# Exploring the attitudes of staff working within mental health settings toward clients who use cannabis

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**Abstract**

**Aims**: This study aimed to explore the attitudes of staff working within mental health settings toward cannabis in general and cannabis use in individuals with severe mental-health problems.

**Method**: Twenty members of staff working within community mental health teams in Birmingham, UK, were interviewed using qualitative research methods. The overarching themes within the staff accounts are described and the interrelationship between themes explored.

**Findings**: Staff use an 'individualized' approach when working with cannabis-using clients dependent on a number of key components, including the positive and negative effects of use, wider evidence base, client vulnerability, engagement, professional and personal views and harm reduction. It is suggested that any approach staff may take toward cannabis use at any one time is greatly dependent upon the above factors and these factors are highly client specific.

**Conclusions**: The findings may help to explain why interventions aimed at reducing substance use in people with psychosis might prove less successful when targeting cannabis use.

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## Introduction

Cannabis use and its association with severe mental-health problems has received considerable attention over recent years (Degenhardt, 2003; Degenhardt & Hall, 2002; Hall, 1998; Johns, 2001; Rey & Tennant, 2002). There are a number of reasons why this might be the case. First, cannabis use can produce short-term psychotic symptoms in individuals without history of mental illness (e.g. Bernhardson & Gunne, 1972). In addition, a number of studies show that higher rates of cannabis use have been observed in individuals with severe mental-health problems compared to the general population (e.g. Hall & Degenhardt, 2000; Menezes, Johnson, Thornicroft, Marshall, Prosser, Bebbington, et al., 1996; Regier, Farmer, Rae, Locke, Keith, Judd, et al., 1990). Furthermore, in individuals with schizophrenia, cannabis use can lead to an exacerbation of symptoms and earlier and more frequent psychotic relapses (e.g. Linszen, Dingemans, & Lenior, 1994; Mathers & Ghodse, 1992; Negrete, Knap, Douglas, & Bruce Smith, 1986; Thornicroft, 1990).

There is little dispute that an association between cannabis and severe mental illness exists. However, there remains controversy as to the exact nature of the association. Research has sought to identify a possible causal relationship between cannabis and psychosis. The results of a number of longitudinal, population-based cohort studies suggest that cannabis use may be a causal risk factor for the development of schizophrenia (e.g. Andreasson, Allebeck, & Rydberg, 1987; Fergusson, Horwood, & Swain-Campbell, 2003; Van Os, Bak, Hanssen, Bijl, de Graaf, and Verdoux, 2002). Fergusson, Horwood, and Ridder (2005) reported that cannabis users may have an increased risk of developing psychotic symptoms at rates of 1.6 to 1.8 times those of individuals who do not use cannabis. Following a review of studies, Arsenault, Cannon, Witton, and Murray (2004) concluded that cannabis use leads to a twofold increase in the risk of developing schizophrenia. They suggest that cannabis use alone is not sufficient to cause the illness, rather it should be considered as a component cause, in conjunction with other factors.

In summary, the research suggests that a minority of vulnerable individuals who have used cannabis may develop psychosis in later life. In addition, cannabis use in individuals with established psychosis may aggravate symptoms and have an adverse effect on the course of the illness leading to earlier, more frequent relapses and hospitalizations. Despite this, cannabis use is elevated in individuals with psychosis and continues to remain the recreational drug of choice for this client group (Green, Kavanagh, & Young, 2005). The National Framework for Mental Health report recently highlighted the need for 'intensive efforts to prevent drug misuse, including cannabis use, in people with severe mental illness' (Department of Health, 2004, p. 73).

The majority of clients with severe mental-health problems are located within community mental health services. As mental health professionals have direct and ongoing contact with this client group and are chiefly responsible for the

implementation of any intervention targeted at addressing substance use, the attitudes of mental health service staff are crucial.

The immediate stimulus to the present study was an observation made in an earlier study evaluating an integrated service for people with combined psychosis and substance-misuse problems in one UK city (Graham et al., 2006). The results of that study suggested that it might be more difficult to address cannabis use in people with psychosis than to address use of other illicit drugs or alcohol. A number of research studies have shown that staff attitudes are central to therapeutic activity; in that they influence the willingness of professionals to address substance misuse in their clients (e.g. Albery et al., 2003; Watson, Maclaren, & Kerr, 2007). We hypothesized that the difficulty addressing cannabis use observed might have been influenced by the attitudes that staff held towards service users' cannabis use. We hypothesized that staff may have been more uncertain and ambivalent about cannabis use by clients than might have been the case for other substances. Staff attitudes, in turn, might have been influenced by the confusion in the literature about the association with psychosis and the general societal ambivalence towards cannabis use (Graham, Copello, Birchwood, Orford, McGovern, Georgiou, et al., 2003; Graham, Copello, Birchwood, Mueser, Oxford, McGovern, et al., 2004; Graham, Copello, Birchwood, Orford, McGovern, Mueser, et al., 2006). In order to seek further evidence, the current qualitative study was designed in order to explore the attitudes, beliefs and experiences of mental health professionals working with clients who have severe mental-health problems and who also used cannabis problematically.

## Method

### Participants

The findings of the current study are based on a total of 20 semi-structured interviews with members of staff recruited from one Early Intervention service (EIS) and three Assertive Outreach teams (AOTs) within Birmingham and Solihull Mental Health (NHS) Trust (BSMHT).

BSMHT is divided into a number of geographical localities each with access to community mental health teams (e.g. AOTs, EIS, home treatment, rehabilitation and recovery). AOTs are based on the Programme in Assertive Community Treatment model (Stein & Santos, 1998; Stein & Test, 1980). Multidisciplinary team staff provide intensive case management to individuals with severe mental-health problems who have a history of poor engagement with services, high relapse and rehospitalization rates and a forensic/risk history. Using a similar model to the AOTs, the EIS provides case management to young people (16–30 years of age) presenting with early signs of psychosis. Both AOTs and the EIS have significant numbers of clients with co-existing substance-use problems

(e.g. Cantwell et al., 1999; Graham, Maslin, Copello, Birchwood, Mueser, McGovern, et al., 2001).

The study was presented to the teams by the researchers and clinicians then volunteered to participate. Twenty members of staff were interviewed. The participants comprised 10 community psychiatric nurses, 4 social workers, 3 support workers, 2 psychology assistants and 1 occupational therapist. As 11 were female, there was an approximately equal gender split. Five members of staff were interviewed from each of the four teams.

### Interviews

Interviews were carried out by 2 members of the research team and a COMPASS Programme clinician. Prior to the commencement of the study, the interviewers were trained together in general interviewing skills, qualitative data collection and data-recording techniques. The interviews were conducted at each participant's place of work in a private room or office. Each interview ranged from half an hour to an hour in duration.

Interview instructions were drafted in a semi-structured format. Each interviewer followed a set of written guidelines. These guidelines consisted of a number of questions deliberately posed to the interviewer (e.g. 'What is the interviewee's general perception regarding the relationship between cannabis use and psychosis?'). These were followed by a short list of subtopics. The interviewer aimed to obtain full answers to each of the questions; addressing each of the subtopics with the participant using open-ended questions, prompts, and obtaining concrete examples if and when appropriate. The interview aimed to explore the participants' views on the relationship between cannabis use and psychosis, the reasons why some clients might use cannabis and how the participant defined problematic cannabis use. In addition, the interview aimed to elicit the participants' specific experiences of cannabis-using clients. The following analysis aims to explore participants' views, perceptions, and experiences of clients using cannabis.

### Data collection

During each interview, interviewers took notes detailing every point made by the participant. These included direct, verbatim words or phrases that served to effectively support or illustrate what the participant had said. Within 24 hours of each interview, interviewers wrote up the notes in report form, each approximately 1000–1500 words in length. The reports were then used as the source of textual data for analysis. This method of data collection was chosen for a number of reasons. First, detailed note taking is a more economical and practical means of data collection when compared with lengthy transcripts of tape recordings, particularly for larger numbers of interviewees. Second, the purpose of this study was to explore what staff had to say on the subject of cannabis use in general and its use in people with mental-health problems. Thus, the primary aim of the interviewer was to capture the main essence of *what* the interviewee meant

during the interview. However, if the aim had been to conduct discourse or conversational analysis (Willig, 2001) then *how* things were said would have been of the utmost importance and full tape recording and transcription would have been essential. Compiling an interview report was a way of condensing and summarizing what was said (with the inclusion of illustrative verbatim quotes), and was therefore more appropriate for the purposes of the current study than a lengthy transcription of events. The success of this method is highly dependent on the reliability and precision of the interviewer in producing accurate accounts of what each participant had to say. Interviewer training and supervision was key in ensuring that this was achieved. In addition, as detailed in the next section, two meetings were held where original participants received feedback on the results of the analyses and had an opportunity to confirm or challenge the material presented. For a more detailed account of this method and rationale see Orford, Natera, Copello, Atkinson, Mora, Velleman, et al. (2005) and for effective implementation see Orford, Hodgson, Copello, John, Smith, Black, et al. (2006).

*Analysis*

The data were analysed using a grounded theory approach (Strauss & Corbin, 1990). Small sections of data were initially annotated with descriptive codes. These codes were then compared, grouped and condensed into a number of conceptually similar themes. Interview reports were circulated to the remaining members of the research team. Commonly emerging themes were identified and the next stage of analysis was agreed. Five members of the research team were independently assigned 4 reports each and requested to consider each in detail; after which the principal emerging categories were formalized.

An iterative approach was implemented throughout the analytical process, whereby developing coding categories were checked and re-checked against the data from which they emerged. Emerging 'core categories' were eventually linked together in diagrammatic form and summarize the main themes and their relationship to each other. Analysts continually re-checked the data in order to explore the overarching themes further. This ensured that the position of each participant was adequately accounted for, and all essential components of the data were encapsulated. Analysts were also careful to identify any 'negative cases', i.e. any participant whose data was not represented within the themes.

To aid interpretation and to ensure that the overarching themes accurately reflected the participants' views, findings were fed back and comments sought at two further meetings with participants.

**Results**

The analysis gave rise to a number of themes summarized diagrammatically in Figure 1 in an attempt to provide a preliminary description of the data. The following description of the themes includes illustrative extracts from interview reports. Short extracts are shown in italics while longer ones are
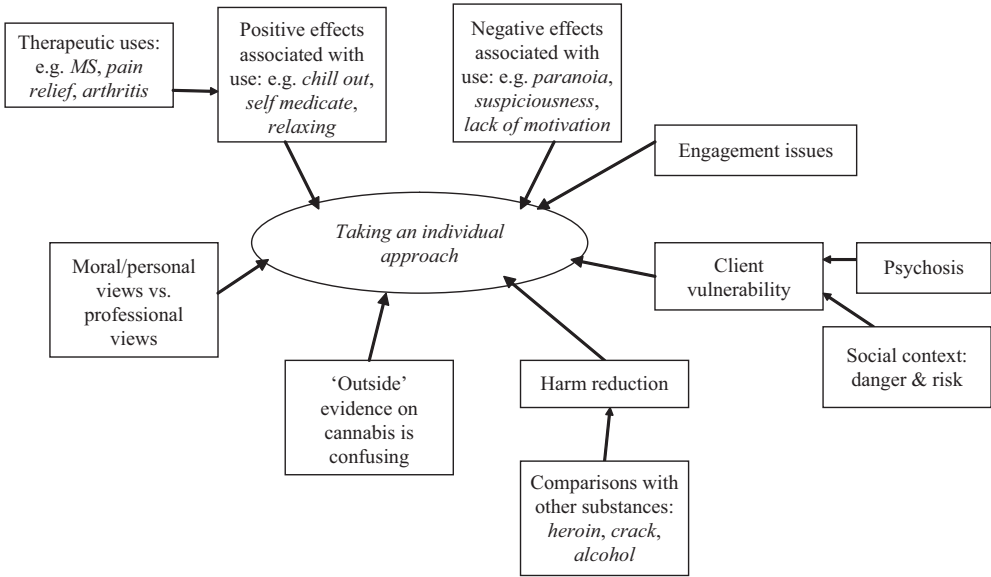
Figure 1. Diagrammatic representation detailing the categories generated following interviews with participants.

displayed and direct, verbatim quotes from participants are shown in quotation marks. Each extract is labelled with a participant number; however, all identifying features have been changed to maintain anonymity.

## Taking an individual approach

A core characteristic of each interview was that individual participants expressed many, frequently conflicting, views regarding cannabis use in people with psychosis. This led us to initially propose that staff were uncertain and confused as to how they felt about cannabis use in clients with psychosis. Participants talked of the *rights and wrongs* of use, of holding *mixed views* about cannabis and being '*split down the middle*' with regard to their position on cannabis use. Furthermore, participants talked of receiving *mixed messages* about its effects (e.g. '*The debate in my head on the conflict in information about the impact of cannabis use makes things more confusing*'). Further analysis led to a revision of the idea that staff were uncertain. Instead it became apparent that although individual participants held diverse and varied views about cannabis and about individuals with psychosis who use cannabis, when confronted with an individual case, participants made a specific assessment relevant to the circumstances of each presenting case. The central theme therefore incorporated the idea that a particular approach a participant may take toward cannabis use at any one time is highly dependent upon specific contexts, clients and situations.

'It is better to look at the effects cannabis has on each individual rather than taking a global view that cannabis use is not a good thing in people who experience psychosis.' (P02)

Any approach in itself was heavily influenced by clinical experience specific to working within community mental health teams. For example:

> It wasn't scientific knowledge that people drew on to answer these questions [about cannabis use in clients] but rather an experience base. . . . Members of his team would express a range of views in response to these questions but they would all share the 'individual approach' to cannabis use. (P10)

The *individual approach* was informed, influenced and dependent upon several factors. These are summarized in Figure 1 as the peripheral components surrounding the central theme. The following sections aim to explore these factors in detail using extracts from individual interview reports where appropriate.

### Effects of cannabis use on clients

Interview reports provided numerous examples of the effects of cannabis use on clients. Participants were often careful to make the distinction between their own observations of the effects of use in clients and those that clients had described to them. This theme had a major role in determining a participant's position with regard to cannabis use in a particular client. Participants often talked about the *positive and negative effects* of using cannabis. Effects of use were categorized as being either positive or negative, and this categorization was highly client specific. Although the effects described below appear contradictory (e.g. exacerbation vs. alleviation of psychotic symptoms), it is important to note that participants themselves were in no doubt as to the effects of use on particular clients.

### Perceived positive effects

Positive effects were closely tied in to reasons participants gave as to why they thought their clients used cannabis. There was an emphasis on cannabis having *relaxing* properties that were particularly useful for *sedation*, *calming people down* and helping them to *chill out*. This was often linked to an alleviation of psychotic symptoms and anxiety and a number of participants felt cannabis was used as a method of *self-medication*. For example:

> . . . he used cannabis 'to transport away' from the voices that asked him to do specific things . . . 'things about killing people and massacres' that he found very unpleasant. He would 'happily' tell her that taking cannabis would make the voices go away. If cannabis made life more 'bearable' for clients then it was seen as a good thing . . .[but] this was only the client's perception of cannabis, not her own. Clients viewed cannabis as 'release from outside stresses, making life easier', but she was unsure as to whether she shared that view. (P20)

An interesting example was provided by a participant who had observed directly that cannabis could impact positively upon the working relationship they had with their client:

> 'Some clients who use cannabis are more chilled and engage better'. . .'after he uses cannabis is more open to discussing his difficulties and appears more relaxed than when he is not using'. (P13)

Cannabis was often described as a more *social* drug compared to other illicit substances, particularly crack or heroin. Some participants felt that using cannabis was positive in terms of establishing or maintaining a social network (e.g. '*cannabis use can make them feel more sociable and they may find this rewarding*'). Clients were often *isolated* from others as a result of their mental-health problems. Using cannabis was often seen as an attempt to *fit in* and a response to *peer pressure* (e.g. *she stated that cannabis use may help people to '*feel normal within their social network and to break the stigma of their mental illness*'*).

When talking about 'pros' of use, many participants commented on the *proven therapeutic* properties of cannabis. Specifically, some participants understood that cannabis could have *benefits* when treating people with multiple sclerosis (MS) or Parkinson's disease and relieving pain in people with arthritis, cancer, or during childbirth (e.g. '*it stops people suffering*'). There was agreement that cannabis would be useful for these individuals under certain circumstances.

### Perceived negative effects

When describing the positive effects of use, many participants shared the view that they could '*only go on what they tell me*'. In contrast, participants regularly drew upon personal observations of particular clients when describing the perceived negative effects of use. There were many examples given where cannabis use led to a *change in behaviour*, primarily a worsening or exacerbation of psychotic symptoms and/or relapse. Increases in *paranoia* and *suspiciousness* were regularly described; as were increases in *voices, negative symptoms, bizarre language, delusions* and *mania*.

> Symptoms had become 'more profound' . . . she described one client ('S'), who she knew to be 'quite gentle' normally, and: 'still symptomatic but in control'. However, she had observed him to be 'verbally aggressive and delusional and a lot louder than he'd normally be' when smoking cannabis: '. . . he'll change instantly' . . . .this was 'quite frightening' for her to witness. 'S' had 'no control' over his symptoms, and 'less insight' into his illness and how cannabis was affecting him: 'he's less aware that he is shouting nonsense and preaching the Bible—there's no getting through to him'. (P19)

Participants had also observed clients becoming *aggressive* and *threatening* as a direct result of using cannabis. Others attributed aggression as an *indirect* effect of cannabis use (e.g. '*my theory is that if a client smokes, it will increase their paranoia and that will make them aggressive*') and others had observed clients display aggressive behaviour because they were unable to get cannabis or because they had stopped using.

There were frequent references to cannabis affecting clients' motivation leading to a *lack of interest in things*. This was particularly frustrating for some participants as it became more difficult to encourage clients to *engage in other activities*. Some participants felt that clients became '*mainly concerned with where they get their next "spliff" from*' thus leaving little time for anything else. Others concluded that use would lead to a poorer *quality of life*, which would in turn hinder recovery (e.g. . . . *one client was '*stoned all the time and everything else is too much like hard work*

*for example washing, caring for himself and no willingness to get involved in occupational activities*').

Participants had also observed a negative impact of cannabis use on clients' relationships with others including family and friends, thus leading to *social isolation* and *family discord*. Participants were aware that cannabis use often caused *tension* between the client and their parents:

> . . . cannabis use was not problematic for the client, and yet the client's parents were very unhappy about it thus creating 'an area of conflict' . . . parents might prefer to attribute their offspring's behaviour to cannabis use rather than to a mental illness: 'when their nearest and dearest is unwell and behaving in ways that are not how they're used to seeing them, cannabis is a useful hook to hang that on'. (P10)

Staff within Assertive Outreach Teams and Early Intervention, become involved in many aspects of a client's day-to-day living; they were therefore able to highlight the perceived negative effect cannabis use had on finance management and other practical issues, such as housing and buying food (e.g. '. . . *putting your last money on* 10 *pounds' worth of cannabis but you won't spend* 50p *on milk*').

*Engagement*

The preceding section suggests a disparity between client and participant perceptions of the effects of cannabis use. Participants often felt that clients did not or could not see that their cannabis use was a problem. Some participants queried the amount of *insight* cannabis using clients had in terms of drug effects. For example:

> She felt that the negative effects of smoking cannabis were something that she herself perceived but the clients did not: 'this puts a barrier up between us'. (P20)

The degree of awareness of the negative effects of use was often different for cannabis compared to other substances and this issue appeared to be indirectly related to engagement. The extract below compares client insight into the effects of cannabis and client insight into the effects of crack:

> She recalled a comment from a friend; 'It's just a herb, what's your problem?' Clients also shared this view and perceived cannabis differently from drugs such as crack. A client using crack would recognize that they had a problem: 'they'd say, "Yes I'm addicted to it"', she did not think that this was the case for clients using cannabis 'they'd say, "Cannabis isn't addictive"', but I disagree, I would say it's very psychologically addictive'. (P04)

A primary aim of the participating teams is to ensure that clients are always engaged with staff (e.g. *there was an 'engagement at any cost'* [*team*] *approach*). Despite believing strongly in the negative effects of cannabis, some participants were reluctant to address its use with clients and risk compromising engagement and the relationship with the client (e.g. . . . *she was unwilling to 'rock the boat' by tackling cannabis use*: '*if it's something they enjoy doing, we don't want to seem like we want to take it away*').

> 'It can seem that our sole purpose is to stop them using cannabis. It feels as if we are an extension of the police sometimes . . .'. Clients were reluctant to accept any help 'because they

just like using' and 'cannabis use is more important than their mental well being' . . . 'Cannabis seems a big part of life and they don't see the impact. It causes problems with engagement, they just don't want to talk to us . . .'. (P08)

It appeared that these situations were particularly common when clients believed (wrongly from the view of the participant) that their cannabis use was *beneficial* to them.

As cannabis-using clients were '*more honest*' and '*more open*' about their use in comparison with clients using crack or heroin, participants might have to '*tolerate*' situations where cannabis was used in their presence (e.g. . . . '*we have to go into their homes and we know it's illegal but* [*the visit*] *it's on their terms—we can only advise them*'). Other participants were more uncomfortable in these situations as they felt they were almost '*colluding*' with the client. This often led to '*anxiety*' for some participants during visits. In contrast, participants would not tolerate clients using '*harder*' drugs such as crack in their presence and would leave the situation or confront the client about use thus *jeopardizing the relationship*.

### Client vulnerability

The presence of an actual or underlying mental-health problem could mean that using cannabis increased the likelihood of clients experiencing symptoms of psychosis. In addition, having a mental-health problem meant that clients were in situations where they were often *targeted* and exploited by drug dealers or other *inappropriate* individuals. These themes are explored in more detail in the sections below.

### Severe mental-health problems

Participants highlighted that there was a relationship between cannabis use and psychosis. However, although participants were sure that a link existed, the issue of causation was often debated.

Prior to a client's first episode it 'is difficult to know whether cannabis triggers psychosis or are they in the prodromal stages and would have developed a psychosis anyway?' . . . Once a person has developed a psychosis there is a 'definite link' . . . 'they will definitely be more vulnerable to relapse, and there is a definite exacerbation in symptoms particularly suspiciousness'. (P02)

Some were certain of the direction of causality and did not believe that '*an individual could develop psychosis solely because they had smoked or were smoking cannabis*' Rather, these participants felt that cannabis was able to *trigger* psychosis in the vulnerable individuals '*so if you're not prone, you won't get it*'. Others felt it was important to take into consideration that the strength of the relationship depended on additional factors such as frequency of use (e.g. *cannabis could* '*exacerbate mental illness when they smoke it a lot*'), type of cannabis (e.g. '*the hydroponic stuff, with a high THC content*'), and the amount of cannabis used. In summary, it appeared that the general consensus among participants was that

cannabis use had the potential to *trigger* psychosis in someone who was vulnerable to developing mental illness.

*Social/situational context*

Some participants talked about social and situational factors that they perceived to increase the vulnerability of clients. Drug dealers were regularly blamed as responsible for *leading* or *exposing* clients to other drugs in addition to cannabis. It was regularly referred to as a potential *gateway* drug. Although most participants accepted that clients were usually polydrug users they felt that cannabis was '*where they start the association*'.

Other participants were aware that clients were particularly vulnerable to dealers because they had regular access to money. Dealers would sometimes confiscate benefit books or follow clients to pick up their money. Whereas others felt that clients were left more vulnerable through losing the support of a social network:

> This would be replaced by 'untrustworthy people', i.e. people who would encourage the client to take more drugs and generally take advantage of them, perhaps even by taking over their home, money and belongings. (P20)

*Harm reduction*

In contrast to the 'gateway hypothesis', the extract below describes a situation where cannabis was used as a way of preventing the use of a drug perceived as more harmful:

> 'He managed to stop using crack and used cannabis to stop cravings from crack. There was a vast improvement in his quality of life . . . cannabis acted like a crutch to help him remain abstinent from crack' . . . 'using cannabis seemed to help him to stay off crack in the same way that methadone helps people stay off heroin'. (P03)

On a related issue, some participants had considered advocating use or were prepared to advocate use under circumstances where they perceived an alternative as having a more negative impact on the client, or when they could see obvious benefits of using. This was most apparent when participants talked about clients using drugs they perceived as more harmful than cannabis, as the following extracts illustrate:

> Client 'R' had smoked cannabis for years: 'she's calm, she copes better in social settings after she's smoked cannabis, she's a nice person to be around'. However, 'R' had 'gone off' cannabis three years previously and now regularly used crack cocaine. This had led to some serious problems for 'R', including the loss of her house, her children, turning to prostitution and getting beaten up. Because of these problems, she remarked that she wished 'R' 'would go back to cannabis'. (P19)

> For client 'D', P12 had advised against further Diazepam, as he believed the cannabis was working sufficiently well. 'Diazepam is physically addictive. Cannabis, dare I say this, is safer. If he was to develop an addiction to Diazepam then that would be worse for him physically . . . 'it [cannabis] is the way he deals with his anxiety, it's the best thing he's found, so I guess I'm kind of passively advocating it, I'd be reluctant to try and get him to give it up'. (P12)

Some participants expressed apprehension and were more indecisive when talking about a situation where they might advocate or support cannabis use. Many found this difficult because, through experience, they were aware that the effects of cannabis were different for different people. Others were concerned that to do so would be perceived as unprofessional:

> But he would try to help the clients look at what those benefits [of using] might be, as well as trying to identify any negative sides . . . 'If there were any positives for that individual, I certainly wouldn't be promoting them, so I wouldn't be promoting use, but I wouldn't be advocating discontinuation either'. (P10)

Other participants were adamant that would never consider advocating the use of cannabis under any circumstances. This was mainly because all drugs were perceived as equally harmful to clients and others. Some would not advocate the use of cannabis for individuals with mental-health problems or would only consider it for people with physical problems such as MS.

### Personal vs. professional views

As participants were requested to draw upon their experiences as a mental health worker, they expressed mainly *professional* judgements about cannabis that were context and client specific. However, some participants also expressed their personal view of cannabis use that was often at odds with their professional approach, as the following examples illustrate:

> . . . 'just because I don't approve, doesn't mean that I judge . . . I may go along with it [cannabis use in clients] but research shows negative effects over the long term'. (P18)

There were occasions where participants had witnessed colleagues outside of their team take a judgemental approach toward cannabis users:

> 'For clients with difficulties being accepted in society anyway, cannabis just makes it worse . . . I know they get a raw deal, staff make an instant opinion about them and further problems are created . . .'. (P08)

Unlike other illegal substances, many staff commented that they had personal experience of cannabis, such as knowing people outside of work that used. This often meant that some felt they had more *liberal* views about cannabis compared to their colleagues. For others, it was individual background that influenced personal beliefs (e.g. *she had been brought up to believe that 'all substances you take will always have a negative effect—that's my belief'*). Despite any personal feelings, many staff believed that ultimately cannabis use was about '*individual choice*'.

### Wider evidence base

A number of participants identified the need for more education around cannabis and its effects (e.g. '*you have to rely on what you've learned or what you've researched yourself*') and other participants commented that clients' attitudes toward cannabis were partly due to lack of information (e.g. *clients are 'ill informed*'). Many participants argued that a call for more information had arisen for two main

reasons. The reclassification of cannabis from a Class B to a Class C drug came into force in the UK in early 2004. For some participants this had been unhelpful and made things difficult (e.g. '*with other drugs legality is not an issue, with cannabis it is*'). During this time there had also been a significant amount of scientific research published suggesting a link between the use of cannabis and psychosis. This had also posed problems for staff (e.g. '*there is so much conflict in research about the impact of cannabis use on mental health that it is difficult to give clients clear consistent information about cannabis*'). The participants below talk about how recent media interest and research findings had affected them and their clients:

> She perceived the recent media interest surrounding cannabis to be 'overdone', 'dramatic' and 'misleading' with regard to the legality of cannabis use: 'what's Class B? There was a whole load of stuff about it and even at the end they didn't really tell you'. . . . reclassification had 'muddied the waters' . . . 'a lot of our guys now think it's OK, some will smoke it in the street now and they might not have done that before'. (P09)
> . . . it had been 'difficult' to decide whether or not cannabis should have been reclassified from a Class B to a Class C substance . . . 'one way or the other, I'm sitting on the fence'. In one way the change in law had made his job harder 'if we're trying to tell people there's a link between cannabis and psychosis, then the government reclassify it, that's sending out two different messages—one side is saying it's OK and the other saying it's not, which do you believe?' (P12)

## Discussion

The overarching themes described in the preceding section were developed from analysis of interviews with mental health professionals working within community mental health teams in the West Midlands, UK. These themes centre on attitudes of staff towards clients with severe mental-health problems, particularly psychosis, who use cannabis.

Initially, it was proposed that staff were uncertain with regard to how they felt about cannabis use in clients. Individual accounts contained many different, conflicting views surrounding cannabis, and staff often gave mixed and contradictory impressions of cannabis use. However, further analysis of the data indicated that staff were, in fact, clear as to how they felt about cannabis use for each individual client. For each client, participants applied an 'individual centred approach' to cannabis use and this became a central theme. The individual approach was influenced by several key components. Importantly, participant accounts indicated how and to what extent each component led to the formation of an overall attitude toward cannabis use for a given client.

As Figure 1 depicts, it appears that through their clinical experience mental-healthcare professionals believe that attempts to address cannabis use in clients with psychosis may differ depending on the individual circumstances of the client. This suggests the need for a range of treatment interventions that can be flexibly tailored to the clients' needs rather than a 'one size fits all' approach; which is reflected for example in the recent UK guidelines from The Department of Health and Turning Point (Turning Point, 2007).

Working with serious mental-health problems requires high levels of engagement with clients, which in turn are seen as key to successful treatment

(e.g. Hemming, Morgan, & O'Halloran, 1999). Accounts in the current study suggest that in some situations, addressing cannabis use might compromise the relationship between client and clinician. Participants discussed their reluctance to compromise engagement by addressing cannabis use, particularly in situations where the client perceived cannabis use as positive but they did not. It should be noted that this was only in situations where cannabis use was perceived as problematic. This may further reduce the likelihood that staff will implement such treatment interventions in their working practice.

Attempts to weigh up both the 'pros' and 'cons' of cannabis use were influenced by direct observation or by listening to clients. In line with scientific research (e.g. Arsenault et al., 2004; Fergusson et al., 2005), participants shared the view that in some individuals there was a definite relationship between cannabis use and psychosis. This was mainly based on direct observations of clients who had experienced a worsening of psychotic symptoms and sometimes relapse as a result of using cannabis. Participants concluded that some individuals would be more vulnerable to developing psychosis if they used cannabis. Despite the high degree of concordance between participant's observations and recent research findings, participants were not convinced that published evidence had been useful. Evidence drawn from the literature identifying a causal relationship between cannabis and psychosis was seemingly at odds with the government's decision to reclassify cannabis.

Some participants were concerned that a more lenient approach to cannabis would lead to an increase in use, or imply that cannabis was in some way less harmful to clients.

There were many clients for whom cannabis use was not perceived to pose problems. There were frequent references to the positive effects and positive reasons for cannabis use, particularly in terms of psychological outcome. Of these, the most frequently reported was that of relaxation, which is often a common self-reported effect of cannabis (Addington & Duchak, 1997; Green, Kavanagh, & Young, 2003). Participants also reported that cannabis was often used successfully for alleviating various symptoms of psychosis, such as voices. However, the self-medication of positive symptoms is not commonly cited in the literature as a frequent self-reported reason for cannabis use. Rather, clients often report using cannabis to relieve negative affect (e.g. Fowler, Carr, Carter, & Lewin, 1998; Green et al., 2005).

Cannabis use was also cited as positive for social reasons, particularly for maintaining a social network with others. In line with this, a number of self-report studies have found that clients themselves often report using cannabis for socializing purposes (e.g. Addington & Duchak, 1997; Fowler et al., 1998; Green et al., 2005). Other drugs, crack-cocaine in particular, were less likely to be perceived as positive by either clients or staff.

It is proposed that this may be one reason why some participants felt that, for some clients, cannabis use could be seen as a step towards harm reduction. This could suggest the need for awareness-raising training that specifically focuses on cannabis. In the light of the present findings it might be suggested that

such training should acknowledge the confusion that exists about cannabis use generally and about the link between cannabis use and mental ill health; and perhaps should also acknowledge that different members of staff will themselves have different experiences of and attitudes towards cannabis use. Relevant training might therefore aim to bring some of this uncertainty out into the open so that it can be discussed, in the hope that as a result a service-providing team would develop a more confident and unified approach that could contribute towards better treatment outcomes. It is hoped that such training will allow clinicians to discuss substance misuse with clients and provide psycho-educational material that could help raise clients' awareness and knowledge about cannabis and the possible links with mental health.

Participants in the current study belonged to teams that had received training in an integrated treatment approach (Graham, 2004; Graham et al., 2004) and have ongoing support to facilitate its implementation. Integrated treatment approaches aim to integrate substance-use problems into the routine treatment of psychosis. One core component of the intervention is to target and facilitate the re-evaluation of substance-related beliefs that are identified as key in maintaining problematic substance use. It is entirely possible that this training may have influenced how participants talked about the 'pros' and 'cons' of cannabis use in the current study. Participants shared a wide understanding of substance use and appeared well equipped to identify, explore and evaluate reasons why clients might use cannabis and other substances. It would be interesting to explore through further research the attitudes of staff that have not received specialist training and support. We also propose that future research would benefit from further qualitative exploration of the relationship between cannabis use and severe mental-health problems from the perspective of the client.

The use of qualitative methods in the current study has been valuable in understanding the views of mental-health professionals toward clients who use cannabis. Employing this methodology permitted exploration of individual attitudes, experiences and beliefs of staff toward this group of individuals. Findings emphasize the vital role of healthcare professionals in any attempt to address cannabis use in clients with severe mental-health problems. The themes identified suggest that professionals believe the impact of cannabis should be assessed for each client and can range from negative to positive depending on individual circumstances. It is suggested that future attempts to develop treatment interventions for individuals with severe mental-health problems with substances-use difficulties may need to address this issue.

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