It ain’t what you do, it’s the way that you do it: A qualitative study of advice for young cannabis users

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Abstract
Introduction: Advice is a widely recommended and practised intervention with young drug users. Study of precisely how advice is given and received in any setting has, however, been limited. Design and Methods: We qualitatively analysed 106 audio-recordings of advice sessions on cannabis use for young people within a randomised trial. Inductive data analysis was guided by a focus on practitioner behaviour which served to engage the active participation of the young drug user in the session. Results: A cluster of ‘Information Management’ activities was identified together with an ‘Interactive Orientation’ evident in a series of specific behaviours. Participants were most successfully engaged when both were combined, understood here as ‘Personalised Advice-giving’. Discussion and Conclusions: These components identified in this exploratory study might assist further research in rectifying the absence of a solid empirical basis for effective practice in advice giving with young drug users and more widely. [Faulkner N, McCambridge J, Slym RL, Rollnick S. It ain’t what you do, it’s the way that you do it: A qualitative study of advice for young cannabis users. Drug Alcohol Rev 2009;28:129–134]

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Introduction
Current UK public health policy emphasises the facilitation of healthy choices by individuals through the provision of information, advice and support [1]. Advice is constituted by information giving when there is an overt and specific intention to persuade towards better health [2]. Information and advice for young people is also a central element of current British drug policy [3]. Advice for young drug users is a common activity, both in the context of dedicated services and in generic youth work settings, in Britain and elsewhere. The effectiveness of advice on drug use given to young people is largely unknown as there has been no real tradition of research study in this area.

For poor diet, lack of exercise, hazardous drinking and cigarette smoking there are now systematic reviews attesting to the effects that advice can have on individual behaviour [4–7]. These are by no means the only areas in which advice giving in relation to individual behaviour lies at the heart of good practice within health services. For example, problems with medication adherence for chronic health problems profoundly undermine treatment effectiveness [8]. Across these reviews and in their primary published work, curiously little attention appears to have been paid to precisely how advice is given. There is certainly much guidance available to professionals in communications skills generally, and common sense ideas of what might constitute good practice are widely shared, yet identifying a solid evidence base for the more detailed delivery of advice giving is far from straightforward.

Within a trial evaluating the effectiveness of a Motivational Interviewing [9] intervention with young cannabis users, we included an advice condition as a credible competitor [10]. We decided, a priori, to undertake a qualitative study, blind to outcome at the individual level and with a primary focus on practitioner behaviour. It was intended that this would assist
further research on the detailed content and methods of advice giving, with a view to enhancing effectiveness.

**Methods**

This study comprises a qualitative analysis of audio-recordings of advice sessions delivered within a two-arm trial seeking to reduce cannabis-related risk among young people. Participants were recruited in 11 Further Education colleges across London. Eligibility criteria were age 16–19 years old, weekly or more frequent cannabis use, literacy sufficient for questionnaire completion and English language [10]. Potentially eligible students were identified by college staff as well as being directly approached by researchers in informal areas. The 326 trial study participants had a mean age of 18 years, 69% were male, and approximately 52% were Black, 11% White and 37% Asian or other. A total of 94% reported having ever smoked cigarettes, 78% had previously drank alcohol, and other drug use was rare; ecstasy was the most common other drug ever used, by approximately 8% [10].

In a standardised protocol, young people were guided through a range of commonly available harm reduction information leaflets and offered the opportunity to ask questions and seek advice about related issues. Advice given was to be directly related to questions asked. No attempt was to be made to elicit conversation on the wider personal context or meaning of the information or advice. The only type of interaction specifically encouraged was the question and answer mode, where opportunities were offered to ask questions and the best quality answers possible were given. Practitioners were provided with guidance on how to begin, continue and end the sessions after training. Practitioners were specifically instructed to refrain from using counselling skills, such as reflective listening, in order to preserve the contrast within the trial.

A total of 75% (112/148) of those randomised to receive advice who participated in intervention gave consent to have their session audio-recorded and analysed. This was sought verbally at the beginning of the session, which proceeded regardless of whether or not it was audio-recorded. Six recordings were lost, inaudible, or otherwise unusable, yielding a final dataset of 106 sessions available for study. The vast majority of these were delivered by four Researcher Practitioners.

We sought to be as inductive as possible, and were guided by the approach of grounded theory as developed by Glaser and Strauss [11]. This seemed most appropriate to the exploratory, hypothesis-generating nature of the present study. For example, it has been described as being ‘designed to discover rather than verify theory within textual data’ [12].

The complete set of 106 audio-recordings was separately listened to by two researchers (NF & RS), without access to each others notes or any other forms of interpersonal contact. The only instruction given to the researchers was to observe the individual sessions as far as possible free of preconceived expectations. After listening to all the sessions, both sets of notes were compared and discussed in detail by the first and second authors (NF and JM) to identify recurrent and divergent themes. Within these discussions, the following primary research objective was refined to direct further study based upon our previously identified study aims; We sought:

To identify precisely what practitioners actually did that promoted interaction, leading to the participant being open to, and actually gaining new information, actively seeking information, enhancing generalised risk awareness and discovering new personalised information.

The dataset was then divided into sessions deemed worthy of detailed analysis \( n = 36 \), and those for which no further analysis was judged useful \( n = 70 \). The basis of this judgement was whether there was any substantial evidence of meaningful participation by the young drug user in the session. Where this was the case, attempts were made to specify exactly what the practitioner did that might have facilitated this involvement. Sessions in which the young person was largely silent or passive, asked only infrequent questions narrowly related to the information presented, or contributed comments in a perfunctory manner were thus excluded from further study.

In total, 21 specific practitioner behaviours were initially identified. It should be emphasised that the data presented here in no way constitutes a representative sample of all available material. Audio-recordings designated as being of further interest \( n = 36 \) were then listened to a second time (by NF), with selective transcribing of sessions. Transcripts were then analysed and re-analysed to refine the categorical system, which was reduced to the 13 categories presented in Figure 1. The categories themselves, and their labels were altered repeatedly to provide best fit with the data (by JM & NF), in part through the construction of definitions and the use of examples in all cases [13].

**Results and discussion**

Observations are organised into two primary clusters of practitioner behaviour, and an overlap between them is identified. First, the label ‘Information Management’ activities describes components of the organisation and delivery of information. Second, an ‘Interactive Orien-
tation’ was used to summarise a series of other behaviours. In the sessions which best promoted the active participation of the young person, both were combined, understood here as ‘Personalised Advice-giving’. These data are summarised in the Figure. The behaviours within each cluster will be described, with selected examples provided in the Box drawn from transcribed passages of audio-recorded sessions.

**Information management**

The clear and coherent delivery of information content lay at the heart of advice giving. This included mastery of technical details and the capacity to communicate inadequacies or uncertainties in what is known about a subject in a style of language appropriate for the young person (Box, 1). It was necessary, therefore, that the practitioner not only possessed communication skills but were also themselves well-organised and well-informed. This information was not presented, however, as a simple monologue. The discussion necessarily involved information being introduced and exchanged by both participants. Although it will usually be desirable to have the capacity for the discussion to proceed in different directions, there was a need for the practitioner to maintain focus, structure the discussion and organise the delivery of key information, in order to achieve the purposes of the communication (Box, 2).

There was no need, however, for any rigid sequence to dictate what actually gets discussed, when or how. Information management suffered when reduced to a dull technical exercise. Creativity in opportunistically linking issues that arose both engendered a naturalistic and conversational experience, and also effectively targeted information gaps and stimulated further thinking and discussion (Box, 3). The delivery of information did not always proceed smoothly when content was unusually novel or complex, or the practitioners were clumsy. It was important in these situations that the practitioner was able to use multiple approaches to the communication of specific data, where this was deemed helpful to communicate. Often advice sessions can be circumscribed by time and other constraints, so it would not be unusual for unmet needs for further information to be identified. Fostering discussions about further information or initiating other forms of help-seeking was a useful way of ending.

**Interactive orientation**

The opening to an advice session appeared particularly important for setting out the purpose as well as framing the discussion.
Box. Data excerpts.

1. P: Why don’t we talk a little about the risks that go with cannabis use. This leaflet, I think, does a pretty good job of saying that there’s a lot that we don’t know about cannabis really. You know it’s not like cigarettes or alcohol where you’ve had decades of research . . .

2. P: Well let’s talk about that in a minute. The final section in this leaflet before we get rid of cannabis is about the legal change . . .

3. YP 156: Has skunk got crack in it? Someone told me it’s got crack in it but?
   P: You hear all types of things said about different drugs . . . its not like going to Sainsbury’s . . . and it’s probably unlikely to be crack because crack is expensive.
   YP 156: Yeah because my friends told me that’s its got crack in it but for ten pounds you wouldn’t put crack in it [both laugh]
   P: And have you ever had crack?
   YP 156: No.
   P: So, it’s sort of, a different kettle of fish.
   YP 156: Wouldn’t do it ever.

4. P: The idea of meeting up is just to have a chat and also to give you the opportunity to have access to information and advice on smoking weed and other drug use . . . Part of the idea is you have the opportunity to ask any questions you want and get answers to them. How does all that sound?

5. P: Another controversial area, so I’m interested to hear your opinion on this, do you think cannabis is addictive?

6. YP 292: Another question if you were to be doing some exercise, not running or anything just lifting weights would that cause any problems as well? Like would you black out or anything?
   P: No I don’t think there is any reason to be concerned something like that would happen. So, is this after you’ve been smoking or before?
   YP 292: Yeah after usually.
   P: OK.
   YP 292: Because I have had some blackouts sometimes.
   P: When you’ve completely lost consciousness?
   YP 292: Yeah, end up waking up someone next to me or . . .
   P: And you can’t remember how that happened?
   YP 292: Nuh, just don’t remember how I got there. I remember where I was but I don’t remember how I got to this next place and then everyone just tells me I’ve just blacked out.
   P: And how often would you say it has happened?
   YP 292: Not that often, I had one about three weeks ago.
   P: Describe it to me. Tell me exactly what happened.

7. YP 290: Sometimes if we go partying or clubbing we go to bars.
   P: Yeah, so you know if you were in a bar, spirits are served in measures; each one of those is one unit. The recommendation is you don’t drink more than about three or four in a day. Do you drink more than that when you go out?

8. YP 290: You know cannabis, does it scrub a bit of your brains?
   P: It doesn’t do permanent damage to your brains or like your memory but you probably find this already. . . . If you’re stoned you just don’t process information in the same way; you just forget lots.
how the conversation was to take place. An interactive orientation was usually communicated in the account provided of the purpose and context of the discussion (Box, 4). Direct invitations were made to, for example, ask questions, recount experiences, or provide evaluative comments on information provided. As the discussion proceeded, the practitioner communicated interest in the young person’s views or experience in various ways (Box, 5).

Not all information that is presented will resonate with the person, and the extent of their active involvement was variable as a result. The practitioner was presented with opportunities to assess what matters to the person themselves. They were able to be especially vigilant about issues that are problematic or worrying and to investigate as appropriate (Box, 6).

Personalised advice giving

The sessions which best engaged the active participation of the young drug user combined these two elements, tailoring information content to that required by the individual (Box, 7). Rather than simply providing information without any overarching strategic purpose, the practitioner was responsive to the needs and articulated preferences of the person themselves. Leaflets and other pre-produced information resources were used flexibly. The person’s own questions, behaviour or situation guided the selection of information, whereas individual perceptions of issues under discussion did not need to be intrinsically personal or intimate. As in Box, 8, ambiguous information held by the person was identified and clarified.

Discussion of wider possible costs and benefits of the behaviour might be a useful stepping stone to more personalised discussion. The flow of information was bi-directional in the sessions in which the participants gained more information as a result of their active involvement. Advice was sometimes imparted in the form of reinforcement of information provided by the participant (Box, 9).

The principal findings and our interpretation of these data are graphically summarised in the Figure. The exploratory nature of these findings is emphasised. It is thus tentatively suggested that these data are in line with our identification of a guiding style within consultations for changing behaviour [14].

This suggestion might also be interpreted as a threat to the validity of these findings: to what extent did we see what we wanted to see in these data? The emphasis given to the management of information in these data is somewhat novel. These findings direct attention towards the content of communication, as well as to interactional style, suggesting that it is both what you do (information management), as well as the way you do it (interactional style), that gets results (personalised advice giving).

There is also a possible connection between these findings and the harm reduction perspective [15] that has informed the intervention content. The provision of high quality information, in ways which are both pragmatic and unbiased, lies at the heart of both sets of ideas. This leads us to suggest that harm reduction information needs to be both well managed and complemented by an interactive style to be effective.

Advice giving is a particular form of communication with objectives distinct from the standard doctor-patient purposes of relationship building, simple information exchange and treatment-related decision making [16]. Notwithstanding this difference, the two primary categories identified in this study have obvious reference points in the wider medical communication skills literature of cure (task-focused) and care (humanistic) oriented behaviours [16]. However, their definition here is specific to this population of young cannabis users, and the hypothesis that their integration...
might be pivotal to the generation of advice effects will inform our own future study and might be helpful to investigations of how advice should be delivered in other settings and populations.

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References