to take their children to school twice in the next week ahead.

These targets could be reviewed and discussed a week later. If they have been achieved, the client should be praised and encouraged. As they gain confidence further, targets can be established towards achieving their long term goal. Each client will have different desires, expectations and struggles. It is important therefore that the targets are fully supported and agreed by the client to reflect their priorities and interests. This stage of the assessment should not be pushed, clients must feel they have 'adequate time to search and deliberate before a final decision is made'(Scott, 1989, p.170).

Relapse back into a chaotic lifestyle needs to be discussed and seen as a real possibility. With each client it should be possible to identify potential high risk situations (triggers). For some clients it may be a particular day of the week when they are likely to have cash in their pocket, for others it may be a particular mood, person or social situation. This would form the basis of future work with the client, assisting and equipping them to develop alternative coping strategies. However, it is important that relapse or struggle is not viewed as a failure, but instead as a learning experience from which greater insights can develop.

CONCLUSION

The value and relevance of the cognitive behavioural assessment, like

any social work approach, depends upon the ability of the worker to communicate, the willingness of the client to seek change, and the interplay between these two. Nevertheless the outlined structure has, for many clients and workers, already proved to be an enabling process. The depth of the assessment can be emotionally tiring. It is sometimes a tearful experience for clients confronting a life they may have been running away from. However, clients often express feelings of relief, at being able talk freely about their life as it really is, without the need to amend, distort or apologise. For some, it is the first time they have ever felt that someone else properly understands and appreciates their particular struggle in life. They often leave the assessment with a clearer understanding of their past, and with realistic and tangible plans for their future.

The process of sharing and reflecting can be a useful foundation upon which clients can attempt to seriously change a drug-centred lifestyle. The relationship already established with one of the workers can continue and in much greater depth; cognitive behavioural techniques, such as identifying triggers understanding craving, teaching dearousal and positive self talk, can be employed. The cognitive behavioural assessment devotes considerable personal resources towards understanding, listening and assessing, to facilitate rational long term planning. Although time-consuming, it represents a good investment of time, which should not be sacrificed in an effort to pursue the short term satisfaction gained from being seen to be doing something more immediate.

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Sex	sometime	when first	How is it	Taken in	How much
GP	in my life	Taken?	Taken?	Last 30 days	a Day

Caffeine

Tea/Coffee/Cocoa-Cola

Analgesics
Asprin/Disprin/Paracetamol

Cough Mixtures
Benylin/Actified/Vick

Alcohol
Been/Wine/Spirits

Solvents
Glue/Lighter Fuel/Petrol

Nicotine
Tobacco

Cannabis
(blow, draw)

Tranx
(Valium/Ativan/
Librium) (Tamazies)

Amphetamines
(speed)

Magic Mushrooms
Heroin
(smack. Scag)

Morphine

Methadone
(tablets, syrup or amps)

Diconal
Palifiucm
DF118s
Cocaine
Crack
Barbituates

Any other drugs
not mentioned

1. Which drug do you identify as the major problem? .....

2. What is the longest period of time you have either been able to go without, or felt in control of this drug?. (exclude periods of hospitalisation or prison).....

3. How and why did this period of control come to an end? .....
Sometime When First How is it Taken in How Much

4. How often have YOU seriously tried to regain control

5. Where have you been for help?

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