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## **Introduction**

### **Background**

The issue of cannabis use amongst people with schizophrenia is well-established. After reviewing 35 studies Koskinen et al. (2009) concluded that approximately 25% of people with schizophrenia met the criteria for cannabis use disorder. Up to 50% of people with schizophrenia use illicit substances (DoH, 2002), often referred to as 'dual diagnosis'. Kipping (2004) defined dual diagnosis as the co-existence of mental health and substance use.

Studies by the US and the UK by Bartels et al (2006) and Fahmy et al (2012) respectively point out that dual diagnosis is an area of growing public health concern with few research or treatment options. Whilst there have been advances in the medicines available to treat people with schizophrenia, professionals, patients and society are not necessarily seeing the benefits because of non-adherence with medication, disengagement and substance misuse all compromising the effectiveness of treatment (Benaiges et al., 2013). In many different countries, mental health professionals have to contend with poor medication compliance; poor physical health; poor self-care; increased suicide risk, and aggression as barriers to adequately treating dual diagnosis service users (Buckley, 2006; Munro & Edward, 2008; Padwa et al., 2013; Di Lorenzo et al., 2014; Borges et al., 2016). In comparison to those people with schizophrenia who do not use cannabis, dual diagnosis service users have a higher prevalence of: homelessness; worsening of psychiatric symptoms; poor medication compliance; HIV infection rates; contact with the criminal justice system; markedly increased use of institutional mental health services (DoH, 2002, Manrique-Garcia et al., 2014). A Canadian study by Kalant (2004) concluded that regular cannabis use contributes to poorer psychosocial outcomes for schizophrenic service users. Similarly, a US study (Bahorik et al., 2013) established that substance use amongst people with schizophrenia is a frequent and long-term problem, which interferes with the individual's potential recovery.

A systematic review conducted in Spain by Gomez Perez et al (2014) found that

the most common reasons for cannabis use in patients with psychosis were related to social activities, mood disturbances and relaxation. Gregg et al (2007) reviewed the self-report literature into the reasons for the high prevalence of substance use amongst people with schizophrenia despite the poorer outcomes. Aside from demographic factors and contextual factors, such as a family history of substance use, the strongest theory why substance misuse co-morbidity develops in people with schizophrenia was self-medication; using substances to mitigate against the unpleasant mood effects and for the “alleviation of dysphoria”. A finding of Graham and Maslin (2002) was that key workers believed pleasure enhancement and coping strategies were the primary reasons for cannabis use in people with schizophrenia.

Childs et al. (2011) investigated the experiences of people with psychosis who used cannabis. Whilst the participants in that study were younger than the service user participants in this study they reported positive benefits to cannabis. The main finding of Childs et al. (2011) was that cannabis use was a journey where experiences of cannabis changed across time and this journey also included negative experiences; including losing all motivation as a consequence of smoking cannabis. A South African study by Parshotam and Joubert (2015) examined the views of schizophrenic patients about the effects of cannabis on their mental health and found that participants responded that cannabis helped reduce tension, reduce anxiety, lift their mood, relax, relieve boredom, feel more energetic, sleep better, reduce auditory hallucinations, and a significant minority believed that the beneficial effects of cannabis outweighed its negative effects.

Wilson (2008) reports that there is limited research into the experiences and motivations behind cannabis use and Koskinen et al. (2009) highlighted it is important to report research findings into substance use in the schizophrenia population as this influences other research areas.

This paper reports on a finding regarding the perceptions of cannabis use from the perspective of service users and clinicians to seek greater understanding of

the experiences of people who had severe mental health problems (SMHP) and a history of disengagement from mental health services.

## **Design & Methods**

### **Research Questions**

#### **Table 1 {Research questions in the larger study}**

This research reports on findings from a part of a larger study (Wagstaff et al, 2016) which was conducted among people affected by SMHP with an history of disengagement from mental health services. A research question of the larger study sought to understand, from the perspective of both service users and clinicians, cannabis use within the experience of men people with a diagnosis of schizophrenia (Table 1)

The study was a cross-sectional interpretative study design, with a qualitative approach. The development of the aim and objectives for the study was an iterative process combining reading the literature on the subject, discussion within the research team, responding to comments from the ethics committee and also professional intuition.

There were two components to the larger study; study 1 consisted of was individual semi-structured interviews with seven male service users who described their ethnic identity as 'black', had a diagnosis of schizophrenia and a history of disengagement from mental health services (Wagstaff et al, 2016). Study 2 involved two focus groups with clinicians who worked in Assertive Outreach teams in the West Midlands, UK (under review). This paper reports on findings from both study components of the study.

Whilst IPA is traditionally used with single participants there is precedent of IPA being adapted to suit the focus group research design (under review, Palmer et al, 2010, Tomkins & Eatough, 2010). Whilst IPA celebrates the generation of unique, interpretative findings of individual experiences, using group interviews could potentially make it harder to develop detailed narratives of a specific phenomenon (Palmer et al., 2010). However there is precedence to demonstrate

that using IPA to analyse focus group data should generate a singular socially constructed narrative, providing detail and depth (Green and Thorogood, 2014).

### **Participants and recruitment**

The service user participants were recruited by the researcher meeting with Assertive Outreach Teams (AOTs) and explaining the research, from where team members acted as ‘gatekeepers’ and introduced the researcher to potential participants. The process of collaborative working with the AOTs echoes Abrams’ (2010) successful work of building connections with gatekeepers as a means to access ‘hard-to-reach’ populations. Taylor and Kearney (2005) and Rooney et al. (2012) have respectively highlighted that differences in the ethnic identity between researchers and the participants and also when participants are drug users could prove to be barriers to recruitment onto research studies. However, in this instance these barriers proved surmountable and the model for recruiting participants proved successful.

During the recruitment phase of study 1 effective working relationships were established with local AOTs and the same teams were approached when recruiting participants for study 2.

Purposive sampling was used in both phases of the study; participants were deliberately recruited for their unique ability to address the research question. The inclusion criteria for the participants in study 1 was a diagnosis of schizophrenia, described their racial identity as ‘black’ had a history of disengagement from mental health services and used cannabis. The inclusion criteria for the participants in study 2 was that they were a clinician working for an AOT.

### **Table 2 {Interview schedule}**

### **Data collection**

The semi structured interviews in study 1 were performed in the service user's homes and the focus groups in study 2 were carried out at both the team's base and at the researcher's university. In both study 1 and 2 the research interviews were digitally recorded and transcribed.

In study 1 the research interviews followed a semi-structured interview informed by the aim and objectives of the study. However, as fieldwork developed the questions were also informed by ideas expressed by the previous participants.

In study 2 the focus groups followed a semi-structured interview informed by the aim and objectives of the study and sought the clinician's interpretation of the themes generated in study 1. The focus groups were facilitated by two researchers, one who asked questions to the group and ensured that there was a calm atmosphere throughout and another who noted the subtleties of interaction, e.g. facial expressions and body language. Each focus group lasted about an hour and between the two focus groups there were twelve participants. In both focus groups the team leaders participated in the study.

### **Data analysis**

Qualitative research, and associated sampling techniques, are not concerned with achieving representativeness (Barbour & Barbour, 2002). A modified interpretative phenomenological analysis (IPA) research method was designed as an appropriate method to study the phenomena under investigation, primarily because it allowed for close examination of the individual service users' experience and for the researcher to interpret and accurately reflect on the experiences of service users from the most informed position possible. An aim of using IPA to analyse the focus group data was to generate a singular socially constructed narrative regarding the clinicians' understanding of the role of cannabis in the lived experience of men with schizophrenia. As Watts and Priebe (2002) have previously argued, the use of phenomenological analysis allows for the examination of the differing perspectives in community psychiatry and recognises that there are different levels of explanation for such a complex phenomenon as disengagement.

The data analysis process was as reflexive and as participatory as possible; including levels of interpretations from the study supervisors, the clarifying interviews, a research diary and, in the service user stage, input from service user reviewers. The final interpretation rested with the researcher. Further details of the research methods can be found in (Wagstaff & Williams, 2014) and (under review).

Both stages of the study were reviewed, and given approval, by both the local research committee (BENS - 11/H1206/2) and the researcher's institution's ethics committee (ERN\_13-0093). The research participants chose their own pseudonyms.

## **Findings**

An interpretative theme that emerged from study 1 was that the participants believed cannabis was a means by which they were able to reinforce their personal resilience and promote a more positive identity for themselves; this was a theme where the participants placed great meaning and emphasis. Whilst both crack cocaine and alcohol were also used by the study 1 participants it was only cannabis that the participants reported as an important substance capable of bringing beneficial effects to users. In study 2 participants recognised this phenomenon and had adapted their clinical practice accordingly, which is discussed further under theme 4.

Below is a chart of the participant's characteristics.

### **Table 3 {Study 1 participant characteristics}**

Six of the study 1 participants reported using cannabis and the seventh (Rebel) said he had not used cannabis since he was at school, yet he praised cannabis and he had cannabis paraphernalia around his flat. Three participants also used alcohol but did not speak about its benefits and similarly Clue and Black Zee used both cannabis and crack cocaine but did not talk of the benefits of using the latter. The study 1 participants had been using cannabis for a long time and are part of a growing group of over the age of 55 dual diagnosis service users about

whom there is limited research. Given the age of the participants and the absence of early clinical notes, details of their cannabis are unclear. One participant was 64 at the time of the interview and said he had started smoking cannabis before he left Jamaica aged 13. Another participant was in his 50s and had been using cannabis since his late teens. The older participants were being admitted to hospital less frequently, were no longer committing violent crimes or serving prison terms, had accommodation and were able to give perspective on their life course.

The participants cited a number of different reasons and benefits to their cannabis use; fitting in with their local community, becoming closer to God, experiencing a little happiness, lifting misery, creativity, relaxation, enjoyment, way of life, identity, pain control, being good for your health, straightening the mind, helping with the voices, medicinal cure, making you conscious of things you want to be conscious of and sleeping.

Four themes were identified related to the benefits of cannabis use: Identity; Conceptions of physical health; Mental well-being and enjoyment; Part of everyday life. These themes allowed us to understand that the use of cannabis in the life experience of men diagnosed with schizophrenia was the contribution of cannabis in their lives.

## **1. Identity**

Central to the experience of using cannabis was the contribution cannabis made in forming an identity, with Clue going as far as to say that,

*“Drugs make you the man you are”.*

This quote comes in the context of Clue was discussing his faith in God, the rights of people and the right to be happy and also reflecting upon lessons whilst he had learned from being in prison. When discussing these divergent ideas Clue felt that throughout his lived experience he had come to believe that cannabis added to his character and identity. Josh cites that, in addition to other benefits of cannabis use, it also contributed significantly to his personality:

*“it’s all to do with my person that makes me, if I smoke that it makes that person who I am become, people become friendly with you because there’s a lot of people smoke those things and do those things, you know, and they’re more friendly with you”.*

Josh took this a stage further, not only was cannabis a component of his identity but also others too. According to him smoking cannabis allowed him to,

*“... I can feel the vibration of people, but it’s people, people”*

Whilst Josh was clear that cannabis was much part of his identity he also realised that his identity as a cannabis smoker this was one of the factors that was used to stop him from seeing his children. The participants only felt benefits from using cannabis and none highlighted any negative consequences of use or concerns about the legal status of cannabis. Their comments suggest that cannabis was prevalent throughout the communities in which they live and part of normal life. Again linking cannabis use to identity Bubbles said,

*“Have a drink and a smoke, I’m just normal. I’m just normal”*

Some of the service users commented on their position within society; with the pervasive sentiment being that cannabis helped them belong more within their community. However, despite Bubbles explaining that through his use of cannabis (and alcohol) he is able to feel as if he is just a normal member of his community, he also said three times himself and others were going, “Nowhere”.

## **2. Conceptions of physical health**

The conceptions of the study 1 participants was that cannabis helped with physical illnesses. However, they could not explain this help and neither the physical conditions. In Arthur’s opinion,

*“I have had my prostate gland removed. ... And I used to have bowel cancer ... So marijuana helps it you know. [researcher: Did it help with the pain control?] Yes, yes”.*

At the time of the interview Clue had emphysema, it was of note that he said,

*“... I like cannabis... it’s good for your lungs as well. It’s herbs”.*

T recognised that cannabis may not solely be good for his health and emphasising his ambivalence towards his physical health T said,

*“I choose to ignore the bad part and I choose to smoke it and enjoy it and not think about its harming my health”.*

Without being able to explain why there was a sense amongst the study 1 participants that the use of cannabis was good for their physical health.

### **3. Mental health and enjoyment**

The study 1 participants' conceptions of cannabis use also related to mental health and pleasure, attributing therapeutic effects. Arthur and T compared the effects of cannabis to the effects of medication. When asked about the relationship between hearing voices and smoking marijuana, Arthur said,

*“Make it better and injection makes it better. The injection sort of straightens the mind, you know? ... And cannabis straightens the mind. [researcher: So cannabis and the injection do the same?] Yes, it straightens the mind”*

Also T replied,

*“Cannabis would make you sleep. ... And the medication doesn’t”.*

Whilst Clue was dismissive of the effects of psychotropic medication he understood the benefits of cannabis on the symptoms of his schizophrenia:

*“[cannabis] keep the voices down ... Yeah, they keep the voices away from me”.*

Whereas Bubbles felt that he benefitted from cannabis because of the impact on his prevailing sense of sorrow:

*“Being weak and depressed and down and out, like I am. Just miserable. That’s why I smoke to get me out of my misery”.*

Additionally Bubbles also said,

*“I just have a little spliff now and then, that just calms me down and sorts my mind out.”*

Josh’s experience though was more generalised, that cannabis helped him with his thinking:

*“When I smoke weed I feel like it’s a knowledgeable being helped to me, it makes me see things clearly .... clearly and helpful”.*

Simplistically the participants expressed that they enjoyed the experience of smoking cannabis, for example Clue said,

*“ ... taking drugs to me it’s a way of life. ... I enjoy drugs yeah, weed and crack”*

Returning to the theme of moving from a sense of misery to a sense of mental well-being, Bubbles said,

*“I just get high and just have a bit of enjoyment in life”.*

Rebel said that he had not smoked cannabis since school, and he is exceptional amongst the participants in that he did not smoke. Yet, despite not smoking, he certainly was not condemning it and praised its value:

*“Herb is a medicine, it is a plant which is a green plant and it is a medicine and it’s written in the Bible. It is used as a medicine for creativity, it’s creation”.*

#### **4. Drugs are part of everyday life**

The study 1 participants only felt benefits from using cannabis and none highlighted any negative consequences of use or concerns about the legal status of cannabis. Their comments suggest that cannabis was prevalent throughout the communities in which they live and part of normal life. When this theme

was raised in the focus groups, in study 2, there was broad agreement, reflecting clinical experience. The clinicians acknowledged that they had to work alongside their service users' drug use and that it was part of the lives of the people on their caseload. For instance Pat said,

*"...we have no control what cannabis they smoke or what they don't, regardless of what the research and information says. We can advise and educate and give information but we can't stop them smoking cannabis; that's a personal choice of theirs".*

The clinicians were willing to work with people who are using cannabis and did not necessarily see cannabis use as problematic. Both focus groups said that they would neither encourage someone to smoke cannabis nor tell anyone that they had to stop. They fully recognised that they had to respond to each person's attitude to cannabis differently and respect their right to individual treatment. As Bernard said,

*"It's about understanding that some people can take humungous amounts of weed ... it does not really affect them too much mentally. It might make them lethargic and less gregarious but some people have just got good tolerance levels and other people haven't. And just because someone has got psychosis doesn't mean to say that they've got an intolerance to cannabis as well, which may be quite a useful thing to understand, because your approach has to be individual."*

Slightly contradicting the views of the clinicians Black Zee questioned that given cannabis was so prevalent within the community why were professionals trying to stop people from using it:

*"It is everywhere, isn't it, it was everyone. I am not sure, but the thing is 'What are they trying to get rid of?' is my question".*

However, the clinicians also took a different attitude towards crack cocaine than they did towards cannabis. Despite the strides taken to offer individualised care,

the clinicians were wary about the impact of crack cocaine on people's lives. Again it was Bernard who said,

*“It attracts them down a route of crime and prostitution and needing money. The harsher comedown and the people they mix with maybe a harder group of people than your friend around the corner who sells you a bit of weed. It drives you into the darker underbelly of the community”.*

Fitting in with the sentiment expressed by Black Zee – *“It is everywhere, isn't it”* – the issue of criminality or the legal implications of the substance use was not an issue that either the service user or clinicians participants raised. The conceptions of the clinicians in study 2 showed that they tolerate the use of cannabis, do not report on the harms of this consumption.

## **DISCUSSION**

The objective of this paper was to understand the role of cannabis use in the lived experience of people with schizophrenia. The study 1 participants expressed the conception that in their experience cannabis use was everyday life (as with others in their community), promoted a more positive identity as well as benefits in physical and mental health and providing more enjoyment to their lives. The clinicians also recognized that it was part of everyday life for their service users and as such recognised that they needed to tolerate it's use. Whilst the service users all tended to speak positively of cannabis use, such sentiments run contrary to much research literature.

Reflecting on this study and the work of Drake et al (2006), Blank et al (2016), Chorlton & Smith (2016) a theme that becomes apparent is that there is a strong sense that through the use of cannabis by people with schizophrenia are able to develop a feeling of belonging and social inclusion.

A study by Drake et al. (2006) on recovery for people with co-occurring schizophrenia and substance use disorders over a ten-year period who achieved some stability, felt more control over the symptoms of their schizophrenia, substance abuse was in remission, most were living independently, some were

employed, some had regular contact with non-substance users and most had overall life satisfaction. Phillips and Johnson (2001) examined different aspects of dual diagnosis and suggested that there is some evidence that people with schizophrenia use cannabis to reduce general dysphoria, and possibly negative symptoms. It is unclear whether these findings match the experiences of the service users in this study who tended to frame their experiences positively, smoking cannabis to bring happiness, relaxation and to feel normal. That is not to say that if the service users had been asked they would have responded that without cannabis they would have felt greater levels of sadness, anxiety and isolation from society.

Blank et al (2016) discussed the different dimensions of belonging for people with mental health and substance misuse problems. They concluded that there was a role for mental health professionals to play in enabling service users to develop embodied feelings of belonging through promoting relaxation. Additionally, Blank et al (2016) also encourage mental health professionals to consider the language used in the discussion of belonging and that each individual will have an idiosyncratic interpretation of what belonging means.

The literature review by Chorlton & Smith (2016) suggest that the motivations of people with mental health problems to use substances reflect both their social circumstances and complex psychological processes. Similar to this study some of the benefits of substance use was found to be that enabled development of alternative identities and social inclusion. For Chorlton & Smith (2016) the goal would be for professionals to work with service users to achieve these goals without resorting to substance use.

With reference to the role that cannabis plays in the development identity within their local community for people with schizophrenia both Robertson (2009) and McDonough and Walters (2001) discussed an understanding human behaviour in modern society through role theory. In role theory the social expectations of a person in relation to their social status produces conformity to that perceived role, typically through family relations or work. Societal expectations encourage fulfilment of these roles through a range of implicit or explicit rewards and

sanctions, which usually facilitates conformity (Parsons and Bale, 1956). In the context of this study the service users were living outside of conventional roles and expectations for men in living in modern UK society yet there was the retention of the idea that there was a social norm to which they expected themselves to conform to. The service users were all long term users of mental health services, all saw cannabis use as beneficial, most had been in prison, all were long term unemployed. Thus despite living unconventional lives there was a powerful sense of wanting to belong within a particular social context. Pleck (1995) spoke of Male Gender Role Strain, not being able to conform to traditionally ascribed social expectations, by conforming to different levels of social expectations these service users did not feel this strain.

Jenkins (2000) argued that individuals partly construct their identity out of the conflict between different boundaries of their multiple possible identities. For Jenkins the process of developing an identity is subject to both internal and external forces, meaning a person's identity will change over time. The process of developing identity is not just a philosophical exercise, it also has practical consequences. Relating this theory to the findings of this study, participants in both highlighted that through their social position, drug use, mental health diagnosis, involvement with mental health services, imprisonment and other issues people with schizophrenia are often estranged from main stream society. Previous identities of being violent man or a psychiatric in-patient had changed but the identity gained by being a regular cannabis smoker gave them a consistent sense of identity. Findings from both study 1 & 2 indicate that people with schizophrenia who use cannabis can develop a sense of belonging within a community where "everyone" used cannabis seemingly unconcerned with any social stigma that cannabis use may attract within wider mainstream society.

Bruins et al (2016) in their study into the associations between physical and mental health concluded that cannabis use in people with severe mental illness is associated with lower body mass index, smaller waist circumference and lower diastolic blood pressure but a great impact from psychotic symptoms. Hill & Weiss (2016) concluded that there were minimal health risks associated with

long term cannabis use but noted the long term mental health dangers of cannabis use, particularly if people start using cannabis at a young age (which the study 1 participants did). Whilst the findings of these two papers support the study 1 participants' inclinations that cannabis use was good for their physical health they also provide a mixed message regarding continued cannabis use. Due to the complex picture of understanding and working with people with schizophrenia, who also use cannabis, there is a need to develop a specialised workforce who deliver this integrated care (Knickman et al, 2016).

### **Limitations of Study**

The small size of the sample and the possible influence of ethnicity and gender between the researchers and participants in study 1 are highlighted as limitations. However, the validity of the research lies in whether at the time of the interview the participants gave the impression that they were discussing the material in an honest and unguarded manner.

The IPA for focus groups does not necessarily allow for disconfirming evidence – people who did not agree with the majority view but did not say anything. The presence of team leaders may have resulted in some participants reluctant to express divergent opinions. This critique can be neither proved nor disproved. However, the clinicians gave the impression of talking openly and freely, no-one contradicted themselves nor was there incongruent body language.

### **Conclusion**

This study provides greater depth to understanding cannabis use within the experience of men with a diagnosis of schizophrenia. The service users perceived cannabis use as a means by which they could re-establish their identity that had been damaged as a result of diagnosis and the social consequences of diagnosis, and held cannabis in a degree of 'reverence' which appeared not given to crack cocaine or alcohol. All the service user participants viewed cannabis use as beneficial. Equally, the clinicians understood that drugs are a significant part of life for their service users. Whilst not encouraging the use, the clinicians took the

pragmatic approach that cannabis use was prevalent in the community that they served.

This study adds different dimensions to the available literature in providing greater depth to the reasons why people with schizophrenia use substances, in particular cannabis.

### **Relevance for clinical practice**

The relevance of this study to clinical practice is for nurses working with 'dual diagnosis' service users. This study highlights the perceived benefits of cannabis use amongst seven men and also clinicians' responses to cannabis use. The contribution that this paper makes to the current body of literature is that whilst the negative consequences of cannabis use amongst people with schizophrenia are well established, there is limited research into the benefits of cannabis use that people with schizophrenia are experiencing. Additionally, the cannabis use described by the study 1 participants contributed to their sense of identity and belonging, issues under explored in the literature. Equally there are some, but not many studies, that investigate staff responses to dual diagnosis service users. Additionally, the study also points to the issue of prolonged cannabis use in an ageing population, an under investigated area.

In both this study and Clutterbuck et al (2009) the attitude taken by clinician's stressed the importance of the need for individualised care and being highly client specific. Although focused on cannabis use, this study points to the importance of mental health nurses attending to the dual diagnosis and to carry out health education interventions in order to care for these people, mainly directed to coping strategies. In addition, it shows the importance of assessing the consumption pattern of these substances. By understanding the conceptions of people with schizophrenia about cannabis use, the nurse will better informed in planning more effective interventions