Please type your details/answers in the grey fields

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**Cannabis Dependence Workbook**

**2011-2013**
About the workbook

- If you are completing this workbook ELECTRONICALLY, then fill out the workbook (which is a specially prepared Microsoft Word document) as you go, remembering to click “save” frequently. You can then email it to us on the email address given below.

- If you are completing this workbook in HARDCOPY (ie on paper), then print out this document and write your answers CLEARLY in the areas shown.

- Put your name and QACPD Number on the cover page so that we know who to allocate the CPD points to.

The workbook contains:

a. An identification front sheet (previous page)

b. The GP Professional Development Survey (to be completed before you commence any of the learning sections of this ALM)

c. Quizzes for each chapter of the Management of Cannabis Use Disorder and Related Issues - A Clinician’s Guide

d. Five clinical vignettes that illustrate typical presentation patterns, recommended assessment and management strategies

e. An exercise on examining our own attitudes to dealing with cannabis-related issues in our clinical practice

h. Case summary sheets

i. Reinforcing activity: Score table

j. RACGP Learning Objectives Survey

General Instructions

1. Complete the GP Professional Development Survey (p5) BEFORE you commence any of the learning sections.

2. Watch the Cannabis Facts: Clearing the Smoke video on the Healthed website.

3. Download the Management of Cannabis Use Disorder and Related Issues - A Clinician’s Guide from the Healthed website, read the following compulsory chapters and complete the related quizzes (pp8–10) in the workbook:
   - Chapter 1: Background information
   - Chapter 3: Screening for cannabis use
   - Chapter 5: Withdrawal management
   - Chapter 6: Brief interventions

If you wish, you can read additional chapters and do the related quiz to reinforce your learning.

4. Read the explanation on Motivational Interviewing (p13).

5. Watch the Motivational Interviewing video on the Healthed website.

6. Read the five clinical vignettes (pp14–23).

7. Read and complete ‘Examining our own attitudes to dealing with cannabis-related issues in our clinical practice’ (p24).

8. Complete the case studies as set out in the workbook. You must screen at least 10 patients using the Severity of Dependence Scale (SDS). You can also use the assessment flowchart to help you if you wish (both of these tools can be download from the Healthed website). You also need to conduct at least three motivational interviews. Fill out the case summary sheet provided for each
9. Collate the scores from the SDS into the summary table at the end of the workbook under the section called “Reinforcing Activity” (p37). Summarise your experiences in the space provided in the same section.

10. Complete the Learning Objectives Survey (p39)

11. Send your completed workbook to Healthed either by:
   - Fax: 1300 797 792
   - Post: PO BOX 500 BURWOOD NSW 1805 or
   - Email: info@Healthed.com.au

12. PLEASE REMEMBER!
   - Include your name and QACPD Number so that we know who to allocate the CPD points to!
   - Keep a copy of the completed workbook with you (electronic or hardcopy) just in case your workbook gets lost on its way to us!
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GP Professional Development Survey

*Please either highlight or circle your answers*

Today’s Date: _______ Name: __________________

1. Age: _______ Years worked in General Practice: _______

2. Gender: Male / Female

3. I currently practice in a: metropolitan area / rural area / remote area

4. I perceive my knowledge about cannabis to be:
   very poor / poor / acceptable / strong / very strong

5. I perceive my skills in screening for cannabis use to be:
   very poor / poor / acceptable / strong / very strong

6. I perceive my skills in managing cannabis use to be:
   very poor / poor / acceptable / strong / very strong

In the past 3 months, I have:

<table>
<thead>
<tr>
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<th>Number of Patients</th>
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<tr>
<td>7. Screened new patients for cannabis use</td>
<td>0 1-2 3–5 6–10 11–15 16–20 21+</td>
</tr>
<tr>
<td>10. Referred cannabis users to a specialist</td>
<td>0 1–2 3–5 6–10 11–15 16–20 21+</td>
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<td>11. Provided a motivational intervention for reducing cannabis use</td>
<td>0 1-2 3–5 6–10 11–15 16–20 21+</td>
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<td>12. Conducted a brief intervention for cannabis use in conjunction with a practice nurse</td>
<td>0 1–2 3–5 6–10 11–15 16–20 21+</td>
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<td>Number of Patients</td>
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<tr>
<td>13. I feel I know enough about the causes of cannabis problems to carry out my role when working with cannabis users.</td>
<td>SA</td>
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<tr>
<td>14. I feel I can appropriately advise my patients about cannabis and its effects.</td>
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<tr>
<td>15. I feel I do not have much to be proud of when working with cannabis users.</td>
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<tr>
<td>16. All in all I am inclined to feel I am a failure with cannabis users.</td>
<td>SA</td>
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<tr>
<td>17. I want to work with cannabis users.</td>
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<tr>
<td>18. Pessimism is the most realistic attitude to take toward cannabis users.</td>
<td>SA</td>
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<tr>
<td>19. I feel I have the right to ask patients questions about their cannabis use when necessary.</td>
<td>SA</td>
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<tr>
<td>20. I feel that my patients believe I have the right to ask them questions about cannabis use when necessary.</td>
<td>SA</td>
</tr>
<tr>
<td>21. In general, it is rewarding to work with cannabis users.</td>
<td>SA</td>
</tr>
<tr>
<td>22. In general, I like cannabis users.</td>
<td>SA</td>
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<td>I need guidance in assessing patient needs for cannabis use.</td>
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<tr>
<td>23</td>
<td><a href="#">SA SSA A N D SSD SD</a></td>
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<td>I need guidance in using patient assessments to guide clinical care for cannabis use.</td>
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<td>24</td>
<td><a href="#">SA SSA A N D SSD SD</a></td>
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<td>I need guidance in using patient assessments to document client improvements in cannabis use.</td>
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<td>25</td>
<td><a href="#">SA SSA A N D SSD SD</a></td>
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<tr>
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<td>I need guidance in matching patient needs with cannabis treatment services.</td>
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<td>26</td>
<td><a href="#">SA SSA A N D SSD SD</a></td>
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<tr>
<td></td>
<td>I need guidance in increasing treatment participation among cannabis using patients.</td>
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<td>27</td>
<td><a href="#">SA SSA A N D SSD SD</a></td>
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<td>I need guidance in improving rapport with cannabis using patients.</td>
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<td>28</td>
<td><a href="#">SA SSA A N D SSD SD</a></td>
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<td>I need guidance in improving patient thinking and problem solving skills related to decreasing cannabis use.</td>
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<td><a href="#">SA SSA A N D SSD SD</a></td>
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<td>I need guidance in improving the management of cannabis using patients.</td>
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<td>30</td>
<td><a href="#">SA SSA A N D SSD SD</a></td>
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<td>I need guidance in improving cognitive focus of cannabis using patients during appointments.</td>
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<tr>
<td>31</td>
<td><a href="#">SA SSA A N D SSD SD</a></td>
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<tr>
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<td>I need guidance in identifying and using evidence-based practices.</td>
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<td>32</td>
<td><a href="#">SA SSA A N D SSD SD</a></td>
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Cannabis Facts: Clearing the Smoke video

It is now time to watch this video on the Healthed website.

Management of cannabis use disorder and related issues – A clinician’s guide

Download the *Management of cannabis use disorder and related issues – A clinician’s guide* from the Healthed website.

Read the four compulsory chapters and complete their related quizzes.

*Please either delete or cross out the incorrect answer.*

Compulsory chapters:

- Chapter 1: Background information
- Chapter 3: Screening for cannabis use
- Chapter 5: Withdrawal management
- Chapter 6: Brief interventions

Compulsory chapters

Chapter 1. Background information

1. Cannabis is/is not the most widely used illicit drug in the western world.
2. People with mental health diagnosis do/do not have higher rates of cannabis use.
3. Cannabis contains one/several biologically active chemicals.
4. Cannabis potency has/has not increased in the past 10 years.
5. The majority of cannabis users do/do not seek professional support for their cannabis use.
6. Cannabis does/does not impair memory.
7. Cannabis use does/does not cause dependence.
8. Cannabis is/is not associated with a withdrawal syndrome.
9. There are/are not approved medications for cannabis dependence or withdrawal-related symptoms
10. Many/few people resume cannabis use after treatment.
Chapter 3. Screening for cannabis use

1. A screen is a brief method for determining whether a particular disorder may be present. **True** or false?
2. Screening for cannabis use **can**/cannot be done easily in clinical practice.
3. Screening is/\**is not** diagnostic.
4. Screening for cannabis use should be targeted to particular groups. **True** or **false**?
5. You **should**/should not discuss confidentiality before screening for cannabis use.
6. You **should**/should not explain why you are screening for cannabis.
7. Cannabis **can**/cannot contribute to wheeze.
8. Name one standardised clinical assessment tool for cannabis use. *Cannabis Severity Dependence Scale, Cannabis Use Disorders Identification Test, Cannabis Use Problems Identification Test, Alcohol Smoking and Substance Involvement Screening Test, Problem Oriented Screening Instrument for Teens*

**Start typing here**

9. It **is**/is not possible to test urine for cannabis metabolites.
10. The results of saliva-testing kits for cannabis use are/\**are not** clinically useful.

Chapter 5. Withdrawal management

1. Give one example of the most common cannabis withdrawal symptoms. **Irritability, anxiety/nervousness, restlessness, sleep difficulties, anger, aggression**

**Start typing here**

2. Withdrawal symptoms typically emerge at one to ____ days of abstinence. **Three**
3. Withdrawal symptoms typically peak between days two and ____ of abstinence. **Six**
4. You **should**/should not provide verbal or written information about what to expect when quitting.
5. Many of the cannabis withdrawal symptoms are similar to tobacco withdrawal symptoms. **True** or false?
6. Cannabis withdrawal **can**/cannot be safely managed in an outpatient setting.
7. Cannabis smokers **often**/don't usually smoke tobacco.
8. There is clear evidence it is better to quit suddenly than discuss a tapering regime to a quit date. **True** or **false**?
9. It is recommended that sleep problems associated with cannabis withdrawal be treated with **progressive muscle relaxation**/short-term benzodiazepine use.
10. Cravings during withdrawal **should**/should not be treated with urge surfing.
Chapter 6. Brief interventions

1. Early interventions for cannabis use are usually planned/opportunistic.
2. The FRAMES intervention has two stages: building motivation for change and ____________. Strengthening commitment to change
3. Motivational Interviewing (MI) is/is not appropriate when incorporated in counselling, assessment and brief interventions.
4. MI requires/does not require the clinician to make clear arguments against the patient's perceptions.
5. Much of MI is telling rather than listening. True or false?
6. Cognitive Behavioural Therapy (CBT) sees substance abuse disorders as partly the result of faulty or irrational thought processes. True or false?
7. Contingency management involves the systematic use of _________________ and negative consequences following a target behaviour. Positive
8. The length and intensity of an intervention should/should not be discussed from the outset.
9. Clients who have set abstinence as a goal should/should not set a quit date.
10. Relapse prevention is/is not an important part of brief interventions for cannabis use.

Optional Chapters

If you wish, you can read additional chapters and do the related quiz to reinforce your learning.

Chapter 2. Working with cannabis users

1. Most therapies are/are not equally effective in treating cannabis use.
2. A strong therapeutic relationship is/is not necessary for effective psychotherapy for cannabis use.
3. Stepped care involves the provision of a series of interventions from the most to the least intensive. True or false?
4. Progress during treatment is usually steady/variable.
5. Early dropout from treatment is common/uncommon.
6. The optimum number of treatment sessions is/is not known.
7. Primary healthcare settings provide an excellent opportunity for delivering brief interventions for problematic cannabis use. True or false?
8. Basic counselling skills are/are not important for engaging cannabis users.
9. Counselling sessions for cannabis users are usually brief/lengthy.
10. Clients with concurrent alcohol dependence should probably be managed as outpatients/inpatients.

Chapter 4. Assessment

1. Early detection of cannabis-related problems is/is not an effective public health strategy.
2. Assessment of readiness for treatment is/is not important in the treatment of cannabis use.
3. Assessment for cannabis use requires multiple consultations. True or false?
4. A comprehensive assessment necessitates careful attention to one domain/several domains.
5. Cannabis use is recorded as the number of grams, _________________, or joints used daily/weekly. Cones
6. The five Ps are presenting issues, predisposing factors, precipitating factors, perpetuating factors and _________. **Protective factors**

7. If possible, you **should**/should not get collateral information from carers, family members and/or friends.

8. The stages of change are pre-contemplation, contemplation, preparation, action, and ________. **Maintenance**

9. Cannabis-specific treatment goals are ____________ or reduction in use. **Abstinence**

10. When reducing cannabis use, clients **are**/are not at risk of escalating other drug use in the short-term.

**Chapter 7. Special considerations**

1. Working with young people **does**/does not require an understanding of developmental issues.

2. Drug services have typically failed to meet the special needs of women. **True** or false?

3. People from culturally and linguistically diverse backgrounds **are**/are not less likely to access drug-treatment services.

4. Cannabis use by Indigenous Australians is more **common*/uncommon* than in the general community.

5. Involuntary referrals are **common*/uncommon* in cannabis treatment.

6. CBT **can**/cannot be effective in a group setting.

7. Nicotine Replacement Therapy should be **offered to*/avoided* by cannabis users preparing to quit.

8. Telephone-based continuing care is an expensive/ **a low cost** option.


10. Bupropion **can**/cannot exacerbate cannabis withdrawal symptoms.

**Chapter 8. Family interventions**

1. Children may experience the negative consequences of their parents’ drug use. **True** or false?

2. Family interventions can be implemented at all/only selected stages of treatment.

3. Family-inclusive practices **can**/cannot lead to better outcomes for the individual.

4. Clients **are**/are not the best judges of the extent to which family should be involved in treatment.

5. It is/is not the right of the client to determine to whom clinicians will disclose treatment details.

6. Release of information forms detail the specifics of what information is to be **released*/withheld*.

7. A level 1 level of engagement in working with families is when individual and joint counselling is provided to families. **True** or **false**?

8. Telephone support is the same as/different to telephone counselling.

9. Single-session family therapy is a level _______ family engagement. **Five**

10. Family therapy can involve facilitated support groups for family members. **True** or false?
Chapter 9. Psycho-education and social support

1. Psycho-education necessarily involves face-to-face contact. True or false?
2. Psycho-education cannot be delivered in a group setting. True or false?
3. Psycho-education does/do not reinforce messages from clinicians.
4. Ideally, psycho-education does/do not involve family or carers.
5. Psycho-education options are knowledge, useful knowledge and _______ Action.
6. You should/need not ask permission to provide further information.
7. Psycho-education is more than providing brochures. True or false?
8. Self-help materials should/need not be accessible by people with low reading ability.
9. Some booklets perform best when worked through together with the clinician. True or false?
10. Consumers are more/less likely to embrace information with 'stop' signs and 'no' symbols.

Chapter 10. Treating mental health in cannabis users

1. A higher/lower proportion of cannabis users have a mental health disorder than non-users.
2. Psycho-education is optional/critical for clients with comorbid mental and substance use disorders.
3. When possible, clients should receive integrated treatment of concurrent mental health and substance use disorders. True or false?
4. Cannabis use does/do not increase the risk of psychosis.
5. Greater cannabis use is/is not associated with a higher risk for a major depressive disorder.
6. There is/is not an association between cannabis use and depression.
7. All clients receiving mental health or substance use treatment should be screened for a concurrent disorder. True or false?
8. Cannabis use among people with severe mental disorders is/is not amenable to treatment.
9. The earlier the treatment of cannabis use in people with a mental disorder, the better the outcome. True or false?
10. Clients with psychosis may experience reducing cannabis use as a loss. True or false?
Motivational Interviewing

Please read the following information about Motivational Interviewing and then watch the Motivational Enhancement video on the Healthed website.

Cannabis users often choose not to seek treatment because they believe it is unnecessary, they are not ready to stop using, or they fear they will be stigmatised for attending treatment.¹ When they do seek help, they tend to seek out GPs.² Further, when they seek help they rarely want to quit. GPs can therefore help engage patients by discussing the pros and cons of their cannabis use, rather than using the “just say no” message.

Therefore, it is helpful for GPs to learn some basic Motivational Interviewing techniques. Motivational Interviewing is a client-centred, directive method for encouraging people to change substance abuse patterns by exploring and resolving ambivalence about changing.³ Techniques used to foster communication include reflective listening, examining both sides of a client’s ambivalence for change, and not pushing for change. The interviewer enhances intrinsic motivation for change by eliciting and selectively reinforcing change talk. In this way, motivational interviewing does not coerce individuals into change that is inconsistent with their values and beliefs. Rather, change arises through its relevance to a person’s own values and beliefs.


**Clinical Vignettes**

**Please read each of the clinical vignettes below** that illustrate typical presentation patterns, recommended assessment and management strategies. Please note that all chapters and page numbers referred to in the vignettes are from the *Management of Cannabis Use Disorder and Related Issues - A Clinician's Guide.*

**Vignette 1: Charlie**

**Suggested reading**

Chapters 1, 2 and 3

Mary and Martin come to talk with you about their son, Charlie. You have treated the family in the past but have not seen them for some time. Charlie is the youngest of their four children and is now aged 15 years. They are very concerned that, unlike their older children, they think he has been smoking cannabis. They have been close in the past but he is doing poorly at school and is very moody at home. They have found cannabis in his room but he told them it wasn’t his and they should mind their own business. Martin is worried he might be developing an addiction and dealing cannabis to pay for his habit. You talk to them about the harms associated with cannabis use and give them tips on how to encourage Charlie to come and talk to you so you can assess his cannabis use. After a couple of weeks, a reluctant Charlie comes to see you.

1. **What screening tools might you use?**

In regards to Charlie’s case, you would want to assess how much, how often, and how long he has been using cannabis. If he has used cannabis more than a few times, you should administer the **Severity of Dependence Scale (SDS)**, which is downloadable from the Healthed website and is on p65 of the Clinician’s Guide.

Your screening questions unveil that Charlie started smoking cannabis a few months ago. He has smoked cannabis less than six times, once every few weeks. He smokes one or two cones per occasion. You do not administer the SDS given his use is quite limited and dependence is unlikely.

2. **How you might give feedback?**

Working with young people requires an understanding of developmental issues as well as the risk and protective factors associated with adolescence. Thus, approaches that consider developmental processes, physical differences, and variances in belief and value systems are needed. As such, you would want to provide Charlie with up-to-date information on the harms associated with cannabis use. You would then need to conduct a decisional balance with Charlie, which involves examining both the pros and cons of using cannabis as a young person. These pros and cons should be summarised and Charlie should be asked where he thinks he should go to from here. Such an approach combines assessment with psycho-education, while enabling a person to make a decision that fits with their value system.
**Additional information**

The literature provides increasing evidence that involving families in drug treatment for youth is best practice; however, not all parents may be able to convince their children to be assessed or treated.

There are many factors that may increase the likelihood of young people not to seek treatment:

- belief in their invincibility
- adolescence being a natural time of experimentation
- executive function not being fully developed

When the young cannabis user is not present, it is important to educate parents about cannabis use and to provide them with resources and referral information. Such referral information can include the Cannabis Information and Helpline (1800 30 40 50), the NCPIC website, NCPIC factsheets, and NCPIC brochures (which can be ordered free of charge from www.ncpic.org.au) such as:

- Concerned about someone’s cannabis use: Fast facts on how to help
- Talking with a young person about cannabis
- Cannabis facts for young people
- Cannabis facts for parents

After reviewing cannabis-related resources, the young person may be willing to present for an assessment. Should the person be persuaded to come and see you, and a problem is noted, a stepped care approach is suggested. Stepped-care involves the provision of a series of interventions, from least intensive to most intensive, with each incremental step made available on the basis of their response to the previous one.
Tony is a 19-year-old male who is new to your practice, having recently moved to the area. He presents after claiming he fell off a ladder at work and requests a medical certificate for some time off as a result. Upon examination he has only minor soft tissue injuries. He says he works full time as an apprentice bricklayer. He describes his general health as good except he has a lingering cough from a cold 4-5 weeks ago. When asked to describe the circumstances of his fall he says things have been stressful at work. Before the fall Tony had been smoking cannabis steadily the previous 48 hours (over the weekend) and before he had come to work that morning.

He doesn’t drink much during the week but generally smokes about 1-2 cones 3-4 times a week when he comes home from work. He goes out on Friday and Saturday nights, and is often at the pub on Sunday afternoons after smoking most of the weekend. On an average night out, he smokes 4-6 cones then drinks a couple of beers while out with friends. Tony is often late for work on Monday mornings and has been having difficulty keeping up with his boss’ demands and is scared he might lose his job, as well as this stress; his parents have been on about him smoking.

1. What screening tools might you use?

After some routine questions he discloses that he has this recurring cough which lingers on for months.

you then ask ……
“Do you smoke?” He answers “Yes”
You then ask ……
“Cigarettes or cannabis or both?”
At this point it is important to ask about quantity, frequency and duration, in other words, how much does Tony smoke, how often does he smoke and how long has he been smoking cannabis?
He then tells you he smokes 1-2 cones 3-4 times a week after work and smokes during most of the weekend, as well as smoking 4-6 cones on the average night out.

Screening is a process for identification of a possible problem and does not always detect the presence of a disorder.

Routine screening for cannabis use is important for many reasons:

- Cannabis users may seek assistance for other problems, such as poor sleep, anger, depression, anxiety, and not mention that they use cannabis
- Early detection of cannabis related issues is important in preventing escalating problems

Psychometric tools are often used as an adjunct to clinical assessment. The Cannabis Severity of Dependence Scale (SDS) has a strong evidence base for use in screening and it is suggested to assist in your treatment of this patient. Screening is used in identification of a possible problem. Screening can be done easily in a clinical practice and may open a gateway to clinical care. A positive screen will usually trigger a more detailed assessment of the behaviour. The SDS can be found on
You tell Tony you have a screening tool to assess cannabis dependence which you would like to administer and could he please fill it out.

He scores 4.

Is this a score that suggests he is cannabis dependent?

2. **How you might give feedback?**

A score of 4 for a 19-year-old suggests dependence. A positive score needs to be followed up with some facts about dependence with the use of open-ended questions.

You need to ask:

“Tony do you know what is meant by the term dependence?”

Depending on the answer, you might then follow up with ....

“We (in the health field) generally measure dependence through tolerance and withdrawal.”

“Do you know what I mean by tolerance?” You need to be able to describe this.

“Do you know what I mean by withdrawal?” You need to be able to describe this.

Then discuss his score of 4 which suggests dependence ... however the score is not so high that he would find it impossible to cut down or quit if he wishes to.

**Example of how to feedback dependent use**

“The level of cannabis use you report and the problems you describe, such as missing work, poor sleep, and difficulty not using, suggests that you may be dependent on cannabis. How does that fit with your view of your use?”

This should be followed by a further discussion about the short and long-term harms related to cannabis AND some factsheets for him to take away and read is suggested. Patient factsheets can be downloaded from: [www.ncpic.org.au/workforce/gps/](http://www.ncpic.org.au/workforce/gps/). If Tony is not interested in reduction and wishes to continue smoking then possible harm reduction tips might be suggested such as:

- Changing from cones to joints
- No inhaling deeply and holding onto the smoke but rather taking four small puffs
- Mulling up with less tobacco

You might also wish to give him information about the NCPIC website (www.ncpic.org.au), point out an Alcohol or Drug service within your Health District or suggest a follow up appointment to see if there are any changes he wishes to make in regards to his cannabis use in the future.

(See assessment and flow chart for cannabis – downloadable from the Healthed website)
Vignette 3: Steven

Suggested reading
Chapters 3, 4, 6 and 9

Steven is a 35-year-old man who presents after being involved in a motor vehicle accident. He has cuts and abrasions but his girlfriend needed to be taken to hospital with fractured ribs. He was not drug tested but knew he would test positive to cannabis on urinalysis as he smokes every day and used on the morning of the accident. Despite starting an engineering degree his career has never developed and he now works part-time in a car wash.

He doesn’t drink much during the week but smokes 5-6 cones a day when he comes home from work. However, on his days off he smokes an average of 10-14 cones and lies on the couch playing video games. He does not use any other recreational drugs. Steven is not often late for work, but has been having difficulty coming in on time the last few months and has been feeling very unmotivated and flat. His boss has called him in and spoken to him about this lack of energy and raised concerns about his “attitude”. He did not admit to smoking cannabis to his boss but decided to come in and see you about his lack of motivation and lethargy. Overall, Steven is in good health.

1. **What screening tools might you use?**

   After routine questions related to his health, mental health, lethargy and lack of motivation you ask

   “Do you use any recreational drugs?” He answers "No"

   You then ask ……

   “How about tobacco or cannabis or both”

   He then tells you he smokes cannabis daily. You will then as per previous case ask about quantity, frequency and duration. Given that he smokes weekly the SDS is suggested to begin a dialogue related to cannabis use.

   As already stated, the Cannabis Severity of Dependence Scale (SDS) has a strong evidence base for use in screening.

   Screening is used in identification of a possible problem. Screening can be done easily in a clinical practice and may open a gateway to further discussion and education. A positive screen will usually trigger a more detailed discussion of the cannabis use and any related problems.

   You tell Steven you have a screening tool to assess cannabis dependence and that you think his cannabis use might be related to his lethargy and lack of motivation however you can’t be sure unless you administer the SDS. You then request that he fill it out.

   He scores 6.

   Is this a dependence score?

2. **How might you provide feedback?**

   A score of 6 for a 35 year old suggests dependence. This score needs to be followed up with some facts about dependence with the use of open ended questions.
You may want to ask …….

“Steven, you scored 6 out of 15, as the maximum score is 15. What do you make of this score in relation to a maximum of 15 where a score of 3 suggests dependence?”

By asking such questions you are attempting to illicit recognition by the patient that there may be a dependency issue.

“How do you account for the increase in order to get the same effect?”

This is perhaps followed up with a discussion about withdrawal, for example:

“Do you know what is meant by the term dependence?”

Depending on the answer, you will then follow up with:

“We (in the health field) generally measure dependence through tolerance and withdrawal.”

“Do you know what I mean by tolerance?” You may want to expand this by asking:

“When you first started smoking at the age of xx, how much did it take to make you feel stoned?" How much do you need now (years later), in order to feel stoned?”

“How do you account for the increase in order to get the same effect?”

Again you are wanting him to disclose some physical symptoms or discomfort, such as insomnia, agitation, irritability etc…

See chapter 5 (p26) on withdrawal symptoms or use the worksheet in chapter 12 p102

Then enter into a discussion when feeding back his score of 6 in relation to the above criteria (tolerance and withdrawal) where a score of 6 suggests dependence.

You might wish to follow this up with a further discussion about the short and long-term harms related to cannabis AND give him some fact sheets to take away and read (downloadable from www.ncpic.org.au/workforce/gps/). Also refer to Chapter 9: Psycho-education.

3. *How might you further assess?*

As per p18 systematic assessment headings particularly patterns of recent history of cannabis and other drug use

*Using questions on p18:*

These questions and this type of assessment may prompt a realisation that there may be more issues related to cannabis use than Steven had previously thought.

Another suggestion may be to use the answers from the SDS as a further means of increasing awareness that cannabis use may be a problem. e.g Q3 “you said that you worried a little about your use of cannabis, tell me a little more about this” or “You said that you sometimes wished you could stop, why is this? Can you expand on this a bit more?”

If Steven is willing to continue to discuss his cannabis use with you further you may wish to administer the Cannabis Problems Questionnaire on p77 of the Clinician’s Guide.

After screening and assessment you may wish to assess his readiness for assistance to change more formally with the use of the questionnaire.
(The Readiness to Change Questionnaire on p85 is suggested or other assessments as per p20)

4. **How might you provide a brief intervention?**

Early and brief interventions are generally opportunistic and are appropriate for clients who have not specifically sought help for their cannabis use but whose use is detected as being risky. The goal of a brief intervention is to reduce the risk of harm from using cannabis. Whilst abstinence will achieve the greatest reduction in harm, not all patients are ready and motivated for it.

**Using FRAMES (p29) as a brief intervention**

- **F** provide feedback from both your clinical assessments (SDS and Cannabis Problems Questionnaire)
- **R** emphasise that he is personally responsible for his cannabis use and any associated problems/consequences and/or any changes he wishes to make
- **A** provide him with clear, practical advice and self help material i.e use joints not bongs, mull with less tobacco, cutting down/reducing by at least two thirds by delaying each smoke by an hour or only smoking on weekends, take small brief puffs and avoid holding on to the smoke in the lungs
- **M** offer a range of behavior change and intervention options such as outpatients, friends' help, phone counseling, better sleeping habits, balanced eating, be active instead of smoking
- **E** express non-judgmental empathy and support
- **S** stress one's belief in the person's capacity for change

Make the connections between his presenting problems and cannabis use.

You may wish to point out referral agencies and/or the NCPIC website or any resources that you think might be relevant.

Structured feedback can bring about significant change in use with some individuals, even without providing more intensive intervention.

*There may be a need to use motivational interviewing techniques and/or cognitive behavioural interventions hence a referral to an Alcohol and Other Drug service may be necessary depending on the time available or the extent to which you may want to provide ongoing counseling and his willingness to attempt change.*
Vignette 4: Judy

**Suggested reading**

Chapters 5 and 8

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Judy is married to Gus, a 55 year old man who is only doing casual work as a fork lift driver. She presents to your practice complaining that he is smoking too much. He is always complaining to her of dizziness, and pains in his chest. He has been a heavy tobacco and cannabis smoker for approximately 37 years. Smoking has always been a part of his social and work culture as he is a child of the ’60s. They have two teenage children and she is worried that he is a bad role model for them. Typically, Gus consumes 8-10 joints a day. On weekends he often smokes more, depending on his social activities. Sometimes he will have one, maybe two, joints in the morning, smoke through the day and always have two before bed so he can get to sleep. Last year, he had a respiratory illness where he found it difficult to breathe and was admitted to hospital. He has received outpatient treatment on one occasion in an attempt to stay off both cannabis and tobacco. His smoking resumed to its old pattern shortly after his hospital episode. Judy would like to talk to him and is asking you what she should do or say.

**Suggested information/chapters to aid discussion and treatment**

It is difficult to intervene when it is someone else who is smoking cannabis. Ideally it would be best if her husband, Gus, were able to come in to see you in which case screening and assessment would need to take place as per the above cases.

As well as screening and assessment, a discussion on withdrawal would also be necessary.

Please refer to - **Chapter 5 - 5.1, 5.2, 5.8 together with a discussion around nicotine and cannabis dependence.**

Involving families in treatment services can lead to better outcomes for the individual. Clients are the best judges of who their family is and of the extent to which their family should be involved in treatment. Families are capable and often willing to change in order to support the individual in treatment.

Effective referral of families to other support services is an important factor in treatment. Clinicians offering effective referrals should keep an up-to-date list of agencies offering family counseling services in their local area.

Other suggestions to be made to Judy might be to ring the Cannabis Information and Helpline (1800 30 40 50) to get some support; read the NCPIC pamphlet “Concerned about someone’s cannabis use: Fast facts on how to help’ or perhaps a referral to an Alcohol or other Drug Service in the local Area Health Service should be suggested.
Jane is a 45-year-old woman who you have been seeing these past eight years for her chronic mental health condition which has relapsed a number of times over the years. The last three consultations have been due to her increasing lack of motivation and anxiety. After more than a year of being abstinent from cannabis use, she tells you she has started smoking again as she is feeling lost due to her kids starting to leave home. She says that it fills a void she is beginning to feel. She tells you that on top of her increased feelings of anxiety and depression, she has started to have paranoid thoughts. Jane claims she hasn’t experienced this before and is extremely worried about her paranoia and ‘crazy thoughts’.

1. **What screening tools might you use?**

Any routine check-up consultation or consultation related to smoking, respiration, mental health, injury, reproductive health, accident or sleep disturbance are opportunities for cannabis screening.

She admits to smoking cannabis again, hence it is important to assess her current level of dependence. Psychometric tools are often used as an adjunct to clinical assessment. The Cannabis Severity of Dependence Scale (SDS) has a strong evidence base for use in screening (p65).

Screening is used in identification of a possible problem. Screening can be done easily in a clinical practice and may open a gateway to clinical care. A positive screen will usually trigger a more detailed assessment of the condition.

2. **How might you provide feedback?**

Recent evidence suggests that structured feedback can bring about significant change in use by some individuals, even without providing more intensive intervention (p22). In Jane’s case it is extremely important to discuss and give feedback on co-morbidity and the relationship between cannabis use and mental health.

3. **How would you further assess?**

In Jane’s case it is important to assess why she feels she relapsed to cannabis use, the pattern of use over the past year and past month and how her use patterns may be influencing, or be influenced by, her thoughts and feelings.

The domains you ask about are:

- Recent history of alcohol, cannabis and other drug use, hence you ask questions on **quantity, frequency and duration** (p18).

Jane has told you that she is now smoking 4-6 cones every day; throughout the day and maybe two more before bed. However on an average weekend she would smoke 10-14 cones on Friday, Saturday and Sunday. She does not use any other recreational drugs.
Note: readiness to change can be assessed by looking at problem acceptance and whether the change is needed, wanted and within reach and treatment acceptance, i.e. whether the patient agrees with the pathway offered. The challenge for the practitioner is to engage the patient into ‘treatment’ and educate how mental health and cannabis use are inter-related.

You may want to discuss problems that directly or indirectly relate to cannabis use, e.g. memory, reading skills, financial problems, cognitive problems, absenteeism from work, demotivation, and how this has changed in relation to her beginning to use cannabis again.

The Cannabis Problems Questionnaire (p77) can help raise awareness of psychological issues resulting from cannabis use which can be discussed at length with her.

To assess motivation to change (p20) use the Cannabis Ladder (p96).

4. **How might you provide a brief intervention?**

Early and brief interventions are generally opportunistic and are appropriate for clients who have not specifically sought help for their cannabis use but whose use is detected as being risky. The goal of a brief intervention is to reduce the risk of harm from using cannabis. Whilst abstinence will achieve the greatest reduction in harm, not all patients are ready and motivated for it. FRAMES (p29) is suggested as a brief intervention to aid the patient to make the decision to stop cannabis use.

- **F** provide feedback from both your clinical assessments (SDS and Cannabis Problems Questionnaire)
- **R** emphasise that James is personally responsible for his cannabis use and any associated problems/consequences and or any changes he wishes to make
- **A** provide him with clear, practical advice and self help material i.e use joints not bongs, mull with less tobacco, cutting down/reducing by at least two thirds by delaying each smoke by an hour, or only smoking on weekends, taking small brief puffs and avoid holding on to the smoke the lungs
- **M** offer a range of behavior change and intervention options such as outpatients, friends’ help, phone counseling, better sleeping habits, balanced eating, be active instead of smoking
- **E** express non-judgmental empathy and support
- **S** stress one’s belief in the person’s capacity for change

It is also important to refer her back to her psychiatrist and to liaise with her/him in her ongoing care and common approaches to the management of her mental health and cannabis use.
Examining our own attitudes to dealing with cannabis-related issues in our clinical practice

At this point in your Active Learning Module it would helpful for you to reflect upon why you are interested in screening and managing cannabis use problems. Similarly to how patients’ motivation to change can wax and wane over time, so can your motivation to assist them. Reflecting on these questions now and after your training can help to ensure that your motivation remains steady.

1. How important do you see cannabis as an issue affecting the health of your patients?

2. What do you see as your own role in relation to cannabis use?

3. How does cannabis use usually crop up in consultations for you?

4. Describe a typical consultation for a cannabis-using patient.
5. How does your cannabis-related practice compare with your approach to alcohol, tobacco, and other illicit drugs?

6. Describe the likelihood that GP intervention could help someone to reduce their cannabis use.

7. How much are cannabis users to blame for their condition?

8. What are the benefits to the local community arising out of GP activity in cannabis use management?
9. What would encourage you to do more cannabis-related work?

10. How could your cannabis-related practice be improved?

If your answers to these questions suggest your motivation may be waning, you might want to take a few minutes to think of ways to increase your motivation. This may include calling the Cannabis Information and Helpline (1800 30 40 50) for advice or speaking to peers who work with cannabis using patients.

We hope that this training will not only increase your knowledge and skills in treating cannabis use, but also increase your motivation to help individuals who use cannabis.
## Case Summary 1

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Briefly describe how the resources as well as the SDS and MI strategies have influenced your ability to manage people with cannabis consumption problems. 100-200 words below:

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## Case Summary 2

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**Briefly describe how the resources as well as the SDS and MI strategies have influenced your ability to manage people with cannabis consumption problems.**

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Briefly describe how the resources as well as the SDS and MI strategies have influenced your ability to manage people with cannabis consumption problems. 100-200 words below: Start typing here
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Briefly describe how the resources as well as the SDS and MI strategies have influenced your ability to manage people with cannabis consumption problems. 100-200 words below:

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Briefly describe how the resources as well as the SDS and MI strategies have influenced your ability to manage people with cannabis consumption problems. 100-200 words below:

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## Case Summary 9

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### Willing for assistance
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### SDS score
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### Appropriate action?
*(please tick the relevant box)*

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| Monitor | FRAMES | FRAMES, decisional balance, high risk situation |

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Briefly describe how the resources as well as the SDS and MI strategies have influenced your ability to manage people with cannabis consumption problems.

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Briefly describe how the resources as well as the SDS and MI strategies have influenced your ability to manage people with cannabis consumption problems.  
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Reinforcing Activity: Score Table

Now collate the information from your case summaries in the table below:

| Number of high risk patients that you can identify in your practice in the past 4 weeks |   |
| Number that have admitted to cannabis consumption |   |
| Average frequency of cannabis consumption of those that say they consume it |   |
| Number of patients interested in receiving assistance of some kind from you |   |
| Number of patients with SDS score in MILD category (0-3) |   |
| Number of patients with SDS score in MODERATE category (4-6) |   |
| Number of patients with SDS score in SEVERE category (7-15) |   |
| Number of patients that you conducted a motivational interview with |   |

In what way have the information and learning exercises influenced the way that you manage cannabis use in your patients?
Learning Objectives Survey

1. Update knowledge on new developments in Women’s Health relevant to my practice. Please underline your answer
   
   N = Not Met   P = Partially Met   E = Entirely Met

2. Refresh and revise my clinical assessment and management strategies in Women’s Health.
   
   N = Not Met   P = Partially Met   E = Entirely Met

3. Help me identify areas of my clinical practice that may be improved by the addition or improvement of systematic strategies to ensure better prevention, diagnosis and management
   
   N = Not Met   P = Partially Met   E = Entirely Met

4. Please rate whether your learning needs were met in general
   
   N = Not Met   P = Partially Met   E = Entirely Met

5. Please rate the relevance of the content to your individual practice.
   
   N = Not Relevant   P = Partially Relevant   E = Entirely Relevant