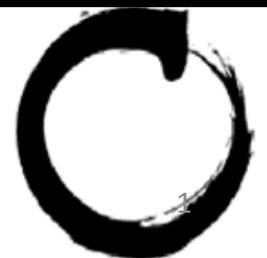




Clinicians' Guide to the Psycho-Education Package

CIRCLE Clinicians' Guide to PE Package v2
NIHR HTA project reference number 09/144/50

The CIRCLE TRIAL



CIRCLE Psycho-education

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Want more information?

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CIRCLE Psycho-education

Guide to Using the Psycho-education Package

This guide is intended to be used alongside the Psycho-education sessions completed with the participant. It is broken down into sections – one for each of the six modules:

Six Psycho-education Modules:

1: Introduction and Facts on Psychosis

2: Cannabis and Mental Health

3: Impact on Life: the Good and the Bad

4: Decision Matrix and Risk

5: Risk Hierarchy and Harm Minimization

6: Summing Up, Quiz and Additional Information

Modules 3 and 4 are combined so can be completed in one or two sessions

Each module is designed to last approximately half an hour. This allows time to read through the pages together, do the activities and fill in charts/tables, watch the video clips and leave time for questions and discussions that may arise.

You can perform the 6x 30 min modules at the same time as the contingency management sessions, or as 3x 1 hour sessions.

CIRCLE Psycho-education

Guide to Using the Psycho-education Package

Preparation:

•The package can be performed on any computer able to open pdf's, and for some of the modules you'll also need to make sure you can play audio and video files. Also provided with the package are hand out materials for the participant to take away. These include both information sheets and worksheets that can be completed during the package.

- This guide will provide information on the theoretical underpinnings of each module as well as practical information on how to deliver the material.
- At the end of each session, please update the psycho-education tracking sheet for that participant and inform the CIRCLE Research Assistant. If they fail to attend, please try to reschedule the session and inform the Research Assistant.

**Cannabis
and Psychosis**

Using the package:

Technical aspects:

On the **bottom right** of the package are **arrows to navigate** through pages

On the **bottom left** is the **Home** button, to go to start page, and '**5 squares**' to go to module selection

On the **left hand side** of some pages are buttons to hear audio, access video links, or get additional info

For audio files – click rewind icon and then play to hear the audio

For additional Information can be found in the participant handouts to be used alongside the psycho-education programme.

KS4

Module 3 and 4 has a pie chart for navigating that module. You can click on each segment in whatever order you wish, and return to pie after each stage.

On most computers, the forms can be completed and printed out if a printer is connected. However, if this isn't possible, you can use the printed versions of the worksheets.

Slide 4

KS4 Is there any additional information any more??
Kirsty Shepherd, 27/02/2014

CIRCLE Psycho-education

Introduction to the psycho-education

Psycho-education

The aim of psycho-education is to empower the patient to understand their illness, its cause and effects, and to help the patient manage and cope with their illness more effectively. In addition to providing information, psycho-education also includes cognitive, behavioural, and supportive therapeutic elements, such as motivational interviewing, coping strategies, and harm reduction with the goal of achieving a behaviour change that can help to improve a mental health disorder.

Psycho-education in First Episode Psychosis

Although the majority of literature relating to psycho-education and psychosis, does not relate to first episode psychosis, Favrod et al. (2011), have recognised that psycho-education provides insight into the illness in the early stages, but it needs to be properly adapted. The primary issue that needs to be considered by those giving psycho-education is that the material needs to be individualised. Information can be useful if it is congruent with their own personal experience of psychosis but can also seem confusing and unacceptable if it is too technical or medicalised. Information is also more acceptable if patients can integrate the given information in a way that allows them to cope better with their experience.

Psycho-education in the Circle Study

Contingency Management (CM) is often theorised in terms of extrinsic motivation, and therefore while it is effective at reducing substance use during the period of the intervention, it could be that the effects are relatively short lived once the intervention has ended and the extrinsic motivation has been removed. On the other hand, CM encourages people to engage with treatment. There is therefore an opportunity to discuss the rationale for reducing cannabis use with the client as well as strategies they can adopt in order to abstain or minimise harm from using. This in turn helps the client to self-regulate their cannabis use once the intervention has ended.

CIRCLE Psycho-education

Introduction to the psycho-education

Psycho-education in the Circle Study (cont.)

One thing you might find helpful in gauging how your client is progressing is to ask them to rate their motivation to change or abstain at each session. For example, you could ask the person: 'on a scale 1-10, with 1 being no at all and 10 being completely committed, how motivated would you say you are to try to reduce your cannabis use?'

This is a useful clinical tool to see if there are changes in motivation throughout the sessions. This can be a helpful and simple way of understanding how well the client is doing. For example, they may in fact not be very committed at all, or they could be really trying but finding it difficult. Either way having that information will help you in tailoring the sessions to their needs. Secondly, by tracking their change in motivation over time, you can feed back any changes to them and it could be a source of encouragement to continue.

The psycho-education package comprises six 30 minute modules. However, these can be done over as many or as few sessions as is best for you and the client. You may choose to deliver over 6x 30 min sessions or 3x 1 hour sessions.

It is also intended to be a framework for the clinician to use their own skills and clinical judgement with, and can be adapted depending on what is best for the participant. For example, you may choose to spend more than 30 minutes on a particular module if the participant would benefit from it, or choose to emphasise harm reduction techniques to someone who doesn't want to quit.

CIRCLE Psycho-education

The aims of this guide

In the Circle trial, psycho-education comprises “optimised treatment as usual”. It is offered to participants in both the intervention/experimental and control groups. The psycho-education package is not intended to provide a substantial intervention in its own right, but instead it should reflect the sort of treatment the participant can normally expect to receive from Early Intervention services. As such, it relies on the skills of the clinician already has, and there is no substantial training associated with it as there would be for a motivational interviewing intervention. This guide explains the aims of each module, providing the theoretical background as well as some suggested techniques. As part of that, it covers some of the principle topics within psycho education for psychosis/substance misuse, including:

Motivational Interviewing

Coping Strategies

Harm reduction

Getting Started:

- Do not feel obliged to use every resource in this guide or in the participant hand-outs. Rather focus on what you think would be most appropriate for the individual client.
- The suggested hand-outs to be used for each session can be found under the ‘Session Aims’.
- As you work through every module of the package it may be useful to discuss and be aware of the barriers to change for your client.
- Module 6 is equipped with further resources should the client require additional information and support, it may be useful to consider if there are any available local resources e.g. groups, drop in centres etc. You may want to include some information on these in your last session.

Module 1

Introduction and Facts on Psychosis

Take Home Message: Using cannabis is a risk to your health. *Make an informed decision.*



Module Outline

Session Aims:

1. To introduce clients to the package.
2. To discuss time commitment and ground rules of taking part in the psycho-education sessions.
3. To enable clients to reflect and discuss their personal experiences and understandings of psychosis.

Hand-outs:

Information:

Welcome
 Want to know more about psychosis (x2)

Work sheet:

Your Story

1. Introduce the package:

- a. Show the participant how it works. Explain that it will provide them with information about psychosis and its connection with cannabis to help them make an informed decision about using it in future.
- b. Explain that you will work through it with them and can discuss any questions/issues that come up.

2. Discuss their willingness to attend 6 sessions:

- a. Discuss any barriers there may be to them attending all 6 sessions.
- b. Ground rules (such as trying to attend all sessions, not attending while high or drunk, etc.)

3. Talk to the participant about their understanding of psychosis:

- a. Discuss their own experience in particular and consider using 'your story' hand-out. Helpful questions: When did you first come into contact with mental health services? What was happening in your life around that time? How has your life been impacted by this experience?
- b. Normalise the participant's experience by encouraging links between their experience and other peoples'.

4. Talk to the participant about their cannabis use:

- a. Explore their feelings and thoughts about cannabis,
- b. In particular, consider how they think cannabis has affected their mental health.

Module 2

Cannabis and Mental Health

Take home message: Experts say that when you have psychosis, the best way forward is not using at all... *“think about it!”*

Module Outline



1. Summarise previous session

2. Explore participant’s cannabis use further:

- a) When did they start using, in what kind of situation do they usually use cannabis? Consider using ‘**why do people use cannabis?**’ worksheet.
- b) How does it make them feel?
- c) What are their reasons for using cannabis.

3. Convey that there may be some good things about cannabis, but there are some bad things too.

- a) Inform them that they are more vulnerable to the effects of cannabis because of their history of psychosis (use participant’s own language)
- b) Discuss the connection between cannabis and psychosis (see next page). Consider using ‘**cannabis and your mental health**’ worksheet to attempt two ratings; one for how much they intellectually believe that cannabis affects their mental health and then an emotional rating of how much they feel or emotionally believe it.

4. ‘Things are different for you now’ → ‘You might need to make some changes’ → ‘Changing your cannabis use may be one of them.’ Explore causes and vulnerabilities to psychosis

5. Discuss with the participant any feelings or thoughts they have after watching the Frank video and listening to audio clip.

- a) Could they relate to anything that was said?

Session Aims:

- 1. To understand the function behind the client’s cannabis use.
- 2. To introduce the evidence base for the link between cannabis and mental health.
- 2. To establish client’s thoughts surrounding the relationship between cannabis use and their own mental health.

Hand-outs:

Information:

How can cannabis affect your mental health?

Work sheet:

Why do people use cannabis?
Cannabis and your mental health

Remember: Rate client’s motivation to change 1-10

Module 2

Cannabis and Mental Health: additional information

What is the connection between cannabis and psychosis?

Cannabis is the most widely used illicit substance in the UK – approximately 21% of 16-24 year olds reported using cannabis within a 12 month period (Roe and Man, 2006) and in FEP populations that number was double (over 40%).

Many theories attempt to explain the aetiology of psychosis. However, it seems likely that psychosis is caused by a combination of biological/genetic and environmental factors. Stress, drug abuse, and social change have each been identified as potentially contributing to the development of the illness in genetically predisposed individuals.

The neurobiological mechanism by which cannabis produces psychosis isn't entirely understood. However, it appears that THC is the cannabinoid that is most likely responsible. How THC produces psychosis isn't entirely clear either. One possible mechanism is via dopaminergic perturbation. Kuepper et al. (2010) found administration of THC in healthy participants increased dopaminergic activity in the striatum and other regions associated with dopaminergic hyperactivity in psychosis. However, this finding isn't conclusive (see Bloomfield et al. 2013). Other possibilities, such as reduction of glutamate in the frontal regions of the brain, are also being explored.

Despite this mechanism not being fully understood, there is enough epidemiological data to indicate that cannabis use significantly raises the likelihood of someone experiencing psychosis. People who regularly use cannabis are twice as likely to develop psychosis (Moore 2007, see Kolliakou et al. 2012); and if they have already had a psychotic episode, they are 2-4 times more likely to relapse (Wade et al. 2006, Linszen et al. 1994, Linszen et al. 1997, Hides et al. 2006). Cannabis users in their first episode of psychosis are more likely to have taken cannabis for longer, and every day, than people without a history of psychosis (Di Forti et al. 2009). They are also more likely to have used high potency cannabis ("skunk"), which can have three or four times more THC than traditional marijuana or resin (Potter et al., 2008; Hardwick, 2008).

However, cannabis use appears to be neither sufficient (enough in itself) nor necessary to cause a psychotic episode. Other factors are always involved, such as stress and a genetic predisposition/family history. A comparison is sometimes drawn with someone with diabetes eating sugar. Someone with a history of psychosis may be more sensitive to the negative effects of cannabis than the average person. They are more likely to see their symptoms improve, or avoid experiencing another episode altogether if they don't use cannabis.

Cannabis use in people with a history of psychosis is a significant clinical issue. It has been linked to delayed recovery (increased symptoms) (Linszen et al., 1994, Hides et al., 2006), delays in admission to crisis teams/hospital, longer durations of untreated psychosis, suicidal behaviour, violence, and homelessness (Wade et al., 2006, Lambert et al., 2005, Verdoux et al. 2001).

Module 2

Cannabis and Mental Health: additional information

What is the connection between cannabis and psychosis? (cont.)

Furthermore, cannabis has been linked with higher rates of depression and anxiety in young adulthood (Patton et al. 2002), dropping out of school/education (Swift et al. 2008), and subsequent unemployment, social welfare dependence, and a lower overall level of life satisfaction/quality of life compared to non-cannabis using teens (Fergusson & Boden, 2008).

The reasons for this are likely to be very complex, and it is not clear that cannabis use is always the cause so much as a substance that people use to cope with such difficulties. Kolliakou et al. (2012) reviewed self-reported reasons people with a history of psychosis gave for using cannabis. They found the most commonly reported reasons were to “get high”, relax, and have fun’. Secondly, to alleviate dysphoria, boredom, depression, and the negative symptoms of their illness. Thirdly, due to peer group conformity/acceptance, and other social effects. There was some evidence supporting cannabis use to cope with the side effects of medication or to reduce positive symptoms, but these were both far less commonly reported. It is likely that cannabis is primarily used for hedonic purposes, however an individual may have multiple motives for their use.

Solowij (1998) found that cannabis use was a significant aspect of social life for people with schizophrenia, helping to create a sense of belonging. They reported finding a common shared belief amongst these patient groups that positive aspects prevail over possible disadvantages. One of the main barriers to abstinence may be the person’s peer group, particularly if they spend a lot of their spare time with them while they are using.

Another possibility is under-engagement in education/employment, or otherwise having a lot of free time by themselves. Thombs and Osborn (2013) argue that substance use can be understood from a behaviourist perspective, as a result of the individual not having sufficiently rewarding alternatives. Being out of employment and education is higher amongst young people with a history of psychosis (ref.). Unemployment has been found to result in increased rates of anxiety and depression in young people in the general population (Montgomery et al., 1999). Some reasons for this include that they are concerned about their future, or that they feel like a burden on their family or society. It is possible that someone who is under-engaged in work or education is using cannabis in order to alleviate boredom, or to improve their low mood due to their education/employment status.

Alternatively, it could be to cope with other stresses, such as strained family or personal relationships. There is some evidence that low levels of positive parent–child communication quality and low levels of parental monitoring are associated with increased adolescent substance use. A possible explanation for these findings is that parent–child relationships that are non-supportive or characterized by conflict can undermine adolescents’ ability to regulate their behaviour in a goal-orientated way, with low levels of self-regulation associated with greater risk of substances use. It has also been suggested that adolescents use substances as a way to cope with family relationships characterized by hostility and low levels of warmth and affection (Hummel, 2013).

Module 2

Cannabis and Mental Health: additional information

What is the connection between cannabis and psychosis? (cont.)

While it may be a common perception in this group that cannabis has an overall positive effect, there is plenty of evidence suggesting otherwise. Furthermore, THC concentration in available cannabis strains is generally increasing (Hardwick, 2008). Large doses of THC were found to produce confusion, amnesia, delusions, hallucinations, anxiety, and, more rarely, agitation in study participants. Amongst recreational users, the most commonly reported negative side-effect of occasional use is anxiety/panic. However, cannabis users can experience a range of symptoms including depersonalization, derealization, paranoia, delusions of reference, flight of ideas, pressured thought, disorganized thinking, persecutory delusions, grandiose delusions, auditory and visual hallucinations, and impairments in attention and memory in otherwise healthy participants (D'Souza, 2007). A review of other studies suggested that heavy cannabis use may increase depressive symptoms in some users (Degenhardt, 2003), as well as subjective effects on cognition, memory, career, social life, physical and mental health, and quality-of-life measures (Iversen, 2005). However, despite a large majority of those same heavy users reporting negative overall effects of their drug use, they did not abstain.

Continued cannabis use has been found to lead to reduced motivation, sometimes referred to as amotivational syndrome (Earleywine, 2002). Amotivational syndrome is characterized by apathy, poor motivation, social withdrawal, narrowing of interests, lethargy, impaired memory, impaired concentration, poorer judgment, and impaired occupational achievement. The syndrome can resemble the negative symptoms of schizophrenia (D'Souza 2009). Other recent evidence showed that smoking cannabis in adulthood was negatively related to the level of commitment to working. Possible explanations for this include that the psychoactive substances and effects of the drugs may cause physical or psychological changes in the individual that affect their ability and motivation to work. Alternatively, their cannabis use and access to the drug may be part of a culture of cannabis use amongst their peers, which rejects work/education values (Hyggen, 2012). Adolescent cannabis users who leave school early are more likely to be unemployed and depend on social welfare, and are less satisfied with their lives and their relationships than are peers in their late 20s (Fergusson, 2008).

In summary, for many cannabis users, the overall effect of the drug may be negatively affecting them in various ways. But at the same time, the user may not be conscious of that, or may overlook the problems it is causing them. This could be due to peer pressure, self-medication, hedonic reasons, or due to dependency and their resulting anxiety about quitting. If the person believes that they should quit, but they find it difficult to abstain, they may seek help and support to assist them.

Modules 3 & 4

Take home message: Cannabis can lead to problems in various areas of your life; *think carefully about your cannabis use*

Impact on Life: The good and the bad



Module Outline

1. Summarise previous session
2. In the first part of modules 3 & 4 encourage the participant to look and think about the different sections of the pie chart. As you go through each section, score the client’s impact rating on the impact matrix in the handouts. You have two sessions over which to go through the 7 sections covered in modules 3&4.

3. Discuss ways in which cannabis might be impacting on:
 - a) *Mental Health* – Watch the ‘Back to reality’ video clip and discuss.
 - b) *Family* – what do their family think about cannabis use?
 - c) *Friends* – do they smoke cannabis with their friends? Spend some time discussing the good and the bad impact of cannabis on the participant’s social life. Often cannabis use is reinforced because their friends are using. Quitting is likely to be more difficult if their peers are all still using, making it a cause for concern for many users. Consider using ‘My social network’ worksheet, you may want to look at social networks with and without cannabis and explore differences.
 - d) *Physical health* – smoking is bad for their physical health too.
 - e) *The law* – think about how a conviction could affect their future.
 - f) *Money* – what else could the money be spent on? Explore impact with ‘financial’ worksheet, looking at cost and other ways in which money could be spent.
 - g) *Work and time* – Did they give anything up, or was there something they didn’t do because of their smoking? Explore alternate activities to smoking with ‘activity’ worksheet, if client struggles to generate ideas consider using ‘activity list’.

Session Aims

1. To explore the positive and negative impact of cannabis use on their life: mental health, relationships, finances, physical health, the law, work, and hobbies.
2. Show back to reality video clip.
3. Listen to audio clips in ‘impact on friends’.
4. To explore to what extent cessation would impact their lives.

Hand-outs:

Information:

Physical health and the law

Work sheet:

Impact rating

My Social Network (x4)

Financial

Activity

Activity list

Remember: Rate client’s motivation to change 1-10

Module 3 & 4

Take home message: Consider the short term and long term impact of cannabis on you.

Continued



Aims:

5. To weigh up the good and bad things about using cannabis or stopping using the decision matrix.

Hand-outs:

Work sheet:

The good and the bad
Impact on you

4. After you have gone through the 7 sections of the pie chart, you can then discuss the good and bad about cannabis use/cessation for them.

Using 'The good and bad' worksheet' in the handouts help participants weigh up the pros and cons of using cannabis. The aim here is for the person to reflect on their cannabis use, and decide whether it is having a generally positive or negative affect on their lives. Having given impact ratings for each area of their life, you can use the decision matrix in the handouts to focus on the most important areas *for them*. The things that are going to motivate *them* to reduce or abstain.

Four principles you could keep in mind when discussing the pros and cons of cannabis use (adapted from Bundy 2004):

- To understand his or her thought processes related to cannabis.
- To identify and discuss the person's reaction to how cannabis affects their life.
- To identify how their thoughts, feelings, and behaviours lead to their cannabis use.
- To assist them in thinking through how to implement alternative behaviours to stop using cannabis if they wish to.

5. Point to the risks – both long term and short term – associated with cannabis use and encourage discussion.

Module 3 & 4

Impact on Life: the good and the bad: Additional Information

Family, Friends, & Quality of Life

Previous research has found that in young adults, higher reported levels of cannabis use were associated with lower overall relationships/life satisfaction, including with work, family, friends, romantic relationships, and leisure pursuits (Fergusson & Boden, 2008). Family members in particular may be disapproving of the patient's cannabis use, and this could be a source of stress in the patient's life and may be worth exploring.

On the other hand, one of most often cited reasons why people use is due to social or peer groups. Use amongst peer groups increases availability, perceived social acceptability, and puts pressure on the individual to conform by using. Adolescents tend not only to select their peers in the light of their own substance-use habits, but also to initiate or increase their substance use when associated with substance-using peers: they submit to the peer-smoking norm or to social modelling (Kuntsche et al., 2006).

Risk factors for starting cannabis use include criminal behaviour, and use of alcohol/other substances, environmental factor such as cannabis easy availability at school, tendencies in childhood to disruptive or norm-violating behaviours (Coffey, 2000). Cannabis use is also associated with lower self-reported mental Quality of Life (QoL). Health-related QoL is a broad concept that includes self-perceived mental and physical disability as well as pain, vitality, social and role functioning. Mean mental QoL scores are lower among cannabis users and individuals with Cannabis Use Disorder compared to non-users, whereas there is a lower prevalence of physical disorders among cannabis users given the relatively young age of cannabis users (Lev-Ran, 2012).

Physical Health

Cannabis and THC have a dose-dependent effect on heart rate, increasing the likelihood of cardiovascular problems (Hall & Degenhard, 2009). Cannabis smoke is similar to tobacco smoke, and contains more of some carcinogens than tobacco smoke. As with cigarettes, smoking cannabis increases the risk of lung as well as mouth, gum, and throat cancers. It also increases the risk of respiratory illnesses (Taylor & Hall, 2003) such as asthma, bronchitis, wheezing, and coughing. Some studies have reported reduced testosterone and sperm production and increased abnormalities in sperm (Kolodny et al., 1974) as a result of cannabis use.

Module 3 & 4

Impact on Life: the good and the bad: Additional Information

Although tobacco smokers generally smoke many more cigarettes than cannabis smokers, cannabis smokers typically inhale more deeply, and hold their breath for longer, thereby depositing more of the toxic chemicals in their lungs (Hall et al., 2001).

Work, education, and money

Cannabis use is associated with poor school performance, higher dropout rates (Lynskey et al., 2003), lower levels of educational attainment (King et al., 2006), and lower workforce productivity in 23 year olds (Hera et al., 2012). Using cannabis appears to lead, via various mediating pathways, to increased risks of educational under-achievement (Fergusson, 2010). Age of onset of is related to the rate of achievement in a series of major educational goals, including high school completion, attendance at university and degree attainment (Swift et al, 2008). Fergusson (2003) has suggested two explanations for this: First, the regular use of cannabis is likely to result in the individual developing a network of peers and contacts in order to obtain and use cannabis. In some cases, attitudes may be common within these groups that encourage the person to avoid making a commitment to their education and/or careers. Secondly, it may be that the heavy use of cannabis may lead to cognitive or motivational deficits that create barriers to full participation in engagement in education/employment (Fergusson,2003).

Furthermore, cannabis has been found to cause acute cognitive deficits, such as loss of memory and concentration, poorer attention, and other issues. Results of these studies show that cannabis use is associated with a pattern of increased activity in some regions, along with a higher level of deactivation in certain memory-related areas. This could reflect either increased neural effort ('neurophysiological inefficiency') or a change in strategy to maintain good task performance (Bossong et al., 2013). Current cannabis use is associated with poorer performance on immediate verbal learning, processing speed, and working memory (Meijer et al., 2012). Cessation of substance use may aid the person in engaging better in their education and careers, and help them to avoid trigger situations for their illness.

Module 3 & 4

Impact on Life: the good and the bad: Additional Information

The Law

It is always a good idea to check the web so you can keep up to date with the law. Some useful websites include:

www.gov.uk

And then use the search term

“cannabis”

This puts you in touch with the latest up to date information about

the law, and gives you useful links to useful materials such as [Talk to Frank: Cannabis stories leaflet](#).

As of July 2013, Gov.uk states that:

- Possession of Amphetamines, barbiturates, cannabis, codeine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (eg mephedrone, methoxetamine) can lead to up to 5 years in prison, an unlimited fine or both.
- Supply and production: Up to 14 years in prison, an unlimited fine or both.
- Police can issue a warning or an on-the-spot fine of £80 if you're found with cannabis.

www.talktofrank.com/

Is a government website that gives more detailed information and has useful resources to look at. As of July 2013, they suggest that:

- If the Police catch you with cannabis, they'll always take some action. This could be a warning, a reprimand, a formal caution, a fixed penalty or an arrest and possible conviction.
- A conviction for a drug-related offence could have a pretty serious impact. It can stop you visiting certain countries – for example the United States – and limit the types of jobs you can apply for.

<http://www.drugscope.org.uk/>

Drug scope states that they are the leading UK charity supporting professionals working in drug and alcohol treatment, drug education and prevention and criminal justice. They also state they are the primary source of independent information on drugs and drug related issues. They have comprehensive details about the law and cannabis. So if you want to find out more, please visit their website.



Module 3 & 4

Impact on Life: the good and the bad

Barriers to change

The literature on the barriers to seeking treatment for substance abuse indicate that main reasons are a lack of available services (Stephens et al., 2007) (ref?) and the social stigma associated with being labelled an illicit drug user (Copeland, 1997). In relation to seeking help for cannabis use the research shows that people are less likely to do this than for any other drug, with only 9.8% of people who met the criteria for cannabis dependence or abuse in 2003 receiving treatment.

In a study by Ellingstad et al. (2006), they reported that the most common reason for not seeking treatment was the belief that cannabis was not enough of a problem and did not warrant treatment (80%), and that clients had a desire to quit on their own without treatment (76%). However Solowij et al. (2002) found that concern about perceived cognitive impairment was one problem associated with cannabis use that led the users in that US study to seek treatment.

Swift, Hall and Copeland (2002) have reported the most common reason for moderating use was as a result of concerns about physical or psychological health (43%), this is followed by boredom with cannabis use or concerns that they were using too much (27%), lack of money (26%) and life circumstances (12%). Relapse was most commonly due to stress or negative moods (27%), availability (25%) and enjoyment of smoking (18%). Chen and Kandel (1998) found that the reason for using cannabis was an important predictor of cessation: using cannabis for social reasons accelerated cessation, whilst using cannabis to change one's mood mitigated against cessation.

Weaver (2003) reported that the most cited reason for seeking treatment for cannabis abuse amongst people with a history of psychosis is concern that continued use of cannabis could lead to relapse. Edwards et al. (2006) have suggested that young people are often traumatized by psychosis and its implications, and the desire to avoid further episodes can encourage reconsideration of cannabis use, providing a 'window of opportunity' to influence behaviour change. However, some people with psychosis describe using substances to try and counteract the side effects of antipsychotic medication, or as a preferred alternative to taking prescribed medication (Schneier & Siris, 1987).

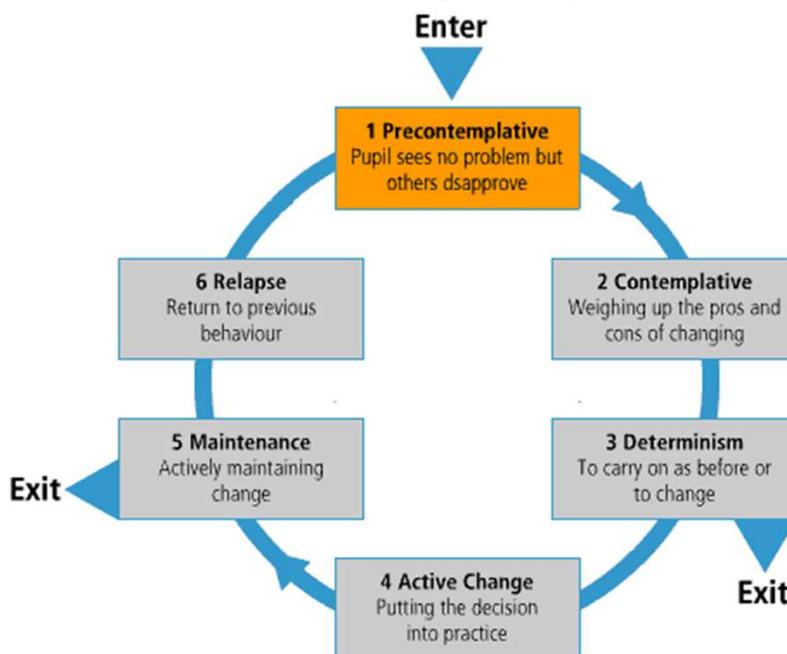
In terms of changing behaviour in relation to cannabis use a study by Strike et al. (2003) suggested that individuals who are dependent on cannabis are less confident in their ability to change than other drug users and arrive at treatment with lower preparedness to change. It is therefore important for clinicians to work with clients to understand the motives for change in their behaviour.

Module 3 & 4

Impact on Life: the good and the bad

Readiness to change

The transtheoretical model of change (TTM) (Prochaska & DiClemente, 1982), looks at how individuals change their behaviour. The focus of the model is on self-initiated change rather than imposed change and makes the assumption that change is a slow and gradual process. The model outlines 5 stages of change and describes the processes of change once it has started. The figure below shows how a person can move through the stages



In the precontemplation phase a person is unaware of the need for change or is resigned to living as they currently do. They move into the contemplation phase as they start to consider the costs and burdens of their current behaviour, however at this point they are still ambivalent and are still enjoying the benefits of the current behaviour. As the person starts to weigh up the pros and cons of their current behaviour and starts to see that the cons outweigh the pros he or she moves into the contemplation phase when they consider how to change their behaviour. As they start to make 'preparations for the change', and decide to change their behaviour in the near future, they move to the preparation stage. To move to the action stage a person must deliberately and actively engage in changing their behaviour. People move into the maintenance stage after they have changed behaviour for 6 months, and from there will either terminate their behaviour (successfully abstain) or will relapse and start the cycle again, from the contemplation phase.

Module 3 & 4

Impact on Life: the good and the bad

Motivational Interviewing

Human motivation is defined as purposeful behaviour; it is 'the why that causes an organism to initiate and persist in certain behaviours as opposed to others' (Bernard et al., 2005). Over the last thirty years there has been a move to make motivation a central feature in the treatment of addiction. Rather than assuming that people are resistant to treatment or that there is perpetual inertia, it is now assumed that there is amenability to change but the motivation to change needs to be brought into awareness.

Motivational Interviewing (MI) (Miller and Rollnick, 1991) is a patient-centred counselling style that encourages patients to explore their ambivalences to change, and to develop intrinsic motivation to change addictive behaviours. In terms of the TTM it can be used successfully in both the pre-contemplation and the contemplation stages. Stephens, Roffman, and Curtin (2000) found that relative to a wait-list control, a two session MI intervention (90 min) significantly increased rates of abstinence among marijuana dependent adults, decreased drug-related problems and dependence symptoms, and was comparable in efficacy to more intensive relapse prevention counselling.

A core part of the technique is that the client's motivation to change will be enhanced if there is a gentle process of negotiation. The clinician should avoid conflict and should not give advice, reassurance or immediate problem-solving but rather should look to develop a collaborative relationship with the client. The role of the clinician is to encourage the patient to talk about substance use and related life events and to make the connection between cannabis use and not achieving important life goals. For some patients the goal of therapy will be harm reduction, for others it will be cessation or maintenance.

There are five central principles of motivational interviewing.

- Expressing empathy by using reflective listening to convey understanding of the client's point of view and underlying drives
- Developing the discrepancy between the client's most deeply held values and their current behaviour
- Avoiding confrontation with the client
- Rolling with resistance, rather than opposing resistance to change. This will reduce any struggle that the client may feel in the session.
- Supporting self-efficacy by building the client's confidence that change is possible. This can be achieved through focussing on a client's previous successes and highlighting strengths and skills that the client already has.

Module 3 & 4

Impact on Life: the good and the bad

Motivational Interviewing (cont.)

There are a number of techniques that can be used by a clinician in MI to increase the intrinsic motivation of a client. Rollnick, Heather and Mill (1992) divide these into micro skills and strategies.

Microskills – these function to open up a conversation with a client about potential problem areas in their life, to understand their perception of the problem, to heighten problem recognition and to start to resolve ambivalence about changing behaviour. Techniques that can be used are: open ended questions, affirmation, reflective listening, and summarising patients comments in a balanced way. When going through the different areas of the clients life (i.e. family, friends, financial etc.) these techniques can be used to encourage to the client to think about the impact that cannabis may have on different areas of their life. For example when talking about finances or activities, clients could be encouraged to think about how else they could spend time and money if they reduced or stopped their cannabis use.

MI strategies – these are increasingly directive techniques for building motivation, which can be used to build intrinsic motivation. These techniques include more direct open questions. Using the ‘good and the bad’ hand-out clinician can start to ask the client to think about the “good things” and the “not so good things” about smoking cannabis, and articulate the pros and cons, and start to see if there are discrepancies between the values held by the client and their behaviour. If the client’s resistance to change arises, the clinician can further explore his or her resistance.

MI and Psychosis

Literature indicates that patients with a dual diagnosis have a low motivation for change (Drake & Wallach, 1989; Minkoff, 1989), and therefore many who specialize in dual diagnosis treatment have emphasized the primary importance of engagement and motivational enhancement strategies (Carey, 1996).

However, work by Martino et al. (2002) suggested that when you using MI with clients with psychotic symptoms it is important to take into account cognitive impairments. Some of the techniques that he has suggested using include: simplifying open-ended questions, refining reflective thinking skills, heightening emphasis on affirmations and integrating psychiatric issues into personalised feedback.

Module 5

Risk Hierarchy and Harm Minimisation

Take home message: If you have decided to quit or reduce your cannabis use, there are some situations that may make this challenging. *Think about the best way to manage the risks.*



Aims

1. To encourage clients to consider the situations that are 'risky' for *them*
2. To develop personal coping strategies
3. If they want to quit – aim to develop effective strategies to help them accomplish this.
4. Based on hazards identified, develop effective strategies to combat/minimise risk.

Hand-outs:

Information:

- Combat strategies (x2)
- What if I mess up?
- Combat cravings
- Imagery Techniques
- Relaxation Tips

Work sheet:

- High risk situations
- Problem Scenarios (x2)
- My Plan – Giving Up
- My Plan – Cutting Down

Module Outline

1. Summarise previous session

2. Be clear about:

- a) Any use of cannabis may lead to further psychotic episodes
- b) If they do not want to quit cannabis, it will still help to reduce their use

3. Discuss the risks involved

- a) If they want to quit: What may get in the way of them quitting? What might lead them to start smoking again? How will quitting affect their life (e.g. social life)? Consider using worksheet 'My cannabis plan'.
- b) If they do not want to quit: legal risks in obtaining cannabis. Health risks mental and physical. Risks associated with being high – poorer coordination etc. Explore How can they minimise these hazards.

5. Discuss ways to minimise these risks - develop some real life strategies for avoiding cannabis use or reducing harm if they decide to continue use. Try to spend some time thinking of specific strategies for the participant e.g. combatting cravings and using relaxation or imagery techniques.

6. Provide them with the print outs of information hand-outs.

Remember: Rate client's motivation to change 1-10

Cannabis and Psychosis

Module 5

Risk Hierarchy and Harm Minimisation

Module 5 Hand-outs

High risk situations: With this hand-out you can identify when a person is more likely to use cannabis and may be useful if clients struggle to generate situations of their own as it contains some examples.

Relaxation Tips: It may be worth strongly emphasising the rationale of relaxation i.e. being the opposite of stress. You could also explore the different ways in which people relax e.g. closed eyes meditation, listening to music, or exercise or reading. Try to find out how your client relaxes and what they can do to improve this. When discussing the breathing techniques it can be useful to frame this in terms of winding the body down from the fight or flight response and this may touch on anxiety coping strategies for some people.

Problem Scenarios: These two worksheets are around noticing the situations in which the client is vulnerable to cannabis use and exploring coping strategies and prioritising.

Note: In the psycho-education package the life areas column is filled in, the hand-out is blank to allow clients to fill this in according to their specific circumstances – the areas mentioned in the package could serve as a prompt.

My plan – giving up: Here is an example of what this plan could look like:

High Risk Situations: Weekends, after I finish work I always smoke/ When I am with certain friends etc.

What should I do: Make different plans for the weekend. When you finish work do something different or inform friends that you are attempting to quit and arrange to see them when they are not using cannabis.

High Risk feelings: Bored/Anxious/Sad.

What will help: Having a list of alternative activities/relaxation techniques/having someone to speak to

High risk thoughts: 'Just once won't hurt', 'I'm never going to manage to give up so there is no point trying'

Alternative thoughts: 'One is likely to lead to more and that definitely will be harmful', 'I definitely won't succeed if I give up now, I've done well so far, it would be a shame to ruin it now'

Where can I get help: Care coordinator, family members, supportive friends, support groups, the internet

My plan – Cutting down: This plan could be more useful if your client is not ready to stop using cannabis altogether but is trying to reduce their usage. For example, some clients might find it easier to stop using in the mornings but think it would be very hard to stop when socialising. Some might set goals such as not smoking around my wife and children or only smoking at the weekend. Any practical techniques can be discussed in this section and motivations can be included in the plan to remind clients why they want to cut their use down.

Module 5

Risk Hierarchy and Harm Minimisation

Giving up – withdrawal symptoms

Although cannabis is not associated with physiological dependence, up-to half of patients in treatment for cannabis use disorder report signs of withdrawal. In general the symptoms begin during the first week of abstinence and will gradually go away after 7-10 days. Although not medically serious, cannabis withdrawal should be a focus of treatment, because it may serve as negative reinforcement for relapse to cannabis use in individuals trying to abstain (Budney et al., 2006).

The withdrawal symptoms can include:

- Feelings of a anxiety, depression, anger, confusion, irritability and urges/cravings to smoke
- Sleep problems – this can include insomnia, vivid dreams or night mares and night sweats
- Decreased appetite and with loss of weight
- Some people report physical symptoms – shaking, sweats, diarrhoea, and restlessness

If the client is rolling spliffs with tobacco they are also at risk of getting nicotine withdrawal symptoms.

Harm reduction

Harm Reduction is a practice that seeks to minimize the risk and extent of harm resulting from addictive behaviours. It is particularly appropriate for people who are not in treatment and are not highly motivated to change their behaviour. Harm reduction approaches are designed to modify addictive behaviour decreasing the frequency and amount of substance use, including substituting a safer addictive substance for another to reduce craving and withdrawal syndrome (Thombs & Osborn, 2013)

The principles of harm reduction are: accepting that many substance users do not initially wish to stop; engaging the active user in treatment; any reduction in the harms associated with substance use is seen as valuable; mobilizing the client's strengths in the service of change; clients and treatment collaboration; giving importance to de-stigmatizing substance users (Tatarsky, 2003). There are a number of techniques to go through with the client about how to reduce harm included in the hand-outs of module 5. These include techniques for reducing the amount and strength of the cannabis that is being smoke, but also looks at reducing harm when obtaining cannabis, and reducing potential interpersonal conflicts that may arise from smoking cannabis.

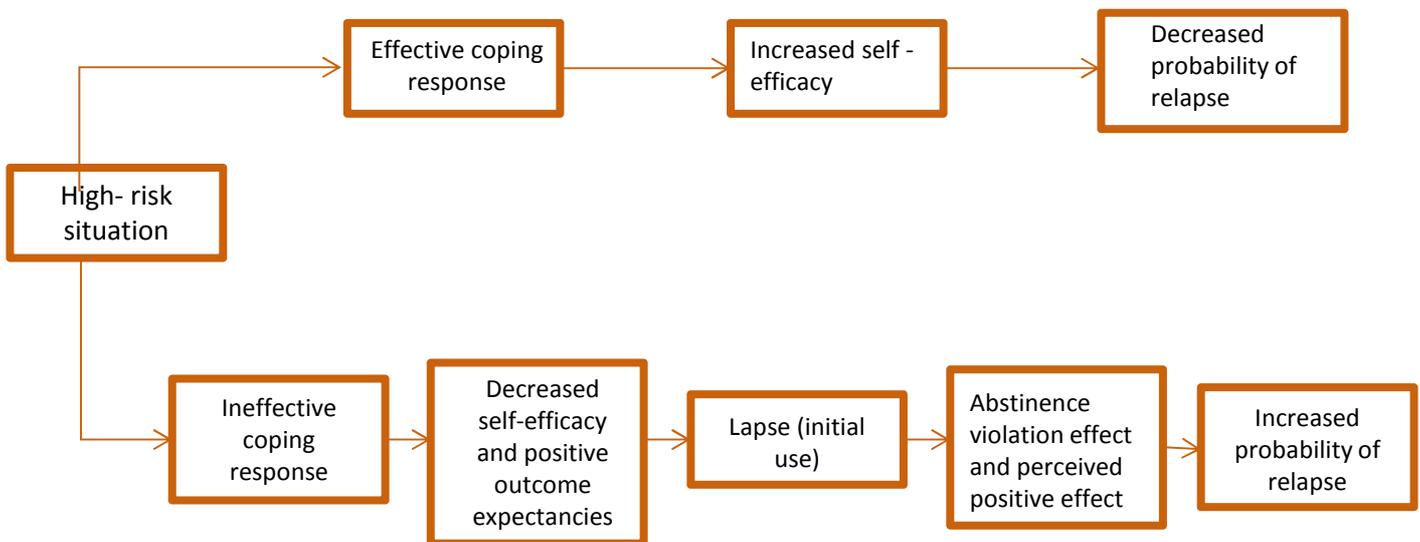
Module 5

Risk Hierarchy and Harm Minimisation

Relapse prevention model

The relapse prevention model (Marlatt and Gordon, 1985) is a cognitive behavioural model that considers factors that could precipitate or contribute to a relapse during recovery, and the behavioural and cognitive strategies that could be used to prevent or limit a relapse episode.

The RP model proposes that the key to recovery is to be able to plan and anticipate the high-risk situations. The model is based on a theory that abstinence is not about will power, but is more about developing and learning a set of coping skills and general strategies that can be used in high-risk situations. It predicts that if a person has developed coping skills to use in high-risk situations then he or she is more likely to avoid a lapse, which in turn will improve his or her self-efficacy and will reduce the likelihood of lapsing in another high-risk situation in the future. If, on the other hand, a person does not have the coping skills to abstain in a high-risk situation, this is likely to decrease their self-efficacy and, combined with a positive expectancy outcome of smoking cannabis, it is likely to result in a lapse. This lapse in turn, can result in feeling of guilt and failure (i.e. abstinence violation effect). The abstinence violation effect, along with positive outcome expectancies can increase the probability of a relapse. For people suffering from psychosis motives for coping (Mueser et al., 1995), poor problem-solving abilities (Carey & Carey, 1995) and restrictive lifestyles and limitations on obtaining pleasure in other ways, may all reinforce learned expectancies of the positive benefits of substance use.



Module 5

Risk Hierarchy and Harm Minimisation

Relapse prevention model (cont.)

High risk situations – Marlatt (1996) identified four types of high risk situation that could trigger relapse episodes:

- 1) Negative emotional states, such as anger, anxiety, depression, frustration and boredom
- 2) Interpersonal in particular interpersonal conflict
- 3) Social pressure, including both direct verbal and non-verbal persuasion and indirect pressure (e.g. being around others who are smoking)
- 4) Positive emotional states, (e.g. celebration)

The most common high-risk situations for relapse into cannabis use are: negative emotional states (33%), direct social pressure (24%), and positive emotional states (24%) (Stephens, Roffman & Simpson, 1994). The high-risk situation of positive emotional states in returning to use of cannabis is more common than with other drugs which suggests that heavy cannabis users use the drug to enhance already positive emotions.

In the 'my cannabis plan' hand-out, the clinician can encourage the client to think about their own personal high-risk situation and rate them according to which is the highest risk for them. The clinician can also encourage the client to recognise early warning signals associated with high-risk situations, such as stress and high outcome expectancy, in order that they can take some evasive action to avoid that situation.

Coping – Whilst the RP model suggests that high-risk situation is the trigger for a potential relapse, it is actually the person's response to the situation that will determine whether he or she will relapse, and a person who can execute effective coping strategies is less likely to relapse.

In the 'my cannabis plan' hand-out there is a table for the client to complete, where they can think about the high-risk situations that they have previously identified and think of coping strategies that could reduce the likelihood of the high-risk situation leading to a relapse. In addition to thinking about coping skills to deal with specific situations, clinicians should also speak to clients about general coping strategies.

Module 5

Risk Hierarchy and Harm Minimisation

Relapse prevention model (cont.)

The hand-out gives a number of coping strategies, such as asking for support, developing refusal skills, relaxation tips etc. It is also worth thinking about changing environments, for example getting rid of cannabis, stopping going to places where cannabis was smoked, stopping associating with people who smoke cannabis, getting rid of cannabis paraphernalia. In addition to coping strategies clinicians should also think about managing cravings, the 4D's in the hand out provides some ideas.

For people suffering from psychosis motives for coping (Mueser et al., 1995), poor problem-solving abilities (Carey & Carey, 1995) and restrictive lifestyles and limitations on obtaining pleasure in other ways, may all reinforce learned expectancies of the positive benefits of substance use.

Self-efficacy

Bandura (1977) has defined self-efficacy as one's belief in one's ability to succeed in specific situations, and higher levels of self-efficacy and predictive with abstinence (Bandura, 1988). When writing about self-efficacy in relation to substance abuse, Bandura wrote 'Efficacy beliefs determine the goal challenges people set for themselves, how much effort they enlist in the endeavour, their staying power in the face of difficulties, and how formidable they perceive the impediments to be' (1999). People with psychosis often have low self-esteem (Barrowclough *et al.*, 2003); thus, self-efficacy may be low, which may further decrease motivation since people with psychosis may feel unable to implement change.

Young et al. (2012) found three main areas in which clients identified low self efficacy in terms of cannabis use, these were emotional relief e.g. situations were feel strong negative emotion, opportunistic factors e.g. being in situations where cannabis is readily available and social factors e.g. times when wanting to feel confident and accepted by a social group. It may be worth exploring with participants their individual high risk situations using 'my cannabis plan' worksheet.

The RP model specifies the importance of enhancing self-efficacy amongst clients who are trying to abstain and suggests two ways of working with the client in order to achieve this. The first is to work collaboratively with the client when identifying high-risk situations and appropriate coping, rather than using a 'top-down' doctor-patient approach, and encouraging patients to look

Module 5

Risk Hierarchy and Harm Minimisation

Self-efficacy cont.

objectively at their life. Secondly another efficacy-enhancing strategy is to break goals down into smaller more manageable tasks; so rather than consider the end goal or life-long abstinence, you set goals with you client such as coping with an upcoming high-risk situation. Self-efficacy can also be enhanced by providing clients with positive feedback about other areas of their lives unrelated to smoking cannabis, such as turning up to appointments, as it can increase a client's confidence that he or she will be able to master the skills needed to abstain from cannabis.

Lapse vs. Relapse

The RP model differentiates between an initial lapse and full-blown relapse, and describes how different clients can have an initial lapse and then return to abstinence while others will have a full blown relapse. If a client has an emotional response to an initial lapse and believe that it is due to stable, global, internal factors beyond their control they are more likely to abandon abstinence; this is referred to as the abstinence violation effect (AVE). On the other hand those who relate an initial lapse to their inability to cope in a specific high-risk situation, can see the importance of learning from their mistakes and may develop more effective ways of dealing with situations in the future.

To reduce the likelihood of a full-blown relapse, one can look to use cognitive restructuring and reframe lapses. For example, one could reframe them so that they are not seen as failures or an indication of a lack of will-power. But instead that there need to be more coping strategies put in place and a better understanding of the warning signs of high-risk situations.

Module 6

Summing up, Quiz and Additional Information



Aims

To provide a coherent summary of the course.

Hand-outs:

Information:

Helpful Resources

Remember: Rate client's motivation to change 1-10 – you could reflect on any changes as sessions have continued.

Cannabis and Psychosis

Module Outline

1. **Summarise what has been covered across all the psycho-education sessions.** It is very important to convey a coherent picture of all the work done.
2. **Try to convey the sense of coherence by making as many references to the participant's personal experience as possible.** This will also serve as a way to refresh their memory.
3. **Present the 'Who Wants to be a Millionaire' quiz.** The quiz is useful as a way to reinforce some of what they have discussed with you. But it isn't obligatory. As this is the final session on psycho-education you may want to manage this ending with the client by forming a coherent overall picture of your sessions entirely through discussion or by using materials from module 5.
4. **Discuss further Resources** if they require on-going support. It would be really useful to highlight any local resources that you are aware of to support clients going forward.

VERY IMPORTANT

Take home message: You now know what the risks associated with cannabis use are. You also know of some strategies to help you quit or reduce your cannabis use...

...Now it's up to you to decide!

Module 6

Summing up, Quiz and Additional Information

Additional support

Provide the participant with links and contact details for if they would like more information or support:

www.talktofrank.com or call FRANK on 0800 77 66 00.

You can also get **Cannabis – too much too often?** The FRANK guide to cutting down and stopping cannabis use, by calling 08701 555 455.

www.knowcannabis.org.uk where you can find out more about the effects of cannabis and how to go about cutting down and stopping.

www.csip.org.uk/mentalhealthandcannabis for more on the research into the links between cannabis and mental health problems.

Mind - A national mental health charity for England and Wales.

Young Minds- A charity that offers information to young people about mental health and emotional well-being.

They can also speak to their Care Co-ordinator or clinician with regards to further information or support.

When you have finished this module with the participant, please complete the tracking sheet with the date you have completed the session.