SMACK IN THE EYE:

An evaluation of a harm reduction comic for drug users

Michael Linnell

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ABSTRACT

A Survey of the readership of 'Smack in the Eye' took place between November 1992 and April 1993. 'Smack in the Eye' is a harm reduction comic produced for drug users and is distributed nationally through drug services in Britain. A questionnaire was inserted into issue #8 of the comic and 400 replies were received. The respondents are divided into different types of drug users, type A, the dependent or 'full time' users and type B the recreational users. The main purpose of the questionnaire is to discover the information needs and sources of the readership, to see if 'Smack in the Eye' is perceived as a high credibility source of information and if any behaviour change could be detected and attributed to the comic. It is clear the comic was seen as a highly credible source of information. A welcome finding was that some behaviour change could be attributed to the comic alone, an example of this is changing from I.V to oral Temazepam, the reason for this it is argued, because a credible and trustworthy source has offered an alternative that gives the same effect, whilst avoiding the highly dangerous practice of injecting the Temazepam 'eggs'. Other behaviours seem to have been reinforced by the comic; some appear less amenable to change than others. Safer sex appears to be harder to influence than safer drug use. Abstinence from drugs altogether is not considered a realistic goal for any mass media campaign, however preventing the spread of HIV is, as it appears that sharing injecting equipment can be influenced by publications such as 'Smack in the Eye'.

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INTRODUCTION

The Lifeline Project was established in 1971 in Manchester, as a voluntary sector project to offer help and advice to users of illicit drugs. In 1987 there was a dramatic shift in emphasis in both the theory and practice of working with drug users. This was a direct result of HIV/AIDS and is summed up by a quote from the Advisory Council on the Misuse of Drugs,

> *"The spread of HIV is a greater threat to individual and public health than drug misuse."* (ACMD 1988 p.17)

For some workers there was a forced change, for others it legitimised their existing practices. As a direct result of this, The Lifeline Project produced a comic for injecting drug users, "Smack in the Eye", that took a harm reduction approach to safer drug use and safer sex. The first controversial issue was produced in consultation with and evaluated by drug users themselves, this process has continued through to the production of the nine issues to date.

The late 1980's and early 1990's saw the rise of a sub-culture of young people associated with the Acid House/Rave scene who used a variety of "Dance Drugs". LSD, Amphetamine and Ecstasy (M.D.M.A.) that has now become the predominant cultural influence on young people's drug taking in the first half of the decade. In 1990 Lifeline embarked on a project to attract these users to the project (though this is now a secondary issue) and to produce a mass education campaign for this target group. The experience of producing 'Smack in the Eye' was applied to the production of a series of publications specifically targeted at this group. The project is a piece of ongoing action research, that involves obtaining information from users and feeding that back in a matter of weeks in the form of both comics and other types of publications.

This dissertation is an evaluation of issue eight of 'Smack in the Eye' to see if it is perceived of as a high credibility source of information and if there are any detectable benefits to drug users from the production of the comic.

CHAPTER 1: BRITISH DRUG SERVICES

British drug services- A Short History

> *"...some years ago, on passing through Manchester, I was informed by several cotton manufacturers, that their work people were rapidly getting into the practice of opium eating; so much so, that on a Saturday afternoon the counters of the druggist were strewn with pills of one, two or three grains, in preparation for the known demand of the evening"*
> (De Quincey 1971 p.31)

At the time Thomas De Quincey wrote of Manchester's early opium users in 1821, the practice of using opiate drugs caused most concern to the medical profession, not because they were worried about the problems of drug use, but because they sought a monopoly over drug treatment. They saw this as under threat by the over the counter sale of drugs by grocer's shops and general stores. The 1868 Pharmacy Act, which limited sales of opiates to pharmacists, did little for the medical profession's quest for a monopoly. It was the importing of the American idea of the 'Drug Addict' as a criminal, through an international narcotics control movement that changed things.

Sir Arthur Conan Doyle's character Sherlock Holmes was a recreational cocaine user, which in the early stories was treated as an eccentricity rather as pipe smoking would be thought of today. His drug use in popular fiction reflected the mood of the times as it increasingly became disapproved of (usually by Doctor Watson) until in 1896 in "The Missing Three-Quarter"; Holmes himself described the hypodermic syringe (invented in 1843) as "an instrument of evil" (from Berridge, Edwards 1981 p.223-224). In "The Man with the Twisted Lip" 1887 Holmes disguises himself and visits a Chinese opium den in London's West End, in an attempt to save one of his bohemian friends from 'the tentacles of lady morphia'. At the time the popular press was full of stories of "evil Orientals" corrupting "innocent" white women into a life of sex and drug taking. Xenophobia was a constant feature of the way drugs were portrayed in the popular press. For a detailed account see (Kohn M, 1987)

Despite the fact that Britain had previously fought a war with China to protect its trade in opium, it was the first signatory to the 1912 opium convention, which sought to confine opium use to "legitimate medical purposes".

The view by pharmacists that they alone should sell opium and the medical professions view of addiction as a "disease" and therefore treatable by themselves, prompted the Home Office to move on to the legal question of who should be allowed to possess drugs. The outbreak of the First World War had highlighted the need for a sober population. The Home Office introduced controls under the Defence of the Realm Regulation (DORA 40B). This legislation defined drug use as threatening to public order and therefore an issue for the police. DORA 40B placed drug use on the penal and criminal agenda. Further legislation, the Dangerous Drugs Act of 1920-23 extended this in both philosophy and penalty.

> *"The ideas behind the Acts were rooted in a criminal rather than medical model of addiction, and the 'vice' conception of drug use dominated the newspaper reports of the period, with stories of 'peddlers' and 'dope fiends'".*
> (Stimson and Openheimer 1982 p.25)

The post war relationship between the Home Office and the medical profession was strained over whether drug use should be in the medical or the legal domain. In 1924 under pressure from the Home Office the Department of Health set up a commission on Morphine and Heroin addiction, (The 1926 Rolleston Committee). The Rolleston report re-affirmed the view that addicts were suffering from a disease, which required treatment by medical practitioners. Doctors were to be answerable to their own profession for accusations of malpractice or over prescribing and there were to be medical tribunals, not police action, for any enquiry into the practices of a doctor prescribing drugs.

However, the possession of dangerous drugs without a prescription was regarded as "unauthorised possession" and subject to criminal law. Rolleston resolved the ambiguity of the 1920 Dangerous Drugs Act, which although allowing doctors to prescribe drugs for 'medical treatment' had been unclear about whether prescribing for addicts was 'necessary and legitimate practice of the medical profession'. The resolution of this ambiguity was incorporated into the Dangerous Drugs Act of 1926, which together with Rolleston laid the foundations of what was to become known as the British System.

Many commentators thought the British System was praiseworthy for its humanity and pragmatism. By treating addiction as a medical problem, 'addicts' could get medical help and legitimate supplies of drugs. This was infinitely favourable, if you were a drug user, to the American system, which criminalised drug addicts. This latter system had the effect of creating a criminal sub-culture where drug users had to meet to obtain drugs. There was no such sub-culture in Britain, where in the first half of the century the addicted population remained constant at around 400-500. They were mostly middle class, doctors, nurses or other professionals with access to drugs or those who had become addicted as a result of medical treatment. The previously mentioned legislation had largely ended the practice of working class self medication with opiates.

Commenting on the addict population supervised by the British System in the first half of this century, Griffiths and Pearson (1988 p.2) make the following comments.

> *"In no sense did these people constitute a cohesive sub-culture. Their troubles were private, a matter between their doctors, their immediate families and themselves. Many continued to hold down responsible jobs and to function well in society."*

Several changes were noted in British drug using habits of the 1940's and 1950's. Most notable were reports that as immigration to Britain from the black commonwealth increased, so did reports of cannabis use, mostly among the black population (Spear

1969). Towards the end of the 1950's there were reports that heroin and other drugs were becoming popular amongst the jazz fraternity.

> *"The first white teenager caught with cannabis in Britain was arrested in 1952, 'having acquired the habit through frequenting "Be-bop" clubs and cafes where addicts congregated'. Cannabis was used most amongst the jazz and folk musicians and their educated middle-class audience. The heroin users, too, were a literate bunch. Devouring De Quincey, Burroughs and others, they knew more than most doctors about the nature of addiction".*
> *(Shapiro 1988 p.106)*

The Home Office became concerned that this new market was being supplied by thefts from chemist shops and hospital pharmacies. This concern lead to the convening of an interdepartmental committee on Drug Addiction. The report published under the chair of Sir Russell Brain in 1961 did not recommend any changes in the status quo, but almost as soon as it was published there were reports of significant changes in the drug using population.

> *"A new generation of opiate users had begun to emerge, who differed markedly from their respectable predecessors. Predominantly young males, often socially marginal, they formed a relatively cohesive sub-culture, saw heroin as a valued component of their lifestyle and had a tendency to proselytise, to 'turn on' their friends and acquaintances. The youth culture of the 'swinging sixties' had begun its well publicised march to notoriety".*
> (Griffiths and Pearson 1988 p.2)

The Brain Committee was hastily reconvened. Its report published in 1965 reiterated its earlier emphasis on drug use as a mental disorder and recommended the right to supply heroin as a treatment be withdrawn from General Practitioners although they were still allowed to prescribe Methadone (a substitute opiate, with less attraction as a drug for users). The report recommended that teaching hospitals should set up drug dependency units under the 'relevant specialism'. Given the Brain report's emphasis on mental health, psychiatry emerged as the relevant specialism.

The 1960's 'Heroin Epidemic' as it became known concerned a population very different from their therapeutic addicted predecessors. The new drug using population were 'poly drug users' in that they were partial to all kinds of drugs (including cannabis, LSD and cocaine). Plant (1987 p.46) observes that they were also seen "to be afflicted with a variety of social and psychological problems and to have adopted a far from 'normal' lifestyle".

The newly formed Drug Dependency Units had the dual role of treating users and preventing a black market in drugs by prescribing to all those on opiates.

> *"The doctor's primary responsibility to the welfare of the individual patient became dangerously complicated by the addition of what could be interpreted as either a public health or policing function".*
> *(*Griffiths Pearson 1988 p.2)

1971 saw all previous drug legislation incorporated into the Misuse of Drugs Act. This act categorises drugs into three classes A, B and C, the penalties for possession, supply and trafficking being highest for class A drugs.

The late 60's and 70's saw the establishment of various voluntary sector bodies as a compliment to DDU's. These agencies did not focus solely on opiates but covered all drugs with the exception of alcohol. They varied from residential services such as Phoenix House to non residential services such as Lifeline in Manchester with a drop-in centre which provided a bit of help, advice and counselling and as importantly, a hot meal. The philosophy behind these services borrowed heavily from the American 'Concept Houses' with an emphasis on confrontation and with drug use seen as a pathological behaviour. As Rowdy Yates the director of Lifeline was to later write with the benefit of hindsight,

> *"It was not that our therapeutic endeavours were wrong. It is quite clear that many drug users are emotionally scarred. That therapeutic techniques applied judiciously and eclectically can provide a powerful remedy. What was wrong was the assumption that all drug users were like this during the 'seventies. What was also wrong was after 1980, all drug users were not."*
> (Yates 1992 p.33)

The seventies was also a time when drug services were unpopular as an issue on which to spend public money. As Yates again states.

> *"It was never possible - as with some more cuddly charities - to place fibreglass models of drug users, with slots in the top of their heads outside Sainsbury's and wait for the money to roll in".*
> (Yates 1992 p.36)

The 'New' Heroin Epidemic

It was not until the 1980's and the 'new' Heroin epidemic that both interest and money came into the drug services. In fact the 60's epidemic had been more of a moral panic than an epidemic as numbers were still small (fig 1). The gradual rise in reported use of the seventies gave way to a real epidemic (for inner cities at least) (fig 1). This was as a result of several factors, price came down due to availability, the fall of the Shah of Iran lead to the country being flooded with cheap Iranian heroin, this brown heroin could also be smoked which removed the barrier of injection which had deterred people in the past. The early eighties were also a time of mass youth unemployment. As Pearson (1987) pointed out this was not a case of young people shutting the curtains and taking their

heroin to block out an uncomfortable reality, but more of a case of heroin being a substitute for employment.

> *"On the one hand, these daily routines of a heroin habit can be seen as a dismal compulsion from which the user cannot escape. But at the same time they offered to people meaningful structures around which to organise their lives in an eventful and challenging way".*
> (Pearson 1987 p.89)

Figure 1

Total numbers of addicts notified to the Home Office
A comparison of the heroin 'epidemics of the 1960's and 1980's

Year	1959	1960	1961	1962	1963	1964	1965	1966
Total number of addicts	454	437	470	532	635	753	927	1349

Year	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
Total number of Addicts	3474	3605	4116	4787	5107	6157	7962	10235	12489	14688

Note: the figures represent only people reported to the Home Office for use of a notifiable drug, this is generally multiplied by a figure of five to give a rough estimate and then taken together with figures for seizures of drugs and drug related arrests to give an idea of trends. The latest figures for 1992 show 24,703 notified to the Home Office.

In July 1982 with the sharp rise in seizures and arrests the ACMD, the government's own advisory body, published its 'Treatment and Rehabilitation' report (ACMD 1982). This put forward the notion of the problem drug taker.

> *"Any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco)"*
> (ACMD 1982 p.34)

The notion of the problem drug taker had supplanted the addict in the same way that the problem drinker had supplanted the alcoholic. The Treatment and Rehabilitation report also noted the involvement of doctors working away from hospitals in treatment. Whilst this was welcomed it was also noted that there was a need for guidelines.

In June 1984 the DHSS issued circular HC(84) 14/LAC (84)12 which required English Health Authorities to improve services for drug users and to report back on their findings (similar requirements were made in Scotland and Wales). From the 25 non hospital based services in England and Wales in 1981 the number rose dramatically as the central funding initiative pumped over ú13 million into 162 new or expanded services. At this time both the media and the government accredited heroin with an almost demonic status.

> *"We see this (drug abuse) as the most serious peacetime threat to our national wellbeing"*
> (House of Commons: Home Affairs Committee 1985)

In 1984 The Guidelines of Good Clinical Practice in the Treatment of Drug Misuse (DHSS 1984) known as the Orange guidelines (because of the colour of the book cover) were issued to all GPs. This stated that all doctors had a responsibility to care for drug 'misusers' and that if drugs were to be employed in the treatment of a heroin user, a reducing Methadone prescription should be used. In theory this would mean they would be weaned off heroin in a period of weeks.

> *"The aim of treatment should be to help the drug misusers to deal with problems related to his or her drug misuse and eventually to achieve a drug free lifestyle"*
> (DHSS 1984 p.1)

The North West Region was the first to take up the provision of large scale services for drug users when they established a community drug team in each of the 19 districts covered by the regional health authority. The aim of these teams, which were multidisciplinary with workers from psychiatric nursing, social work and similar backgrounds was to act as a "passkey" to the existing health and social welfare services so that those services would be opened up to see more drug users. In fact the reverse quickly happened.

> *"Despite satisfaction with the new services, generalists appear to have adapted their practice so as to see fewer drug misusers: instead of drawing the generalists into the vacuum, CDT workers appear to have filled it themselves"*
> (Strang et al 1991 p.6)

The psychiatric units such as the unit at Prestwich in Manchester which covered the North Western Region were used for the more chaotic clients or those who had gone through several detoxification's with methadone in the community. At Prestwich Drug Dependency Unit in the mid eighties, clients who were mostly heroin users, were given an in-patient detoxification at the start of a programme lasting up to three months. This was designed to leave them drug free.

In her report into the 'Fate of Drug Addicts on a Waiting List' at the Prestwich Unit Penny Watson (1985) noted that whilst there may have been some benefits to seeking treatment, abstinence from drugs was not one of them as the sample studied who did not receive treatment stood a better chance of having stopped using than those who received treatment. She also noted that,

> *"Doctors and clinics would be seen as helpful only if someone wanted to stop using drugs, or if there was a temporary break in street supplies. They (the drug users) felt that since most young drug takers would not want to stop using drugs until sometime in the future, medical treatment for drug problems could become increasingly irrelevant".*
> *(*Watson 1985 p.63)

At the height of the mid eighties heroin 'epidemic' the statutory services in the North West of England, which were the most extensive in the country, were providing a service that was designed to attract those heroin users who wanted to give up, but had a poor record in achieving abstinence in this client group.

Heroin Screws You Up - The Government's Public Education Response

In 1985/6 the DHSS commissioned a series of high profile press and T.V advertisements, under the general title of 'Heroin Screws You Up'. These were judged to have been 'successful' in that according to the government's own research conducted by Andrew Irving and Associates,

> *"(the campaign)..fostered and reinforced negative attitudes and beliefs about heroin misuse. (but in doing so)..demoralised existing users by encouraging them to (be) negative about themselves and society to be even more hostile and rejecting".*
> (Rhodes 1990 p.16)

As Tim Rhodes wrote in his article on the politics of the anti-drugs campaigns,

> *"The campaigns have not solely aimed to prevent non-users being initiated into drug use, as they have also targeted drug users. It is commonplace to suggest that they also serve as a political marketing ploy to acknowledge the Government's concern over problematic drug use. But one might also tentatively suggest that the campaigns are of more covert significance: as an ideological stratagem to protect conservative moral ideologies by opposing these to popular perceptions of the drug user as 'addict' and 'deviant'....The more drug users become alienate from mainstream society, the more they also become alienated from the help and information sources they might some day require".*
> (Rhodes 1990 p.18)

The campaign was heavily criticised from within the drugs field for a number of reasons. It focused solely on heroin and ignored drugs such as amphetamine. The posters which featured young people supposedly 'screwed up' would show thin young rebellious youths with 'James Dean scowls' and were reportedly used by teenage girls as pin ups. (Private correspondence with drug agency in Liverpool). Andrew Irving Associates did the research so quickly, and before the adverts were produced, that a literature review of previous research was not possible (Dorn 1986). Research from America where there had been a heroin problem for much longer, pointed out some interesting paradoxes.

One of the two TV adverts used in the campaign in England and Wales,'control', which featured a young actor saying that he could control his heroin use, when the viewer is lead to believe with his rapid deterioration before the camera that he obviously could not, makes the point that heroin is a difficult drug to manage. Fieldman's research which took place in 1968, in Boston and New York suggests that this is also part of its attraction.

> *"Status as a 'stand-up cat' had been commonly achieved through being adept at thieving and fighting, thereby facing and overcoming various challenges to one's emerging manhood. However, heroin came to be a most effective form of challenge precisely because of its fatal notoriety. Whether the 'stand-up cat' was prepared to accept the challenge, and whether he would be able to use the drug without succumbing to addiction and dependence, could be a crucial test of his manhood..'can you control it or will it control you ?'These were a much more mortal form of combat than the street fight"*
> (Quoted in Pearson 1987 p.79)

Quite apart from the specific criticisms of the campaign, the idea of using any form of mass media campaign *" ..contravened the principle that mass media should not be used for complex and sensitive issues, especially where the goal is to change behaviour"* (Tones quoted in Health Education Journal No4 1986 p.223). As Nick Dorn, Research Director of The Institute for the Study of Drug Dependence (ISDD) told the 'Media Show' in March 1990, the evidence is that media campaigns are *"absolutely useless in terms of reducing the level of drug consumption".* (Dorn 1990).

Enforcement Strategies

With the advent of the heroin 'epidemic' in the 1980's in Britain and a Cocaine epidemic in some parts of America, the focus of most Governments throughout the world has been on reducing supplies of drugs through both domestic law enforcement and international efforts to stop trafficking and production. In its summary of its own strategy for dealing with drug 'misuse' (Home Office 1988) the Government states that it hopes to tackle the problem on five main fronts:

> **Reducing supplies from abroad**
> **Making enforcement even more effective**
> **Maintaining effective deterrence and tight domestic controls**

Developing prevention
Improving treatment and rehabilitation

Vast amounts of money have been spent in a diverse range of programmes such as crop substitution, encouraging poor farmers to plant food crops instead of opium, but the bulk of the cash has gone into anti trafficking measures. In 1989 America appointed a 'Drug Czar', William Bennett, with an annual budget of $7.8 billion to engage in a 'War on Drugs'. As Wisotsky states.

> *"The War on Drugs is clearly stuck, mired in paramilitary rhetoric that obscures understanding while worsening the problem. Enforcement does not work to control supply....Without real goals; there can be no accountability. Not once in the history of the War on Drugs has the Government ever stated a realistic objective. Vague and ridiculous aspirations of "ending" drug abuse are all the public ever hears. This lack of goals guarantees that the system will continue to generate its infinite spiral of unworkable policies to 'crack down' on the drug supply."*
> *(*Wisotsky 1986 p.173)

As with the earlier Volstead Act (The act which lead to the prohibition of Alcohol in America between 1919 and 1933; this period actually saw an increase in use of Alcohol), the number of users of drugs in America rose by 5,000 a day in 1985 (David Mellor to the House of Commons, quoted in Marks, 1987) despite the 'War on Drugs'. In Britain whilst policies differ in a number of ways, there has been a willingness to join in both the American style 'just say no' campaigns and a willingness to support military action such as the use of a Royal Navy frigate to aid producer countries in South America.

The amount of drugs seized and the number of arrests for drug related offences has risen dramatically over the last decade, but this does not necessarily mean that the Police and Customs have been more successful in any real terms. It could mean that there are more drugs coming into the country and more people using. This is borne out by statistics from services and reports of both availability and purity of drugs. Customs officers estimate a figure of roughly 10% of drugs smuggled are intercepted (Customs and Excise Group 1984 p.10). This would mean that even if they were to double the size of the customs service (which in fact is shrinking) according to the officers they could not expect to intercept more than 20%. As Ray Kendall, Secretary General of Interpol told a conference of Forensic scientists in 1987.

> *".... no matter how sophisticated these attempts (to stop drug trafficking) become, the traffickers still manage to stay one step ahead".*
> (quoted in Linnell, Gilman 1987)

The impact of the various police and sentencing policies that both tend to vary and change over periods of time, from giving long sentences for possession of small amounts of drugs to cautioning and concentrating on higher level supply and trafficking is a discussion that is too complex to engage in a short space. (For a fuller discussion see Dorn, Murji and South (1992) and Wagstaff and Maynard (1988)). The effectiveness of these approaches

is difficult to measure, but whatever the success or failure of these approaches the numbers of users continues to rise, at best enforcement can be seen as a way of containing the extent of the problem not as a means of solving it.

Education/Prevention Responses

Drug prevention/education is the fifth part of the Government's strategy for tackling drug misuse. This will be discussed fully in a later chapter and is briefly mentioned here only in the context of understanding the rationale for harm reduction. Drug education is not a single entity but comes in a variety of forms, as Davies and Coggans state,

> "*Exposure to drug education of whatever type, seemed to have very little bearing on patterns of drug use".*
> (Davies and Coggans, 1992 p.78)

CHAPTER 2: AIDS AND HARM REDUCTION

The Emergence of HIV/AIDS

It is now apparent that HIV had been in Britain for several decades before it was identified. The Human Immunodeficiency Virus is contracted in two main ways, through sexual activity and through the exchange of blood. Its impact in the 1980's were felt first in the Gay community, but it quickly became apparent that drug users were also in a high risk group (though the notion of high risk groups is now frowned upon by some). Injecting drug users are at risk of infection by sharing injection equipment with somebody who has the virus. This includes needles, syringes, spoons, water, filters etc. It is then possible for them to pass on the virus through further sharing or sexually or if pregnant from mother to foetus. Reported levels of sharing of injecting equipment in Britain are high, 62% among non-attenders of a needle exchange scheme (Monitoring Research group 1988) and even higher in some areas (76% in Scotland). Non injectors are at risk because of the disinhibitory nature of drugs including alcohol on safer sexual practices.

> *"An individual heavily intoxicated with a stimulatory drug is in danger of foregoing safer sex practices due to its disinhibitory effects. At the other end of the spectrum, where heroin has decreased the sex drive and interrupted the menstrual cycle, there is less incentive to use barrier contraception on the infrequent occasions when sexual activity takes place."*
> (Robert Power from Strang, Stimson 1990 p.74)

Reports into prostitution and I.V drug use suggest figures of between 20% and 47% of prostitutes are injectors (Bloor et al 1991, Thomas, Plant 1989) although the same reports suggest that in Britain prostitution is not a bridge for HIV to spread into the wider community.

The Impact of HIV/AIDS on Drug Services

I.V drug users have always been prone to potentially fatal blood borne infections such as Hepatitis B. HIV, which is nowhere near as infectious, was initially treated by both workers and users as another of the hazards associated with injection. Information on the percentage of those with the virus who would go on to develop AIDS and die, was confused, but at first thought to be low. The realisation that large numbers would contract the virus from sharing injection equipment lead to a radical change. This was summarised by the ACMD (1987) in its report, AIDS and Drug Misuse; Part 1:

> *"The Spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly services which aim to minimise HIV risk behaviour by all available means should take precedence in development plans."*
> (ACMD 1988 p.17)

The advent of both HIV and the statement by the ACMD forced a change in practice for many working in the drugs field, for others it legitimised practices seen as marginal or controversial,

> *"There is much about the arrival of HIV for which we should be grateful: the re-examination provides an opportunity for improvement in the quality and distribution of care across society and should result in alterations of attitudes and practices towards those who have so often been marginalised and have so often been poor consumers of health care".*
> (Strang, Stimson 1990 p.14)

For drug services it was no longer acceptable to try and work with those motivated to give up and abstinence from drugs although still a stated aim of the ACMD report, was not a condition of contact with services. Drug services were to 'maximise contact' with all injectors not just heroin users and attempt to halt the spread of HIV.

The Normalisation of Drug Users

As the number of drug users increased the people using drugs (statistically and in other senses) are likely to be more "normal". Whilst as has been stated earlier the users of the 1970's were on the fringes of society and those who presented to drug services had a range of social and psychological problems, those of the 1980's were less indistinguishable from the general population.

> *"When a city with a couple of million inhabitants has only one or two dozen heroin users then this group will probably be deviant and abnormal in many ways but as this behaviour becomes more widespread the abnormal characteristics will become less noticeable. By the time there are several hundred thousand drug takers in such a city their characteristics would be much more similar to the non-using population"*
> *(*Strang 1984)

This did not mean that users presenting to services were without problems or as Brian Pearson points out, were similar to the drug workers who helped them.

> *"We're just like you, except we've got a home and a job, we're not strung out on smack, we haven't got a court case coming up and we can throw you out if you're not nice to us, but otherwise..."*
> *(*Pearson 1990)

What it did mean was that services, who had set up with workers with a range of skills appropriate to the users of the 1970's, found these skills often inappropriate for the clients they saw in the 1980's. Some adapted their practice, others either catered for the minority with the range of problems they felt comfortable in dealing with, still others made drug users fit into the mould of how they thought drug users should be.

High Time for Harm Reduction

There was not a consensus (and still isn't) from drug services or anybody else of how to confront the emergence of HIV, arguments raged in journals and at conferences for a number of years. The response came in a fragmented way with one or two agencies and individuals both taking the lead and the risks. For many practitioners involved in the prevention and treatment of drug use, harm reduction was something that never went beyond conference rhetoric.

Whilst British drug policy has been strongly influenced by the U.S. approach of criminalizing the drug problem, the model for both HIV prevention and harm reduction came from Europe and the more liberal approach of the Dutch.

> *"Because the results of drug-free treatment were disappointing and few addicts were being reached, Amsterdam reviewed its policy in the late 1970's towards a more pragmatic non-moralistic approach. The principle is: that if it is impossible to cure a drug addict one should at least try to create a situation that greatly reduces the risk that the addict harms himself or his environment".*
> (Bunning et al 1986)

In 1984 the Amsterdam Municipal Health Service in co-operation with the Association of drug addicts (Junkies Union) set up a needle exchange programme, on a new for old basis. By 1985 they were distributing 100,000 needles and syringes a year, as a measure both to halt the spread of HIV and as a way of attracting users into services. This also involved the distribution of oral doses of Methadone in syrup form (a non-injectable, long acting opiate) either in clinics or from a bus that stopped in various districts of the city

Needle Exchange Schemes

The Dutch Model was adopted firstly by the Mersey Regional Health Authorities Drug Training Unit in Liverpool where Britain's first needle exchange scheme started in 1986, dispensing a range of injection equipment, condoms and advice. At the time there were doubts over the legality of such schemes (Ashton 1987) and it was only after they had been in operation for some time that they became government sponsored experiments. The schemes proved a success in attracting clients not in contact with services (the Liverpool exchange attracted 57% not currently in treatment) and as importantly acted as a focus for the shift into harm reduction policies.

Maintenance Prescribing

Running in tandem with the syringe exchange schemes there re-emerged a willingness by some doctors to prescribe drugs to attract users into the service and as a means of stabilising their lifestyles, some even harked back to the 'British System' where they saw their prescribing as a way of competing with the illicit market, prescribing both injectable methadone and in some cases heroin, even heroin cigarettes. The majority in the early

eighties did not prescribe except on a reducing basis as part of a detoxification programme.

> *"The prescribing of opioid drugs to addicts, unless strictly controlled by the practitioner, may foment the growing problem of drug abuse, by increasing supplies to the illicit drug markets"*
> (The General Medical Council's submission to the Social Services Committee, session 1984-85)

> *"If you deliberately contrived so to do, it would be difficult to imagine a more unhealthy, more dangerous, more criminalizing, more socially destructive, more expensive, more efficient way of making heroin available than we do now under prohibition"*
> (Marks, 1987)

As can be seen from the opposing views above, there was never a consensus from doctors about prescribing. In the 1990's the view from the ACMD that there should be flexible prescribing has in reality meant that some users get long term maintenance doses (usually of oral methadone), others get no substitute prescription at all - but this depends on which part of the country they live in, rather than any particular needs. However, evidence is mounting as to the effectiveness of maintenance prescribing. A seven year US study (Ball and Ross 1991) concluded that methadone programmes reduce crime, drug abuse and other deviant behaviour, including a 71% reduction in injecting. In 1992 a study from Australia concluded that each year of methadone use was associated with halving a patient's illegal opiate use and criminal behaviour (Ward, Mattick, Hall 1992). The benefits of maintenance prescribing for both the drug user and society are now established. However, scientific evidence has seldom been responsible for drug policy, drug use is an emotive issue, attitudes and morals may well dictate future policy as they have so often in the past.

CHAPTER 3: DRUG EDUCATION

Drug Education

A popular conception of drug education is of some activity that goes on in a school, with the aim of stopping young people from using drugs. Whilst it is true to say that this is an over simplification and that the range of educational responses are extremely varied in both their aims and methods, there is also some truth in it. Drug Education is synonymous with Drug Prevention not just for the general public but for many people involved with it. As Les Kay states.

> *"'Prevention' has itself been mystified. For example, we assume prevention and education are allied and supporting concepts. Prevention and education may instead be mutually exclusive, antagonistic concepts".*
> (Kay 1986 p.10)

Formal Drug Education in Britain takes place as an activity almost exclusively in schools and for the most part is intended to stop people using drugs, even though the overwhelming weight of evidence suggests this does not work (Moskowitz 1983, ISDD 1984, Davies and Coggan 1992). Drug education does not take place in a vacuum; it is laden with all the value judgements of the society we live in. Drug Education is often held out as a way of preventing drug use in the same way a cross is held in front of a vampire, often with as much scientific basis.

> *"I do believe in primary prevention, I think it's like a religion quite frankly"*
> (Official of the Substance Abuse Office, quoted in O'Hare 1989).

Some of the more zealous drug educators in the U.S are aiming for 'zero tolerance' in other words they will not be happy unless there is no drug use at all. If however, one accepts that a drug free society is not possible then the setting of realistic targets becomes possible. For this to happen one would need to know present levels of drug use. Those campaigns that are evaluated have been heavily criticised (HEC 1985, Moskowitz 1983) for being less than rigorous in their methods of evaluation. Most studies, certainly many of those that are conducted to test the effectiveness of any particular campaigns, aim to measure a change in attitudes or behavioural intentions, their criteria for success being a shift in attitudes and intentions, but as McGuire states.

> *"Drug use is a matter of behaviour rather than a state of mind and so the pay off for a drug education program is actions, not attitudes....when the question is drug abuse, changing the person's attitude - even when it includes a change in the person's intentions regarding his own drug use - may be of only academic interest."*
> (McGuire 1974 p.1)

Official statistics only show the numbers using notifiable drugs (basically the opiates and Cocaine) and the number of people in treatment usually for the same range of drugs and

these are very rough estimates (the Home Office multiply them by five to give an idea of the numbers using). Prevalence Studies into drug use in young people of school age (Newcombe 1992a) indicate that the drugs used by a school age population are not the notifiable ones, but 'recreational' drugs such as cannabis, amphetamine etc. Newcombe's research also points to high levels of use with over a third of those sampled (15 to 17 year olds in Manchester) having experimented with drugs. There is to-date no national research of this type available so the extent of young peoples drug use is to an extent unknown. The problem with this is highlighted by one of the few prevention campaigns to claim success. The evaluation of high school pupils in Bowling Green, Kentucky U.S (Adams 1989), showed a reduction of pupils admitting to cannabis use from 45% to 30% over a five year period. However, it may be the numbers using has been reduced to above the national average, it is unlikely that a third of pupils using cannabis would be viewed as acceptable by most schools. It may be that even after rigorous research and evaluation reducing the incidence of drug use through drugs education is just not possible.

> *"The clear unpalatable truth, is that we don't know how to prevent drug use. We should stop colluding in the fiction that better prevention strategies could solve the drug problem. Better to be honest and say we don't yet know how to do it. We may also have to concede that it is just not possible, at the moment we are acting as if the prevention of drug problems must be possible. Prevention activities should be the product of scientific enquiry, not an act of faith".*
> (Kay 1986 p.10)

One of the major problems with drug education has been the lack of clarity in stating aims and objectives; in many cases these are assumed and not specified. The reality may be that only an aim of reducing the incidence of experimental drug use, would be politically acceptable. For a criticism of drug education it is only possible to look at the success in the stated or implied outcomes, that is a reduction in use or experimentation, but failure to achieve this does not necessarily mean that they are invalid in an educational sense. If for example, one accepts that raising self-esteem is a good thing, then it is a good thing regardless of its effect on drug use. Knowledge about drugs may likewise not have an effect on levels of use but this does not mean it is necessarily a bad thing for potential users to be informed of the effects of drugs. When referring to success or failure of the different types of drug education approaches it will be success or failure with reference to the reduction of drug experimentation or use.

'Shock Horror' approach

This has been the traditional drugs education approach and has worked on the assumption that information about drugs, or usually information about the dangers of drugs will stop people using. This is often taken to an extreme of showing dead bodies with the hope of scaring people out of their drug use. Research evidence from many sources says this is not successful (Kinder et al 1980; de Haes and Schuurman 1975; Schaps et al 1981; Bagnal 1991). Fear arousal has also been shown to be ineffective for a variety of behaviour change messages, psychological resistance can be built up if the

message is thought to be too horrific. This approach however has remained popular as it gives the impression that the provider of the message (the source) is taking a tough uncompromising stance to the use of drugs.

Information Approach

The factual information approach works on the premise that people do dangerous things like taking drugs because they are unaware of the facts and that acquainting them with the facts will make them stop. This argument is flawed in a number of ways. Firstly people do many dangerous things like climb mountains, parachute jump etc. by choice in the full knowledge of the dangers involved. Another problem is the ambiguity of a society that tolerates legal use of drugs with clear health risks such as tobacco that kills an estimated 100,000 people a year in the U.K. whilst making it an offence to possess a drug such as cannabis that has no clear physical health risks and has never reportedly killed anybody. Factual information approaches are often selective with the truth as Davies and Coggans state.

> *"Misleading assertions, such as passing off opinion as fact, will detract from the success of an educational programme, especially where the target audience is knowledgeable about the drug scene, as many young people are".*
> (Davies, Coggans 92)

Knowledge/Attitudes Approach

Similar to the information approach in practice, the knowledge attitudes approach has a slightly different theoretical model, one of which is Fishbien and Ajzen's Behaviour Intention Model (Fishbien and Ajzen 1975). This asserts that increased knowledge about drugs produces more negative attitudes towards use. The model assumes that behaviour is a volitional act and that the intentions to perform a given behaviour are the immediate determinants of that behaviour. Furthermore, intentions to engage in an activity are considered to be a function of attitudes towards the activity and related subjective norms. Schlegal and Norris (1980) found that only some beliefs were amenable to change and as has been stated earlier, even where attitude change occurred this did not lead to any change in intentions or behaviour. There is also some evidence (Huba et al 1981) suggesting that adolescent drug use is not a planned behaviour.

Values/Decision Making Approach

This approach focuses on the individual living in a drug using society and aims by the promotion of self understanding and decision making skills to reduce the likelihood of drug use. In a classroom young people are taught how to make autonomous decisions. In reality this means they are taught refusal skills, for the whole of this approach works on the assumption that the only valid answer to being offered drugs is to say NO. It is highly unlikely that if these skills were used to say YES that the programme would be tolerated. This approach also assumes that peer pressure is responsible for the majority of young people experimenting with drugs. As Davies and Coggan point out,

> *"While this may be true in certain cases, a generalised picture of teenage drug use as arising from the inability of naive innocents to withstand the pressures exerted by others does not conform to available evidence. People take drugs on purpose because they want to; and most young people who take drugs are attracted by the prospect of new and pleasurable experiences and a natural desire to find out 'what it is like'".*
> (Davies, Coggan 1992 p.77)

Behavioural Approach

This approach looks at skills and social competence and aims to increase the ability to cope with social pressure. Related to this approach is an approach where young people are thought to use drugs because of a lack of self-esteem. Horan and Williams (1982) found that a programme of assertiveness training could reduce the actual level of use of Alcohol and Cannabis amongst a group of high school students, however, as they point out the sample were 'relatively uninvolved with drugs' both before and after the programme and whilst the group that received the assertion training showed slightly lower levels of Alcohol and Cannabis use, they also had higher levels of heroin use. There is no clear evidence that low self esteem can lead to drug use, indeed the basis for this assumption is often that people of low self esteem will be influenced by their peers in a negative way, the most comprehensive study of this in relation to drugs (Kandle 1978) suggests that if there is a peer influence it is more likely to be positive than negative. There are many other criticisms of this approach.

> *"This model places little emphasis on structural factors such as environment, social conditions, class, race, gender, etc. as influences on or reasons for people making decisions about their lives. By not considering social factors and only exploring personal skills, it becomes easy to decide in what way an individual is deficient and needs 'improving' - the standard is the educator's own lifestyle and value structure. Accordingly, drug education strategies based on primary prevention view drug use as 'wrong' or 'deviant'.*
> (Clements, Cohen, O'Hare 1988 p.9)

The claims for any degree of personal autonomy in the decision making process are made a nonsense of by the limiting of the choice down to refusal. Indeed in a classroom where pupils are often told what to wear, to call teacher 'Sir' and are not attending by choice, the idea of any sort of 'empowerment' is difficult to comprehend. Again there is very little evidence that this approach has any impact on levels of use (Goodstadt 1981).

Other Approaches

The situational approach looks at decision making skills, where decision making skills become relevant to facts and feelings about a situation. This suffers from the same flaws as the decision making approach in that whilst there may be an improvement in

knowledge and decision making skills, the decision may well be to use drugs. Another approach is the so called 'alternative highs'. This works on the assumption that young people crave excitement and need to do potentially dangerous things to satisfy this. This is one of the few approaches that tends to take place outside the school and involves such things as 'bunge jumping' or rock climbing. There is no evidence to suggest that this results in any reduction in drug use or experimentation. The problem is that whilst young people may enjoy the activity, at the end of the day or weekend they return to their home environment where the influences on their drug taking are unaffected. A cultural approach looks at the individual's position in society and would take into consideration race, class income and economic power. There is no evaluation of this available and it is an approach rarely adopted.

Harm Reduction Approach

The harm reduction approach uses the same methods as many of the above approaches, the main difference being in the aims and objectives. Harm reduction aims to reduce the harm both to the individual as a result of their drug use and to a wider society, in the same way that 'sensible drinking' approaches would aim to reduce harm rather than stop the use of alcohol. To-date this approach has been slow to be adopted in schools although a harm reduction teaching pack has been recently produced 'Taking Drugs Seriously' (Clements, Cohen, Kay 1991). The reluctance to use the Harm Reduction approach comes from a fear of being seen to condone drug use,

> *"..will this approach encourage drug use amongst those who might not have otherwise tried drugs? In addition, even when drug educators are personally in favour of this approach, there are clear difficulties in targeting the group for whom this is most appropriate. Finally, there is the problem of the acceptability of the approach to parents, school boards and other concerned groups".*
> (Davies and Coggan 1992, p.79-80)

This argument may be relevant if levels of use are low but become difficult to sustain when, as in Newcombe's study, over 30% of pupils have experimented. To-date there has been no evaluation of a harm reduction approach to drug education.

One of the most recent approaches to drug education involves peer education. This involves all of the methods above, but the educator is a person of the same age and background as opposed to a professional educator. At present though it is still only possible to say that more is known about what doesn't work than what does. As Jasper Woodcock the director of the Institute for the Study of Drug Dependence commented at the 1992 European Drug Prevention Week Conference,

> *"We simply don't know how to prevent young people using drugs, but even if we did, think what that would mean, we would be able to manipulate the thoughts and actions of an entire generation, an absolute gift to a totalitarian regime bent on creating a race of obedient robots"*
> (Woodcock 1992).

CHAPTER 4: SMACK IN THE EYE

Smack in the Eye Background

The summer of 1987 saw The Lifeline Project in the sometimes painful process of shifting from a predominantly abstinence orientated service, to a predominantly harm reduction one. Like a few other drug services throughout the country, Lifeline was 'in the process' of setting up a needle exchange scheme, although it was a full year before it actually started. At the time harm reduction was seen as both exciting and dangerous (if we went too far our newly acquired funding could easily disappear). Although many people talked about harm reduction, few actually did anything. Lifeline had been given a grant by the Regional Health Authority to produce a leaflet on HIV/AIDS. The resulting leaflet, took a harm reduction stance and the form of a 'naughty' comic; 'Smack in the Eye'. The reasons for choosing to produce a comic are explored in the 'persuasive communication' chapter. The rationale for the comic to take a harm reduction stance, was the perceived threat posed by HIV/AIDS together with the failure of the abstentionist approach, as Gilman commented,

> *"Given drug users' dismissal of the more formal health education material, the style and content of a comic has to reflect aspects of the drug user's own milieu if it is to be valued by them. The reality of aspects of the social milieu of groups of drug users may be unpleasant to some, however, there is a significant lobby arguing that the presence of HIV infection poses such a fundamental threat to society that no risk reduction option should be rejected because it conflicts with our own feelings and attitudes to drug use".*
> (Gilman 1989 p.14)

The production of the pilot issue in 1987, was evaluated (Gilman 1987) and even though it was viewed by drug users in an overwhelmingly favourable light it took nearly a year before distribution was permitted by Lifeline's own management committee. During this time influential individuals, who could be affected or were likely to have to justify or pass judgement on the comic or Lifeline were canvassed. Public backing was seldom received; it was more a case that we were tolerated. An example of this was when it transpired that the Department of Health had been approached by an unnamed group with a view to stopping Lifeline's overall funding because of the production of the comic. The Department of Health did not back us publicly but quashed any threat to our funding and allowed us to continue producing the comic as an 'interesting experiment'. However, the hostility aroused in some professionals was matched by the support and fan mail the project received from drug users.

The comic acted as a useful exercise in boundary clarification. Before its production nobody seemed sure of the limit to which harm reduction materials could be taken (but many were convinced we had exceeded them). After 'Smack in the Eye' had been produced and we had 'got away with it', the ground was clear for many other harm reduction publications to follow. Above all 'Smack in the Eye' has acted as a focus for the

shift of Lifeline to a radical harm reduction service and inspired genuine missionary zeal in many of its workers. As Rowdy Yates the former director of Lifeline states,

> *"Many - including drug professionals - found 'Smack in the Eye' outrageous and disgusting. One said we were "degenerate scum". Another member of the Advisory Council on the Misuse of Drugs formally complained to the police. As a result two officers said they were considering prosecuting me under the Obscene Publications Act. I replied that I would be overjoyed to test the publication in the courts. They left bemused. I was so convinced of the virtue of the comic that I could not conceive I would be convicted. Probably more significant were the changes the comic brought about. 'Smack in the Eye' became a focus for our belief that Lifeline could, and should, be visibly, tangibly different from NHS services. It was also pivotal in altering drug users' views of the organisation. We began to be seen as 'on their side'".*
> (Yates 1993 p.13)

Smack in the Eye production

'Smack in the Eye' is produced as an action research project, that changes as the issues and concerns of drug users change. From issue three to date the production has involved an editorial board, made up of professionals working in the drugs and HIV field and current drug users. Topics are brought forward together with current knowledge of the changing drug scene. The author then researches, writes and draws the cartoons. The background research comes from current available literature and from speaking to drug users or more usually speaking to drug workers, researchers etc who have regular contact with the target group both in and out of treatment settings. 'Smack in the Eye' is currently produced twice a year, whereas the ideal would be a bi-monthly production. The main constraint to this is the time available for production. The comic is sold to other drug services who either give it out or sell it to drug users, this makes the comic self-financing and therefore under Lifeline's own editorial control.

Aims and Objectives

Outlined below are the original aims and objectives from 1987 (internal discussion document, M.Gilman), but as importantly, drug users had to want to read it and find it credible. This is explored fully in the later chapter on persuasive communication.

General Aims

a) To promote the theme that safer sex and safer drug use permit pleasure without regret and that unsafe sex and unsafe drug use is anti-social to the drug using sub-culture.

b) To establish an ongoing dialogue with potential consumers of drug services and their service providers that is educationally beneficial to both parties.

Objectives

a) To impart honest and balanced factual information.

b) To develop an appreciation of the diversity of options available which allows safe drug use and safe sex.
c) To stigmatise unsafe drug use.
d) To establish dialogue via the readers page with current drug users.
e) To encourage drug users to organise as the gay community have done.
f) To penetrate the drug using network beyond the 'first generation' distributors.

CHAPTER 5: PEANUT PETE AND RECREATIONAL DRUG USE

'Smack in the Eye' first appeared in 1987 as a response to the emergence of HIV/AIDS amongst injecting drug users. It has been continually adapted, through the nine issues to date, as patterns of drug use in the target group have changed. The early 1990s has seen an unprecedented growth in recreational drug use, latest figures from the University of Manchester to be published in October 1993 suggest that close to 50 per cent of teenagers aged 14-16 in urban areas have used illicit drugs (Kershaw 1993). Rather than widening the format of 'Smack in the Eye' to include recreational use, which would mean it is not as accurately targeted, Lifeline attempted to produce separate materials for this group of drug users.

The Emergence of the 'Rave' scene

The October 1985 edition of the magazine 'The Face', known as the 'style bible' of the eighties, contained a well-researched article 'Ecstasy, a Yuppie Way of Knowledge' (Nasmyth, 1985). This is widely believed to be the first reference to the use of the drug Ecstasy (now commonly called 'E' in street parlance) in Britain. Ecstasy is 3,4,methylenedioxymethamphetamine or MDMA, a synthetic drug of the methoxyelated amphetamine family. It is predominantly a stimulant drug although it is often described as a hallucinogenic amphetamine. This is not an accurate description, as it does not produce hallucinations. Shulgin describes it as an 'entactogenic'- it makes the user 'in touch' with their feelings and emotions and empathic to other people. For a full description see (Shulgin 1992). The family of methoxyelated amphetamines consists of over 200 such drugs. (fully described in Shulgin (1992). The parent drug of this family is MDA, or methylenedioxyamphetamine. MDA was widely used in America from the 1960's onwards and was known as 'the love drug'. The reported use of Ecstasy and MDA (sold as Ecstasy) in the late eighties in Britain was confined to fashionable clubs in big cities (Naysmth 1985). From these early reports the drugs used in what was initially the 'Acid House' scene (now more commonly known as the 'Rave' scene) evolved into the predominant youth culture of the early 1990's. Along with the use of Ecstasy, there were other drugs (sometimes referred to as 'Dance Drugs') that were equally popular, Cannabis, LSD and Amphetamine Sulphate, but it was the use of Ecstasy that was the catalyst for the rave scene.

> *"Loud, captivating music, psychedelic lighting, heavy use of dry ice or smoke, a tropical climate, and a mass of dancers are essential factors in sparking off the orgasmic 'trance dance' atmosphere sought by ravers, described as 'mental','happening' or 'kicking'. Comparing a rave to a disco is like comparing New Year's Eve celebrations to a quiet drink in the local pub"*
> (Newcombe 1992c p.26)

'Rave' is used both as a generic term to describe the sub-culture and is the name of dance events. The term 'Dance Drugs' will be used to describe the use of drugs such as Ecstasy, L.S.D, cannabis and amphetamine in a rave setting.

There was of course nothing new in the use of stimulant drugs used to aid all night dancing - the Casino in Wigan, now a popular rave venue, had been famous for this in the 1960's and early 70's. What (in Lifeline's and many other drug agencies opinion) is different is the numbers involved. The only figures available are estimates, the Rave Research Bureau estimated in 1991 that twenty to thirty thousand young people attended raves in the North west of Britain every weekend (Pearson et al 1991, from Ashton M, p.16). The proportion of these who use 'dance drugs' is unknown and can only be guessed at. We will come back to the question of numbers using later on in this chapter.

The initial concern over the use of Dance Drugs was media lead, where the 'Acid House' scene (new! sex, drugs, young people) was gratefully seized on by the tabloid newspapers, who printed such headlines as 'Acid Fiends Spike Page Three Girl's Drink' (The Sun 24,11,1988). At the time, although agencies throughout the North West were getting calls from worried parents and journalists, there was not one reported user of the drug being seen by drug services in the North West of England (N.W.R.H.A Database 1988). This presented a problem for drug services who had just come to terms with the threat of HIV and were concentrating their services on preventing its spread, only to be told there was a burgeoning drug scene for which they were not catering.

Target Groups,Group A and Group B

In 1990 Lifeline produced a report 'Seeing More Drug Users; Outreach Work and Beyond' (Yates, Gilman 1990). An integral part of this report considered how a drug agency might go about targeting under-represented groups. These groups included black people, women and young people whose drug of choice was not from the opiate group. In 1990 Lifeline's advice and counselling service had to move premises, the new site was a shop fronted premises in the city centre. The new site happened to be in the heart of the area where clothes and record shops were catering for the 'rave' scene. A scene that at the time was flourishing in Manchester to such an extent that 'Madchester' (as it was dubbed in the press) was seen as a national focus for the 'new' music, fashion and drugs. Faced with large numbers of young people engaged in drug taking literally outside of the window, Lifeline set about the task of trying to make contact with this group. These early contacts were often as a result of the young users being arrested, and facing trial. From these contacts it was possible to build an identikit profile of the target group:
Aged between 15 and 25 from working class backgrounds, followers of local football teams (increasingly associated with drug use) local bands and regular club goers; officially underemployed or unemployed but familiar with and occasionally involved with the workings of the 'irregular economies'. They had grown up with drugs throughout their formative years to such an extent that they viewed drug use as a perfectly 'normal' non-deviant behaviour. They used drugs such as cannabis, LSD, Amphetamine and Ecstasy, their drug use fitted into their lifestyle rather than the traditional client of a drug service whose life revolved around their drug use. They took drugs for 'fun' not because they were addicted. They were in short, hedonists living for the weekend, as an 18 year old raver states,

"However much money I had, I would never be as happy as I am on Friday, Saturday and Sunday"
(Quoted in Gilman 1991 p.16)

They were also far less likely to inject and therefore at lower risk of contracting HIV than an injector. They had quite strong anti-injecting and anti-'junkie' feelings. Their knowledge of both the drugs and drug laws seemed very patchy. They did not see drug services as being accessible to them as they were seen to be catering solely for opiate users.

It was clear that these young drug users were different from the existing client group of drug services throughout the country. They were also different from the target audience for 'Smack in the Eye'. In producing 'Smack in the Eye', a clear idea of who the target audience was, was needed. This was based on years of experience of clients coming into Lifeline's advice and counselling service, bail assessment programme and needle exchange, as well as contacts through research initiatives and outreach. We had statistics from the North West Regional Health Authority's Regional Database and a wealth of research literature. This picture of the types of users (as there are many) is constantly updated as new recruits come into the scene and as our existing target audience age and change. The picture that we have, admittedly, is mainly of drug users in treatment, but with the change in policy to the large scale provision of 'flexible prescribing' which has gone on since the inception of Smack in the Eye, this is an increasing proportion of the target audience. This change in policy for a number of drug users has meant a shift away from the patterns of use outlined in the earlier chapter and described fully in 'The New Heroin Users' (Pearson 1987)

"...the new heroin users soon found 'getting off' much easier than 'staying off'. Without something to fill the unemployment vacuum, daily heroin use "won by default" again and again. Spells in prison and treatment were the only interruptions to the busy drug-centred lifestyle. Then two things happened. First, many turned to injecting; second, HIV appeared and 'flexible prescribing' was adopted as a way of making and maintaining contact with opiate injectors. Easy access to substitute prescriptions is now well established in many areas, offering an 'early retirement' option for those tired of 'taking care of business'. Wholesale resort to this early retirement option has seen large numbers of (now not so new) heroin users shunted into therapeutic cul-de-sacs where they mark time, serviced by prescriptions and injection equipment. These clinical cul-de-sacs are seldom visited by today's prospective new heroin users. The "dangerous streetwise runts" have been neutralised. No more the attractive anti-heroes busily taking care of business; just normal people operating from within a legal opiate bubble."
(Gilman 1992 p.16)

The target group for 'Smack in the Eye' contains the older maintained user as well as new recruits to the scene who have gone straight into injecting drugs. This group has a range of demographic variables and personality characteristics. What would appear to be a common shared characteristic is that their drug use is central to their lives; they could be

described as 'career Junkies'. For the purpose of the publications Lifeline produce and for the evaluation of 'Smack in the Eye', it is their drug use that has been used to separate them from the group of recreational drug users. (See Methodology chapter)

These two distinct groups can be viewed as 'recreational' drug users and 'dependent' drug users. This definition presents some problems and is obviously a generalisation. The distinction does not necessarily come from the drug used, for with alcohol, an alcoholic uses drink in a very different way from a social drinker even though they consume the same basic drug. It also does not imply that recreational use is non-problematic, as with alcohol you do not have to be an alcoholic to experience or cause problems with drink. The distinction Mark Gilman made for Lifeline (Gilman 1992) was between group A and group B. Group A being the dependent injectors and group B the recreational users. For the purpose of the evaluation it was necessary to assess which group the user came from, so a formula based on the questionnaire was used (see Methodology chapter). There were of course overlaps of the two groups,

> *"In many areas these (groups A and B) are currently quite distinct groups, but they are interlinked. The clearest overlap is around the illegal nature of the drugs and some of the multi-commodity dealers that sell them. Overlaps involve friends and family members. The most pressing policy task I see is to keep the two groups as far apart as possible."*
> (Gilman 1992)

Peanut Pete

In 1990 with the opening of Lifeline's new city centre premises, an attempt was made to see if the lessons of 'Smack in the Eye' could be used to attract group (B) users into the service. Two stories from 'Smack in the Eye', 'The Time Tripper' - a story about a 'hippy' taking such a strong brand of LSD that he travels from 1969 to the present day, and imparts his knowledge of LSD and Ecstasy to a couple of young naive drug users and 'Call the Cops' a story on the cartoon cat, 'Tough Shit Thomas' being arrested, were reprinted on a simple A4 folded sheet and distributed to a record shop specialising in dance music and a stall in an indoor market selling clothes, records, haircuts etc. From this, it became clear that there was an overwhelming demand for such materials and that whilst it would be desirable to attract those most in need into the project, the numbers involved in this scene (group B) seemed so large*, that what we could most usefully do, was provide this group with information. A character who was based on an early client of the service was produced - 'Peanut Pete'

* The term 'large' is obviously a vague and imprecise indication of the number of group B drug users. However, there were few type B users in contact with services. The best indication of the rise in type B use comes from school based surveys such as Newcombe's (1992a) where over a third of 15 to 17 year old had experimented with a drug. We also have the 1992 Gallup/Wrangler (Gallup/Wrangler 1992) survey of 625, 15-24 year olds, which replicated a survey done in 1989. This shows that admissions of drug use virtually doubled from 15% to 29% (as has been stated, use in this group is of what

we have described as dance drugs). The annual report from Exeter University's Schools Health Education Unit (Balding 1991) shows an equally dramatic rise; cannabis used by 1 in 50 of 14-15 year olds in 1988 rising to 1 in 10 by 1991. For harm reduction materials such as Smack in the Eye, the targeting through drug services means there is little leakage of these materials to non-users. With materials such as 'Peanut Pete' distributed in a variety of outlets, the likelihood of non-users of school age seeing them is great. Here the number of users becomes vital. If the reported use was, say 1%, it would be hard to argue that harm reduction was appropriate to all pupils, but with figures as high as 30% and no indication of the rise slowing, it becomes a more rational argument to provide harm reduction information to all young people. To give some idea of the numerical contrast in the two groups we can look at the sales figures for 'Smack in the Eye', aimed at group A and 'Peanut Pete' aimed at group B. 'Smack in the eye' is produced twice yearly and sells all of the 6,000 copies it prints. 'Peanut Pete' has sold in excess of one million leaflets in the last year.

'Peanut Pete' as an action research project

The production of 'Peanut Pete' leaflets, is part of an action research project. Information from users of the service, together with reports from workers and volunteers at clubs and raves is used to buy credibility with the target audience and to highlight problems. The leaflets are culturally specific to such an extent that somebody not familiar with the jargon, humour and context, (i.e. outside the target group), would have trouble understanding them. Distribution takes place through record/clothes shops, at raves and clubs, through rave organisers mail shots etc. They are also sold to numerous outlets throughout the country. There have to date been seven leaflets covering topics such as the law, paranoia, excessive use, avoiding group A use and heatstroke.

There have also been attempts to target young women in the scene. A group of young women users were brought together to aid in the design of a set of postcards. There have been materials aimed at football supporters which were put into football fanzines, a book produced for BBC Radio One that is now widely used in schools (The Big Blue Book of Dance Drugs, BBC/Lifeline 1992) and numerous other adaptations of the format.

Aims and Objectives

The overall aim of the leaflets is to reduce the harm from drug use to both the client group and the wider society. The objectives have developed and changed along with the changing information we have from the target group.

* Initial objectives: to produce credible and accurate information that is acceptable and read by the target group.
  Information covered:
  Drugs and the law
  Paranoia as a result of excessive stimulant drug use
  Set and setting with hallucinogenic drug use
  Adulteration of drugs
  Heatstroke due to stimulant drug use in a club setting
  Drug information
  Neurological effects of MDMA use

* Repeat and reinforce safer drug using patterns, discourage more harmful types of drug use

* Make drug services appear relevant to the client group, with the hope of attracting users to the project.
  (Whilst this is still valid for some users, for the majority the provision of accurate, credible information is most relevant).

* Encourage negative attitudes towards group A use, with the hope of preventing any widespread movement from group B to A

To-date there has not been any formal evaluation of this project.

CHAPTER 6:
Persuasive Communication theory applied to Lifeline's harm reduction comics

McGuire's Model

'Smack in the Eye' was initially produced as an experiment that seemed a good idea; it was then evaluated by showing it to a group of drug users (Gilman 1989) and adapted into an action research project. It has been seen as a success with drug users, measured in terms of feedback to the project, fan mail etc. and importantly has been financially viable (it is sold to drug agencies all over the country). Whilst much of the thinking behind the comics relied on intuition and common sense, it has been possible to theoretically test the comics to see if they are effective using existing models of persuasive communication. There is not a model available to theoretically test harm reduction materials - the nearest being McGuire's, Communication-Persuasion Model for drug education (McGuire 1974). McGuire's model uses research that often comes from the laboratory on the ways in which persuasive communication changes attitudes and behaviour and applies these to the area of drug education that is designed to stop use and experimentation (primary prevention). The communication has five main aspects: (1) The characteristics of the perceived source, that is, the individual or individuals to whom the recipient attributes the message: (2) the characteristics of the message itself, that is what it contains and how its contents are presented: (3) the aspects of the channel or medium through which the communication is transmitted: (4) characteristics of the recipient of the message and (5) characteristics of the destination or target variable, that is, the kind of effect that the message is designed to produce.

1) Characteristics of the perceived source (source variables)

One of the initial tasks when producing 'Smack in the Eye' was to change the image of the Lifeline Project. It seemed from anecdotal evidence that drug users saw Lifeline as an agency that was abstinence orientated and therefore only of use if you wanted to give up or were forced into giving up temporarily by an impending spell in prison. With the increased professionalism brought about in the mid 1980's by the influx of workers with a qualification in one of the health or social services, there was also a danger of Lifeline being seen as another branch of the Social Services with all the perceived mistrust of authority this implied for drug users. Our first task was then to change the perceived image of Lifeline so that we were seen to be 'on the side' of drug users.

Source credibility

Source credibility is how expert or trustworthy the perceived source (who the receiver of the message thinks is giving them the message) is thought to be by the receiver of the message. This means that source credibility is achieved if the source is a recognised expert and not perceived as warping the truth due to self-interest. The target audience for the comics is primarily existing drug users; one of the questions in the evaluation in the later chapter is designed to find out who they think is both expert and trustworthy. Our

conjecture was that drug users would not trust official sources such as the Government or the police as they would be seen to be warping the truth due to self interest, in other words they had not given factual information in the past but had engaged in anti-drugs propaganda by over stating the dangers. This was reinforced by the initial evaluation of the pilot issue of S.I.T.E. where there was "unanimous suspicion of 'official' messages" (Gilman 1989 p.43). The format of the 'naughty' comic was designed to distance itself from official sources and the evaluation of the pilot issue seems to have confirmed that this was achieved (Gilman 1989). It was also seen to have been 'on their side' and therefore trustworthy. The perceived expertness of the comics came from cashing in on a detailed knowledge of both the drug scene and the drugs themselves. Fundamental to this was the portrayal of drug use as 'normal'.

> *"In-depth conversations with this group (the users interviewed about 'Smack in the Eye' suggested that just as advice on contraception has to start from an acceptance of sexual activity as 'normal', so harm reduction messages and advice have to come from a user friendly and non-judgemental agency which accepts drug use as an activity that may lead to problems but is not in itself pathological behaviour"*
> Gilman 1989 p.10).

Source attractiveness

Source attractiveness can be seen as how the source relates to the receiver in terms of similarity, familiarity and liking. According to Byrne (1971) the closer the similarity between the source and the receiver the more persuasive the communication. As with satire, in the use of the comics the closer we can reflect the lifestyles of the user the more effective the communication becomes. It is of course not quite as simple as that, as McGuire points out.

> *"Does this mean that a communication warning against drug abuse is most persuasive to twelve year old recipients when the message is attributed to twelve year olds rather than say, to the Surgeon -General of the United States, one's high school coach, or a world famous hockey player? Not quite. We must bear in mind that other aspects of the source are also important, such as perceived expertise ...in this case, it would follow that twelve year olds would be more influenced by those they perceive as slightly older than themselves"*
> (McGuire 1974 p.5)

The comics have often used an older drug user with novice drug users in cartoon strips, as both a trustworthy and expert source. For 'Smack in the Eye' the character of 'Grandpa-Smack Head-Jones' was used as a wise old drug user who could impart information to younger users. The initial evaluation of the comic found that most drug users get their information from other more experienced users, (Gilman 1989) although they had a great deal of detailed information there were also examples of dangerous information that had become part of 'junkie folklore'. As one respondent reported by Gilman (1989) commented:

> *"I went over the other week (overdosed) and I was with this young kid who didn't know the crack so the next thing I know I'm in the fucking hospital...This is what I mean about these kids, if they knew the crack they would have just given me a good kicking or something to bring me round 'cos you can tell when someone's properly dying or just over can't you...either way you can always leave 'em in a phone box"*
> (p.55)

Source attractiveness can be seen in terms of similarity, familiarity and liking, for a group that has been so disliked and shunned by society, as have drug users this seems particularly important. Kar terms it as 'social class distance'.

> *"The communication is likely to be more effective if the communicatee has a high level of identification with the communicator and share common values; similarities in sex, age, social class, etc. can enhance this identification. Similarity in dress patterns, religion, patterns of aspiration and language could also contribute to levels of identification with the source".*
> (Kar 1976)

The services that have the job of dealing with drug users, the Police, Probation, Doctors, Health Service etc. do not generally accept that drug use is a valid way of life and aim to take away the liberty or lifestyle of the drug user. Certainly in terms of the traditional Opiate injecting drug user, messages perceived to be from one of the above mentioned statutory services would struggle to be seen as an attractive source for a persuasive communication. Messages from these sources would have to rely on 'sleeper effects'.

> *"...if warnings about drug abuse are attributed to a source that is authoritative but so different as not to inspire trust, the immediate impact may be depressed by suspicion about the source, but with passage of time it will gain in impact due to disassociation from this dampening source factor"*
> (McGuire 1974 p.11)

The Sleeper Effect

Hovland and Weiss (discussed in Kar 1976) conducted experiments in the 1950's into what became known as the sleeper effect. In these experiments they gave information to a group from a perceived high credibility source and a perceived low credibility source. They found that although the same amount of information was acquired regardless of the credibility of the source, the group agreed with and found the high credibility source more trustworthy and believable. After a period of four weeks however, the extent to which they tended to agree with the high credibility source had lessened whilst they tended to agree more with the low credibility source. This was due to them forgetting the source of the communication. Hovland and Weiss hypothesised that there were conditions that could remove the sleeper effect; if the message was repeated or if the source and the position advocated are so intimately linked that the recall of one evokes the other. The comics

with their strong visual impact may fill this criteria and are designed to be produced regularly (though not every four weeks) however, we are aware that the comics are often collected and re-read more than a pure text based leaflet would be, so it may be that the sleeper effect is removed by the visual impact and 'naughtiness' of the comics, by their regular production and distribution and by the common practice of collecting and re-reading them.

Source Power

In McGuire's model the third source variable is source power. This is the degree of perceived power the source has over the receiver of the message. Compliance with a message while under the scrutiny of a powerful and concerned source is of much less use than an internalisation of the message or internalised attitude change. For instance if a drug user were told that his drug use was harmful to himself by a judge who then sentenced the drug user to a spell in prison where (in theory) he could no longer use drugs, the net result would be behaviour change, but only if this behaviour change were internalised would it be likely to continue on release. They would have to develop a belief system that justified the new behaviour. This is only likely to come about if the person believes that the overt compliance had been perceived as (a) having serious consequences on the person's own life or on others; and (b) having been to some extent due to their own volition.

2) Message factors that Affect Persuasive Impact (Message Variables)

Message variables include such things as positive or negative (fear) appeals, as has been mentioned in the earlier chapter on drugs education it has been shown that fear arousal is counter productive and can produce psychological resistance to a message so the obvious solution is to go for positive appeal. In terms of discouraging drug use, this would take the shape of offering 'alternative highs' or some positive aspect to life without drugs but with harm reduction this becomes more complicated. A positive message to an injecting drug user may be, for instance, the promotion of a non-injectable drug such as cannabis. The pilot issue of 'Smack in the Eye' had this message but was taken out at the insistence of Lifeline's solicitors (the first and only time they were asked for an opinion) an even finer line could be drawn by encouraging a Heroin injector to smoke their drug; this message was put out in the pilot issue and was one of the areas that the police saw as possible grounds for taking action. However, the message was thought unrealistic by users, so it was dropped anyway.

What should be included in a message?

According to McGuire's Model for drug education (McGuire 1974) stating a conclusion and giving both sides of the arguments would be included in a message for drug education. Stating a conclusion, is where the message is explicitly spelt out rather than implicitly implied, e.g. this is what X does to you therefore do or don't do X. Giving both sides of the argument is about giving a one sided or two sided message. An example of this might be if you were trying to encourage condom use, how much would you say about failure rate.

Research tends to be inconclusive as to two sided versus one sided (Kar 1976) but put into the context of information for existing drug users, who have been the recipients of drug education which bears little or no relationship to their often high level of knowledge about certain aspects of drug use, any attempt to present a one sided argument would lose all credibility.

> *"The 'germ free' message which ignores the opposition arguments has been found more effective than the message that refutes them as far as immediate impact on receivers' beliefs is concerned; but the mention and refute messages are far more efficacious in conferring resistance to the subsequent counter-attacks favouring experiments with drug usage, and in our society likelihood of exposure to such attacks is high".*
> *(*McGuire 1974 p.7)

Ordering of Effects

In McGuire's model for primary drug prevention, 'ordering of effects', would mean, in what order you stated the positive and negative aspects of drug use. His view is that it would depend on the initial position of the audience with a naive audience warning of the dangers first may have more effect whereas with an audience 'favourably disposed' to drug use, "mention and refute opposition arguments first" (McGuire 1974 p.7). It would be harder to find a group more favourably disposed to drug use than the audience for 'Smack in the Eye', so the positive effects of drug use are included first in most story lines.

Positive appeals

Positive appeals in terms of McGuire's primary prevention model would be more effective than negative ones, however as he states.

> *"....it is a tall order to produce a drug education campaign that stresses the benefits to be gained from not using drugs, since many segments of the population particularly prone to drug abuse come from environments that are economically, emotionally and recreationally impoverished. It is a grim challenge for the communicator to describe to this target audience everyday pleasures accessible to them if they avoid getting hooked on drugs".*
> (McGuire 1974 p.8)

This does not prevent such a problem for a harm reduction message, as the choice is not between use and no use. The aim has never been to present an alternative to use, rather to find ways of continuing or maximising pleasure, whilst reducing harm. For example the use of one particular drug by one particular method of administration can be substituted by the same or another drug used in a different, less harmful way. A relevant analogy was made by a Dutch journalist who worked for a lifestyle magazine for drug users produced in Amsterdam. Their magazine never had more than 30% of content related to HIV, because it would be like producing a motoring magazine and having it full of car crashes.

Message style

This is one of the factors in McGuire's model, which is of vital importance in relation to 'Smack in the Eye'. The use of comics in health education is fairly well documented (Leather, 1980). The decision to use this format came about because of a number of factors. Firstly because of the nature of the new contact with IV drug users in the late 1980's through needle exchanges, the contact that workers had with users was normally fleeting; users of the service did not come for counselling but to receive injection equipment and therefore the opportunity for inter-personal communication was limited. The option was narrowed to something that could be thrust into the hand of users of the exchange (see channel variables). It was noted from the experience of workers on needle exchange schemes that existing text based materials were discarded immediately the user left the exchange. From the Evaluation of the pilot issue (Gilman 1989), it was apparent that the target audience found the text based materials boring. In choosing to use a comic format it allowed us to do several things. It was a style familiar to our target audience through the success of adult comics such as 'Viz'. There is a history of underground 'head comics' such as 'The Fabulous Fury Freak Brothers' from America, where there is a tradition of comics about drug taking and drug takers. The use of comics also had a long tradition of being anti-authoritarian, which allowed us to distance ourselves from official sources. It was comparatively easy to make the comic format culturally specific, for example where a text could describe a person taking a drug, in a certain setting, wearing certain clothes, thinking certain thoughts etc. the comic format allowed us to show this in one picture. Humour is often part and parcel of a comic book format; this not only entertains the audience, but also allows the use of quite grotesque imagery without it being seen as 'shock horror'. From anecdotal evidence it became apparent that some people outside of the target group read the comics as 'shock horror' style primary prevention, whereas those within the target audience understood and laughed at the grotesque. An example of this can be found on the cover of 'The Big Blue Book of Dance Drugs' where a man's brain is seen exploding from his head as a result of the drug he has taken (Appendix XVII). This can be viewed as the terrible consequences of drug abuse or alternatively as the desired 'buzz' from the drug of choice. Sexually explicit materials are often clearer and easier to accept if illustrated with drawings and text rather than text alone, the use of the comic format can be made to be either erotic (Appendix XVIII) or humorous (Appendix XVIIII), rather than sterile and 'sexless' as is the case with some of the more traditional sex education illustrations. As has been mentioned with relation to the sleeper effect, there is also a tradition of keeping and reading comics. Above all, regardless of content, unless our materials were read they would have no impact, so we had to make them entertaining.

(3) Channel Factors that effect Persuasive Impact: Channel Variables

The channel of communication can be seen as the medium, through which the message is transmitted, this can be divided into two categories: interpersonal communication and mass communication or mass media. In order to be effective any communication must fulfil the following criteria: Exposure to the message; level of interest in the subject matter

to ensure complete exposure; comprehension of the communication and assimilation or internalisation of the message (Kar 1976).

Interpersonal communication is where there is a face to face exchange between the communicator and the communicatee; this can take the form of a one to one session or conversation or a talk or group discussion etc. The important factor is that there is the opportunity for the communication to be 'two way'.

> *"Research in this area suggests that interpersonal approaches which include a two way dialogue and a group setting can be more effective than a one way communication in changing attitudes and behaviour"*
> (Kar 1976 p.29)

Mass communication as the name applies, takes place on a large scale, and involves largely a one way communication. Any media which can be used for this purpose is called mass media i.e. T.V. radio, printed materials. Obviously because of the scale, it reaches far more people than an interpersonal communication but as has been stated above, is less effective at attitude and behaviour change. It is most effective at imparting information.

From this it would be safe to assume that 'Smack in the Eye' is most effective at getting information to drug users. Given that our original Aims and Objectives did not assume that reading a comic would lead to behaviour change and any form of behaviour change with drug users is extremely difficult to both achieve and demonstrate, this seems a realistic aim: drug users get reliable trustworthy information, we may be attracting them to or at least informing them of services and whatever factors bring about behaviour change in this group, information must be a starting point. But, without some behaviour change in this group, however it happens, drug services must be seen to have failed. This will be discussed under destination variables.

Group B Targeting

The use of harm reduction comics in the 'rave' scene by group B users, although similar, in that we produced credible, culturally specific comic based materials, can be viewed in a slightly different way. From what we know of this target group, on the positive side we assume this group to be less at risk of contracting HIV, they seem to use fewer drugs in a less problematic way and are less entrenched in their behaviour. However, they are not as likely to be in contact with services, are younger and know less about their drug use and (if our estimates of prevalence are correct) are in such numbers as to make the idea of a group of professionals using interpersonal communication impossible. Again the provision of information has been seen as vital, particularly as this group seemed to have less knowledge and there were few if any other sources of information available for them. Their drug use although not exclusive to raves and clubs was much more of a group activity and part of a lifestyle that is hard to separate from fashion and music. This enabled us to give out information leaflets in huge numbers; it has also been possible to hypothesise on a possible form of behaviour that we could influence.

Diffusion of Innovations

The 'Rave' scene like many of its predecessors such as punk, mods etc. is fashion- lead. Wearing flared jeans in 1993 at a club in Manchester would get you laughed at, whereas in 1990, everybody in that club would have worn them. The wearing of flares did not spontaneously erupt so that people awoke from their sleep to find a pair of 16" trumpet flares under their pillow. A few fashion leaders started to wear them and it caught on in the clubs, from there quite ordinary people on the streets started to wear them until they end up being sold at high street shops. Rogers and Shoemaker (1971) describe this process as a diffusion of innovations; in their model the innovators and early adopters (opinion leaders, fashion leaders) can be influenced by outside influences, this is often from the mass media; in terms of fashion it would be style magazines etc. They then influence their peers who are early adopters who influence the early majority and so on. The information the later adopters receive is the same as the early adopters and innovators but they are largely influenced by interpersonal communication or a process such as Bandura's concept of modelling (Bandura 1977). The drug use of young people in Britain in the 1990's is diverse, but for large numbers it is a part of their lifestyle hard to separate from music and fashion. It is our hypothesis that, if our materials aimed at recreational users are successful in re-enforcing the positive aspects of the innovators and early adopters, it is possible that the comics can be viewed as an innovation themselves,

> *"The inventor(s) or writer(s) of the material may be considered the innovator and the material itself the innovation".*
> (Macdonald 1992 p.192)

In diffusion innovation theory a change agent or project/research worker employed to promote or monitor an innovation practice or programme can play a positive role in diffusion and adoption. This process is enhanced if there is homophily (mutual respect, similarity of class, age etc.) between the agent and the target group. It is possible to view the workers and volunteers at clubs and raves who distribute the materials in this way. It may be that we can have an impact on the drug using sub-cultural norms (the normative system) of the wider group of users. We have tried to reinforce and define taboo or frowned on behaviour amongst this group. Whilst acknowledging the importance and pleasure of their drug taking, our message for this group (group B) has been about avoiding group A use, by not injecting and not using heroin or rock cocaine. There have been attempts to influence the normative system (what is considered normal, acceptable behaviour) in the past. By changing the normative system it is hoped to make a particular behaviour seem deviant. This can obviously back fire if the (now deviant) individuals are made to feel isolated and unable to seek support as they are shunned by their peers, but if the choice were a small number of individuals moving from group B to A this would be infinitely preferable to the whole group moving en masse.

4) Receiver Factors that Affect Persuasive Communication (Receiver Variables)

Receiver variables can be classed as the personality characteristics of the target audience of the intended message. This has been discussed in the section on message variables in terms of the audience being favourably disposed to drug use, but includes such things as age, social background, intelligence etc. McGuire states that anxiety arousal should be kept low when there is a feeling of vulnerability to illness or death, but where there is a complacency to illness and death higher levels of fear arousal can be more effective. This is a problem for harm reduction publications, because of the overwhelming amount of 'drugs mean death' opinion prevalent in both the media and from various official sources, it is difficult to warn of real dangers as there are so many people 'crying wolf' or claiming all drugs lead to addiction and death. It is the author's opinion that credibility needs to be established first: you would need to tell the truth about the real pleasures as well as dangers before a message of death or illness would be taken seriously with an audience already experienced in drug use. This also backs up an earlier assumption that you would need to distance yourself from the official sources which put across the drugs-death message.

For a description of the target audience characteristics see previous chapters.

5) Destination factors that Affect Persuasive Communication (Destination Variables)

Destination variables would include general effects beyond the specific target issue and the delayed impact (sleeper effect) mentioned under Source Variables. We will consider the type of behaviour change under Output factors.

Output Factors

If the five previous aspects of the communication are the input factors, then the output factors are the target behaviours that the communication is designed to affect. McGuires Communication-Persuasion model contains the separate sub-steps of the output side of the persuasion process.
(A) Assuring exposure to the message: If your target audience are not exposed to the message the impact will be zero. The aim of the comics was to be as accurate as possible with the target audience, in other words knowing who you're aiming your message at.

(B) Assuring attention to the material: No matter how worthy the material it has to be not just of interest but interesting.

(C) Assuring comprehension of the material: The materials must be understood, in general the higher the intelligence of the audience the better their comprehension of the message. There is of course a balance to be struck, aiming at the lowest common denominator or least intelligent members of the target audience could alienate or patronise the more intelligent and aiming at the most intelligent could mean that the not so intelligent do not understand it. 'Smack in the Eye' gets round this by having a variety of styles and

messages on different pages and the use of cartoons allows quite blatant, simple messages to be put across, using simple language.

(D) Assuring acceptance of the conclusion being urged: This is the most dramatic step in the process so far and would involve many of the steps already outlined, as McGuire states,

> *"For example, acceptance can be enhanced by making use of source characteristics such as credibility, attractiveness and power. Message factors in the drug education programme are extremely rich in suggesting ways of motivating acceptance of the conclusion".*
> (McGuire 1974 p.15)

(E) Assuring retention of the agreement elicited: This is the short-term impact of a message as opposed to its long term or permanent effects.

(F) Assuring action in accord with the persisting attitude change: As has been stated earlier, it is actions that are the payoff with drug use. Behaviour change with drug users is both difficult to achieve and to measure, even where there is behaviour change it is hard to pin down the cause or causes of change as the target audience are exposed to many influences. It is however possible to speculate on both the type of behaviour change that is involved and what likely influence 'Smack in the Eye' may have on this. If 'Smack in the Eye' has had an influence on behaviour, it is likely to have been a contributing factor. It could serve to reinforce a decision to act in a certain way, it could act as a catalyst, it could work on changing group or sub-cultural norms, in short it could have a delayed impact and be indirectly responsible for a change in behaviour. To find that the comic was directly responsible on its own for a major behaviour change would be very unusual.

What is the nature of the behaviour change that 'Smack in the Eye' is most likely to contribute to? A useful model can be found in Lifeline's own Prevention Development Report (Lifeline 1988 p.23) 'The Hierarchy of Harm' (fig 4). For a drug user to move from daily poly-drug use to abstinence is a major behaviour change, which would involve a change to most aspects of a user's lifestyle. Probably a more achievable change would be a minor change to patterns of drug use, something that could be easily achieved by the drug user without drastically affecting their lifestyle - not sharing injection equipment is just one such minor change, but one which would have major impact. In a harm reduction model, success in terms of behaviour change can be seen as a move down the scale.

(fig 4)Hierarchy of Harm

HIGH Poly-drug use of impure synthetic substances by communal IV administration with poor injection technique and alcohol consumption.

As above using own IV equipment.

As above without Alcohol.

As above using less dangerous substances

INJECTION BARRIER

Smoking heroin

Oral Methadone

Oral amphetamine

Smoking Pure Cannabis

LOW

Total Abstinence

Each point on the scale represents a potential reduction in harm. Within each point there may be further potential for reducing harm when one considers factors such as quantity and frequency of use, attitude of use, legal considerations, attitudes/concerns of family, friends and wider society, type of housing and access to hygienic conditions etc.

In short this diagram shows the stages that could be passed through on the road to abstinence or could be defined as ends in themselves and therefore as criteria for measuring/evaluating the success of interventions.

The Communication-Persuasion model of McGuire's is designed for use in primary prevention and although it is designed to change attitudes, as he acknowledges, attitude change does not have a clear relationship to behaviour change. Given the difficulty already mentioned in both measuring and changing behaviour, it is a useful model for theoretically testing 'Smack in the Eye' or any other drug education materials, particularly those used outside of a school setting, to see if they are effective communications.

CHAPTER 7: METHODOLOGY

Current Drug Research

One popular definition of a drug is

> *"Any substance taken by a young person that gives rise to an academic paper"*

There are a number of ways information is obtained on drug use. Forensic analysis can provide information on purity and composition of drugs. With few exceptions this knowledge is only available to the police force who rarely share it with drug services. Clinical trials on the possible effects and side effects of illicit drugs on humans is again rare and often prohibited under the Misuse of Drugs Act. There are exceptions to this, for example Shulgin, who provides detailed information on a range of psychoactive drugs (Shulgin 1992). The problem with this information is it takes no account of what Zinberg would describe as set and setting (Zinberg 1984). For example American research told of the effects of using MDMA or Ecstasy in therapeutic settings, but this did not help when the drug was used in the British 'rave' party setting and did not explain the deaths associated with the drug. For this we had to wait until a team from The National Poisons Unit had examined the bodies (Henry 1992).

Another source of information available is the official statistics; these comprise of the Home Office Index that was designed to stop a drug user from obtaining drugs from more than one doctor. This has been used as a way of estimating numbers by multiplying by 5 (though the original figure was supposed to be multiplied by 5 to obtain the number of users in treatment, not an overall number of users). This is being replaced by a data base system which, although an improvement, is still only a measure of drug users who seek help from services. To get some kind of overall picture of what happened last year (as the figures are always a year behind) the amount of drugs seized by police and customs, the number of arrests under the Misuse of Drugs Act and the Home Office index are added together to give some figures that are an indication of prevalence. Other indications of prevalence come from schools based surveys such as (Newcombe 1992a) and (Balding 1991). These are the best indications of the use of non-notifiable drugs that we have.

Research is also available from treatment centres (usually regional drug units, run by psychiatrists) this has traditionally taken the form of studies to find out if the treatment has been successful. One major flaw in this type of research is that it has concentrated on the unrepresentative sample of chronic, usually opiate, injectors who get this far through the system.

Ethnographic research gives us a picture of what is happening, but even research such as Pearson's, 'Heroin Users in the North of England' (Pearson 1987) which was completed in six months, could not have kept pace with the rapidly changing "Rave scene". It is information about what is currently happening that is of most use. This has traditionally been gleaned from clients by drug workers, who generally carry round a wealth of

information in their heads that is rarely formalised in any academic way. The last couple of years have also seen the appointment of outreach workers, some of whom have provided valuable information about users not in contact with services.

For us to provide useful information, that can be fed back to our target group in a credible form, it must be up to date. Information even a year old could be flawed to an extent where it would lose the credibility with the target group, that has proved vital in our mass media campaign. For this reason it is anecdotal evidence from workers that is as important as anything else in informing the comic production.

Evaluations of prevention initiatives tend to focus on knowledge, attitudes and behavioural intentions, as has been stated by McGuire,

> *"Drug use is a matter of behaviour rather than a state of mind and so the pay off for a drug education program is actions, not attitudes".*
> (McGuire 1974 p.1)

Behaviour change is hard to measure and even harder to attribute to a single source. A reduction in problematic drug use and high-risk sexual behaviour, although desirable, was not felt to be realistically achieved by the comic alone. However, an attempt at measuring any change and attributing the source of that change, was deemed desirable.

'Smack in the Eye' can be seen as an action research project, its production relies heavily on anecdotal information that often only exists in the heads of workers in the field and users in contact with the project, informal feedback on the comic takes places all the time. The prevention development officer for Lifeline also produced an evaluation of the pilot issue that involved semi structured interviews with thirty drug users (Gilman 1987). Part of the reason for choosing to use a postal questionnaire was because of the richness of ethnographic research and anecdotal evidence the project has on the comic. It was, however, the opportunity to use the network of distribution points throughout the country and the size of the readership of the comic that made the choice of a questionnaire an obvious one. A large sample size could be hoped for and the evaluation would be national. This was important, as 'Smack in the Eye' is a National publication.

Postal Questionnaires

The postal questionnaire is a fairly normal method for magazines assessing their readership. The use of them with current drug users, who after all are involved in an illicit activity, is however very rare and for this reason it was extremely difficult to gauge what the response rate was likely to be. The sample represents a good cross section of the actual readership and probably a good cross section of drug users in contact with services. It is not representative of drug users as a whole, as drug services cater mainly for those users described as type A users and are probably under-represented by women.

A postal questionnaire had been used twice before in connection with 'Smack in the Eye', but both of these were targeted at drug workers from agencies who receive the comic, the

questionnaires were not included in the comic, but addressed specifically to the workers in question.

Aim of Questionnaire

The questionnaire was designed with the main purpose of discovering the information needs and sources of the client group, to see if 'Smack in the Eye' was a perceived high credibility source of information and if any behaviour change could be detected and attributed to the comic. The secondary purpose was a content analysis of issue 8.

Pilot Questionnaire

The questionnaire was piloted using a drug users group in Manchester. Eight pilot questionnaires were returned with comments from the respondents. The pilot had asked questions about the comic reflecting the lifestyle of the respondents, but this was felt to be confusing by some, this was replaced with question 9, on the final version which was asking which of the sources of information provided the most accurate information. Other changes involved making the questions simpler.

Questionnaire Design

The questionnaire is four sides of A4 asking seventeen questions in all. Most of the questions are multiple choice, but there is room provided for more detailed answers and comment on some sections. The questionnaire is arranged with simple questions first, followed by more detailed questions with the demographic questions last. The questionnaire does not ask for details of respondent's name or address, only the area of the country in which they live. As part of the questionnaire a tear off strip is provided, which enables the respondents to enter a prize draw for a ú200 holiday voucher. The questionnaire and prize draw is advertised in the comic after a cartoon strip about a character 'Tough Shit Thomas' going on holiday to Amsterdam, a popular destination with many of the target group. A Freepost envelope was also provided for the completed questionnaires. There was not a covering letter provided for the agencies who buy the comic, it was just inserted into the magazine itself.

Criteria for Groups A, B and C

Smack in the Eye is aimed at group A (see Target groups A and B, pages 50-54). From anecdotal evidence it was apparent that some drug users outside the target group were reading the comic, this appeared to be because they were generally interested in drugs and had read the Peanut Pete range and wished to read 'Smack in the Eye' and as importantly were now more likely to be in contact with a drug service. For this reason several storylines for this group, group B, had been included in past issues. It was decided that splitting the groups into group A and B, would make an interesting comparison and would also test the validity of the specific targeting of these groups.

It was assumed that the extremes of type A and B users would be easy to spot through their drug use, for this reason drug use and injection were used as the criteria for separating the groups. The extreme of group A would always inject and use a variety of dependence producing drugs everyday. The extreme of group B would smoke cannabis and no other drug and never inject. Therefore anybody who said they always injected, would be classed as Group A, the only exception to this would be if there the respondents used steroids and no other drugs daily, as steroids are used by bodybuilders. We were aware that some people had experimented with injection and that some people smoked drugs such as Heroin and Rock Cocaine on a daily basis, but never injected and many were now prescribed methadone. For this reason, 'never inject' or 'sometimes inject' were not in themselves grounds for inclusion into either group.

Cannabis is a drug that is so endemic in Britain, its daily, weekly or occasional use would not denote membership of either group. Any of the other drugs on the questionnaire used on a daily basis, would put the respondent in Group A, the only exception to this would be if the respondents were using a benzodiazepine, listed as Temazepam, Tranquillisers, as these are widely available on prescription, daily use, by a respondent who never injected and used no other drugs daily would not indicate membership of group A.

Weekly use of any of the drugs is not in itself an indication of group A style use. However, this is the cross over area between the two groups and was the area that required some interpretation. Some respondents were clearly members of group B, e.g. they never injected and used amphetamine or Ecstasy weekly. Some respondents sometimes injected and used one or more drugs weekly. In those cases where it was unclear which group the respondents should be assigned to, it was decided that those in this grey area would be put into another group, group C. In practice it was only five respondents

Group C also contained those respondents who stated that they were workers in the drugs or AIDS field and those that used no drugs (two respondents). Also included in group C were the daily users of Benzodiazepines who never injected and used no other drugs (one respondent). It also included several spoilt forms (no details other than those necessary to win the competition) and odd forms (several respondents completed more than one form). The criteria for group inclusion is as follows.

Group A: Always inject (excluding steroids) and or; daily use of Rock Cocaine, Amphetamine, Cocaine, Heroin, Methadone, other Opiates, Temgesic, LSD, Ecstasy. Daily use of Benzodiazepine/Temazepam if always inject.

Group B: Never inject or sometimes inject but with no daily use except Cannabis. Never inject but daily Benzodiazepine (orally) with other drug use.

Group C: Non users, Workers in drugs/AIDS field, daily non injected Benzodiazepine use with no other drug use, spoilt or odd forms, grey area.

Ethical Considerations

The ethical considerations involved in harm reduction are well rehearsed, and have been covered in many parts of this dissertation. The concerns most often expressed regarding a comic like 'Smack in the Eye', are that by providing information on drug use, one could encourage use. There are similar concerns regarding sex education; that is, that giving information about contraception to young people is encouraging promiscuous behaviour. With the advent of HIV/AIDS many of these concerns about both contraception and drug use are no longer relevant. The priority has been made the halting of the spread of HIV.

It is clear from the returned questionnaires and lack of complaints over the years, that non drug users not involved in the drug scene are extremely unlikely to obtain a copy of the comic. Even if they did there is no evidence it would encourage them to use, if anything, from the response of many group B users it may even put them off. The Peanut Pete range of materials aimed at group B are far more likely to find themselves in the hands of non drug users, but with use as high as has been reported, a third at school age experimenting (Newcombe 1992a), arguing for keeping potentially life saving information from young people is obsured if not obscene.

Having said all this, there are limits to which harm reduction can go. These were reached when in an earlier production of 'Smack in the Eye', the drug Cyclizine was put forward for inclusion in the comic. The use of this drug which is legal, cheap and extremely dangerous is not wide spread, it is confined to small pockets of the country. It was decided after sending a questionnaire to sixty workers whose agencies receive the comic, that having an article on the drug, when there was little we could do but warn of the dangers, was unwise given few users were aware of it.

CHAPTER 8: SMACK IN THE EYE EVALUATION

Demographic Variables

The evaluation took place over a six month period between November 1992 and April 1993. During this period 4,855 copies of the comic were sold. 400 questionnaires were returned within this period and the eventual number of returns was over 450. The 400 completed questionnaires represent a response rate of 8%. The sample consisted of, Group A 60% (n=241), Group B 29% (n=114), Group C 11% (n=45). The result is as expected with the primary target audience (group A) being the biggest group, as they make up the bulk of the client group of drug services, the main distribution point for the comic. The modal age for group A was 25-30, this concurs with available data (Donmall, Miller 1993). For group B the modal age was 16-21 and for group C over 35, the overall modal age was 25-30. There were very few under 16's (n=6) but the spread of ages was fairly even, particularly in group A.

Table 1. Age of respondents

	Group A	Group B	Group C	Total
U/16	2(1%)	1(1%)	3(7%)	6(1%)
16-21	42(17%)	38(33%)	2(4%)	82(20%)
21-25	47(19%)	22(19%)	2(4%)	71(18%)
25-30	66(27%)	25(22%)	13(29%)	104(26%)
30-35	41(17%)	12(11%)	5(11%)	58(14%)
Over 35	43(18%)	12(11%)	16(36%)	71(18%)
No data	0	4(4%)	4(9%)	8(2%)
	(99%)	(101%)	(100%)	(99%)

Group B tended to be younger than group A, as expected (chi square=14.54 on 5 degrees of freedom, $p<0.025$). The over 35-year-olds in group B were mainly users of cannabis only.

The vast majority of the sample excluding group C were unemployed. Group C largely made up of workers in drug services had 76% (n=31) employed. Group A had 86% unemployed (n=200) and 14% (n=33) employed. Even within these figures a couple of women stated that they were employed in prostitution so would not be officially classed as employed. The majority of group B were also unemployed, 62% (n=66) with 38% (n=41) employed, this difference between group A and group B was highly significant (chi square=25.125 on 1 degree of freedom, $p<0.0005$). Overall 78% of Group A and B combined were unemployed; this concurs with published data (80% according to Donmall, Miller 1993). The number of men in the sample was much greater than the number of women, 27% of group A were female and 30% of group B, there was no significant difference in this proportion between group A and B. The number of women in the sample

is a reflection of the proportion of women seen by drug services (24% in 1992, Donmall, Miller 1993). The demographic spread of the sample covered just about every county in Britain, the only surprise in this is the low number (n=1) coming from Liverpool a neighbouring area of high reported drug use. This can be accounted for by the fact that very few services in Liverpool purchase or distribute the comic, which is surprising given the high profile harm reduction services in the city.

Familiarity with the comic

Nearly half the respondents (46%) had only recently come into contact with the comic, (within the last six months), this proportion was highest among group B (62%) as opposed to group A (39%), suggesting Group A had been in contact with drug services for longer. Overall the contrast between group A and B was highly significant (chi squared=16.139 on 2 degrees of freedom, $p<0.0005$). More than half the sample (59%) had seen more than two copies of the comic, as in the above, group A were more likely to have seen more issues than group B. Group B (chi squared=10.874 on 2 degrees of freedom, $p<0.001$). Sixty two per cent of group B, had only come across the comic in the last six months, although fifty per cent had seen more than two issues, which suggests they have seen copies published at least a year before issue 8. The probable explanation for this is that drug services keep stocks which they distribute at a later date. Overall fifty nine per cent had seen more than two issues, suggesting a readership familiar with the materials. It may be the case that the sample are 'fans' and those that had disliked the comic in the past no longer read it, this is backed up by the number of respondents who said they thought the idea of a comic is a good one, 96% answering yes, 4% unsure and 0% answering No. It seems likely that as drug users loose contact with drug services they can no longer get hold of the comic, several respondents mentioned that the comic was hard to obtain.

Distribution

The majority of respondents (75%) obtained their copy of the comic and questionnaire from a drug worker/counsellor, group A being more likely to obtain it this way than group B, who were more likely than group A to obtain a copy from a friend (chi squared=70.090 on 4 degrees of freedom, $p<0.0005$). This result is unsurprising and goes along with the earlier findings that group A were more likely to be in contact with a drug service. The respondents were asked to specify where else they obtained their copies from, three per cent (n=7) of group A got theirs from a pharmacy pack, one per cent (n=3) from prison, one respondent from group A and six from group B (5%) said they got their copy from an outreach worker. It is probably the case that some respondents who got copies in this way simply put it down as a drug worker/counsellor, if 'outreach worker' had been listed separately it is likely to have had a bigger response. Group B responses included prison (n=2), Rave (n=1), Health Education Department (n=1), Youth club (n=2) and relative (n=5) or (4%). Group C included 14 who obtained their copies direct on subscription from Lifeline.

'Passing around' the comic

A pleasing finding was the number of people from outside the sample who saw the comic, with 40% (n=155) showing it to more than five other people. It is possible that these other people who see the comic are involved in the drug scene but not in contact with services, although there is no way of telling this from the responses, it is unlikely that drug users would show it to those not interested in the drug scene. It was apparent that some people passed the comic on to many more than five people,

> *"Your comic has been passed all around this jail".*
> Group B, 21-25, Male, Essex.

The proportion of group B who showed the comic to more than five people was higher than group A, 43% (n=49) as opposed to 35% (n=84), although this was not significant. It was noticeable that some group A saw it as their job to pass on the comic to younger users.

> *"..I do give copies of SITE to quite a lot of young smackheads who aren't with a clinic"*
> (Group A, Male over 35,Crewe)

Table 2: How many people apart from yourself see your copy of SITE?

	Group A	**Group B**	**Group C**	**Total**
Yourself only	21(9%)	5(4%)	5(11%)	31(8%)
One other person	41(17%)	14(12%)	5(11%)	60(15%)
Two-Three people	65(27%)	27(24%)	7(16%)	99(25%)
Three-Five people	29(12%)	18(16%)	3((7%)	50(12%)
More than five	84(35%)	49(43%)	23(51%)	156(39%)
No Data	1(0%)	1(1%)	2(4%)	4(1%)
	(100%)	(100%)	(100%)	(100%)

Drugs used by respondents

Comparing group A and B responses is not valid in this category, as this was one of the criteria for group designation. It is possible however to look at how clearly defined the groups were. As has been mentioned it was only not possible to place five individual drug users into either group A or B. Group B and A had similar levels of daily cannabis use 56% (n=136) for group A and 55% (n=61) for group B. Apart from this the contrast is marked with group A using a much wider variety of drugs, much more frequently. As would be expected group B were more partial to the stimulants and hallucinogenics, this group would typically list two or three drugs used, whereas group A responses typically involved a shopping list of a wide range of drugs.

Rock Cocaine is viewed in Lifeline's analysis as a drug difficult to control and is firmly in the group A category of drugs. 5% (n=13) of group A used daily and 4% (n=10) used weekly, but 39% (n=94) used occasionally. Group B had no weekly use of Rock Cocaine, had this number been high it would have indicated Group B on the edge of Group A style drug use, as it was 9% (n=10) reported occasional use.

Amphetamine is a drug that is often used in different ways by group A and B, it can be a drug that is injected daily, or swallowed once a week at a club or party, weekly use although problematic, would not necessarily indicate Group B use sliding into Group A. Use of Amphetamine was as expected high with both groups. Group A 23% (n=56) daily, 12% (n=29) weekly and 26% (n=63) using occasionally. Group B weekly use was 16% (n=18) with 41% (n=47) using occasionally.

Cocaine use produced similar figures for Rock cocaine use with group A. 5% (n=13) daily, 4% (n=9) weekly and 45% (108) occasional use. Group B had 2% (n=2) weekly use and slightly more occasional use than Rock Cocaine 22% (n=25).

Heroin use amongst group A was as expected high, 33% (n=77) daily, 13% (n=32) weekly and 30% (n=72) occasionally. Group B had 3% (n=3) weekly users and 12% (n=14) occasional users. Weekly use by group B may well indicate a slide into group A use, it is in any case a grey area, where membership of either group A or B is unclear, it is also unclear if group B use of heroin is stable recreational use or is, as has been reported anecdotally, used to 'take the edge' off a weekend of stimulant use. This is also the case with Methadone and Other opiates as well as Temgesic, Temazepam and the other Benzodiazepines (Tranquillisers). Of the Benzodiazepines, Temazepam is by far the most popular being used more than all the other benzodiazepines put together.

Group A use of both the opiates and Benzodiazepines was high, notable in this was 58% (n=141) who used Methadone daily indicating the high numbers of group A on maintenance doses, (it is unlikely they are all buying it or are detoxing). As has been mentioned the use of Temazepam by Group A was high 23% (n=56) daily, 7% (n=17) weekly and 40% (n=96) occasional use.

LSD was used daily by 4% (n=10) of group A, with 4% (n=10) using weekly and 32% (n=76) using it occasionally. Daily use of LSD with no other daily use or injecting, would have indicated Group B use out of control, rather than the patterns of type A use previously described, however the daily users of LSD all used a range of other drugs daily and all injected, the majority, if their accounts were to be believed, were drug hogs par excellence. It is probable that some individuals exaggerated the frequency of use, as some individuals used staggering amounts of drugs daily, however this frequency of use is not unheard of by drug services. High levels of LSD use was reported by group B 11% (n=13) weekly and 41% (n=47) occasionally. This is unsurprising, as LSD is both cheap and popular.

Group B used **Ecstasy** weekly 9%(n=10) and occasionally 34% (n=39), this was more than group A, 4% (n=10) weekly, 28% (n=68) occasionally, group A had often tried every

drug listed, much of the use of Ecstasy by group A seemed to be experimentation, however 2% (n=6) used Ecstasy daily, none of the individuals used Ecstasy exclusively, but several may well have crossed from type B to type A use.

Of the other drugs group A listed over thirty different ones that they used**, Magic mushrooms** (n=9), **DF118** (n=9) and **Alcohol** (n=11) the most popular. Group B only mentioned nine other drugs, **Alcohol** (n=14), **Magic Mushrooms** (n=3) and **Poppers/Amyl nitrate** (n=4) most popular. It is highly probable that if **Alcohol** and **Tobacco** had been listed they would have had much higher reported use. Alcohol and tobacco were not listed as these are usually excluded from this type of data. With hindsight this was a mistake as we now have anecdotal evidence that group B stimulant users are now much more likely to drink than they were a year or so ago and it would have been interesting to see if this was borne out in the responses. Group C included reported use by some drug workers, mainly of cannabis, a result that would surprise few in the drug field.

Injecting

Use by group C was made up of five individuals who did not fit comfortably into the criteria for the groups, this was because they sometimes injected and used a variety of drugs weekly. This, as has been mentioned, was rare, as the distinction was quite clear and usually dramatic. Those individuals who were in group B who had sometimes injected 21% (n=24), had no weekly use of injectable drugs. Their injecting could be seen to have been experimental, though this is unclear from the data.
One individual used steroids (drugs popular with bodybuilders), these were injected daily; the only other drug he used was the occasional use of cannabis, therefore he was classed as a group B. This accounted for the one type B user who always injected. Group A had 58% (n=141) who always injected, 30% (n=72) who sometimes injected and 9% (n=22) who never injected.

General comments

Comments on the comic in general were often not just in the box provided but scrawled all over the questionnaire, the most common comment was a request for the comic to be produced more frequently and for it to have more pages. The general comments were overwhelmingly favourable.

> *"This was the first copy I paid for it was so good".* Group B, over 35, Male, Hull.
>
> *"Better than Viz and cheaper".* Group B, 16-21,Male, Newport.
>
> *"This issue of the comic is excellent. I have liked all the issues I have seen, they are full of useful information, but brilliantly funny".*
> Group A, 30-35,Female, Stockport.

"I think it's absolutely, really, properly, brilliantly, fabulously, excellently astonishingly fab".
Group A, 16-21, Male, Preston.

"Pucka". Group A, 25-30, Male, South London.

"I really do think it's the bollocks of a mag' and should continue as such, not only is it amusing, it tells one such a lot. If one is prepared to read between the lines there is so much help in this so called comic strip, that is what is so original with S.I.T.E., it's the bollocks!". Group A, Over 35, Male, London.

Humour was mentioned as being important by many respondents. Several seemed to re-read the comic under the influence of drugs,

"Me and my mates like to read it when were 'off our box', it makes it even funnier".
Group B, 16-21, Female, Manchester.

Several respondents mentioned the humour as a necessary way of defusing the stress and tension involved in raising difficult issues,

"It is a good way of taking out the stress that is automatically thought of when thinking of using safely or safer sex. I feel that publicity behind high risk behaviour and such like is so serious and gloomy that it creates a kind of stress. To look at these issues in a humorous manner, can build awareness in oneself if it is a laugh instead of serious all the time".
Group A, 25-30, Male, Manchester.

"The life of a junkie is not a happy, easy lifestyle - often the depression needs removal and things need to be seen in a lighthearted way - that's where the cartoon characters come in - humour!".
Group A, over 35, Male, Aberdeen.

One woman respondent felt the humour was important in its own right,

"No one understands our sense of humour towards drugs and ourselves.... in my sometimes very painful depression, S.I.T.E. makes me laugh when nothing and no one else can".
Group A, 25-30, Female, Preston.

Isolation

A recurring theme in the comments was a sense of isolation felt by some users, the comic seemed to play a role in reassuring them that they were not alone,

"Reading S.I.T.E. helped me feel less isolated and I realised that I am not the only one with a drug problem. Being a so-called 'ordinary housewife' and mother, I've always felt very embarrassed and stigmatised by my dependency".
Group A, 21-25, Female, Cornwall.

"It makes you feel that you are not alone". Group A, Over 35, Male, Gwent.

A number of respondents commented that the comic was 'on their side'. This was both an aim at the outset and is part of the formula needed for source credibility to be successful. From the numerous comments it is clear that many respondents felt the comic trustworthy, non patronising and empathic,

"It's made me realise that there are a lot more people who understand".
Group A, 25-30,Male, Cambridge.

".. I would not be afraid to talk to anyone from S.I.T.E. regarding drug abuse".
Group B, 16-21, Male, Cornwall.

"Funnier than any other comic I've read, not patronising, on my side".
Group B, 25-30, Male, Nottingham.

"I feel that it is good that an effort has been made not to patronise drug users".
Group A, 25-30, Male, Cleveland

Understanding/Clarity

Most of the comments pointed out that the comic format made for easy comprehension of the message,

"Easy to understand because the comic format and cartoons have a moral, so it's a magazine full of helpful advice." Group A, 21-25, Male, Oldham.

'*The way it's put across makes me pay more attention because it's easy to understand."* Group A, 16-21, Male, Cardiff.

".. it seems funny at first, but because the characters portrayed are close to yourself or someone you know, it seems to sink in more".
Group A, 16-21, Male, Manchester

One respondent disagreed and found the cartoon style confusing,

"Sometimes the serious message in the comic strip is obscured, it is hard to decipher real information from light hearted jokey parts".
Group B, 21-25, Male, Leeds.

One respondent felt angry that a previous issue had not contained enough information,

".. when I was pregnant there was one page on using when pregnant. It was even more basic than an article in 'Mother and Baby', at a time when I was desperate for information about possible consequences, I got nothing to help".
No data provided.

Complaints

Complaints in general were rare and did not generally fall into patterns as there were so few, these included the comments that the comic was racist, sexist, did not cover 'gay issues' or rape issues and used too many "swear words", all of these comments were made by drug workers from group C. The only underlying theme for complaints, made by two respondents was on stereotyping,

"I think it runs the risk of reinforcing stereotypes particularly sexual - by not balancing this with the pleasure and value of relationships, love, care between people. Whilst I see the comic strip value in laughing at stereotypes, you sometimes take the risk of making this acceptable. I think Grandpa Smackhead Jones is too lobbying pro-drug users, some of those are complicated and should not be trivialised."
Group C, over 35, Male, Somerset.

one respondent found the way the comic had dealt with safer sex issues offensive,

"Question, should children under the age of consent, be allowed to read or look at this magazine. Some of the cartoons are not really messages and are disgusting, e.g. A-Z of safer sex" (published in issue#3)
Group A, 30-35, Male, London.

Content analysis

Cover

The cover was generally liked 68% (n=274), 3% (n=12) disliked, 10% (n=39) were unsure, but it did not provoke any comment.

Letters Page

57% (n=229) liked the letters Page, 4% (n=18) disliked it and 17% (n=70) were unsure, in general it was thought a good idea to have a letters page but it was felt by some respondents, that it could contain more and could be improved.

"Maybe the letters page could be expanded to two pages or use smaller type, with a number of different columns; Agony Aunt; Medical Consumer etc".
Group A, Over 35, Male, London.

"Sack the Letters Page Editor". Group B, 21-25, Male, Manchester

Tough Shit Thomas

Overall 73% (n=291) liked the Tough Shit Thomas page, making it the most popular page, it was more popular with group B 86% (n=98) as opposed to 70% (n=168) from group A. 3% (n=13) of the total who stated an opinion disliked it and 10% (n=41) were unsure. Some of Tough Shit Thomas's popularity appeared to be due to identifying with the character's use of cannabis,

> *"I like Thomas because he smokes 'blow' and he's 'off his box'".*
> Group A, 16-21, Male, Cleveland.

Several respondents seemed reassured that potential problems with cannabis were highlighted,

> *"I've not tried 'Skunk' yet, but I probably will eventually, but I will treat it with more respect than I would have done had I not read TST".*

A daily cannabis user commented, probably with some irony,

> *"I was pleased to see the T.S.T article about cannabis.... I'll certainly keep away from it if that's what it does to you".*
> Group A, 25-30, Female, London.

Several respondents seemed to have had their interest in 'Skunk weed' aroused,

> *"I wasn't really worried about going to Amsterdam until I read Tough Shit Thomas in this issue. I want that Skunk!!".*
> Group B, 16-21, Male, Northamptonshire.

This highlights the ethical consideration commented on in the methodology section. If the drug mentioned had more potential for harm than Skunk and the comic was read by non-users, this may have caused some concern. As it is, this is existing cannabis users being warned of a stronger brand they are likely to come into contact with.

The Dark Side of the Spoon

'Dark Side of the Spoon' was liked by 60% (n=242), disliked by 6% (n=26) and 16% (n=64) were unsure. The impression given by several respondents, was that the portrayal in the cartoon strip, although accurate was unfairly negative,

> *"Once again another excellent issue, however, I found that 'Dark Side of the Spoon' was a bit extreme. These places are effective for some people and cost a lot of*

money per patient per week. I know it's meant light-hearted and I enjoy the humour, but I feel that this cartoon was too negative."
Group A, 25-30, Male, Bedford.

This was felt to be an even more sensitive area by those workers from Therapeutic Communities, one of whom commented,

"Unfair portrayal of expectations made by therapeutic community - gave negative impression, I don't think it will encourage users to go or be honest. Makes life harder for workers."
Group C, 30-35, Female, Suffolk.

Several respondents clearly identified with the portrayal in the strip,

"Dark Side of the Spoon' was spot on and typical of 8 out of 10 people I've met in rehabs. It was nice to see her change at the end and become real and the reaction of others was also spot on."
Group A, 25-30, Male, Birkenhead.

"..another sacred cow (drug rehab methods and practices) is slaughtered!! excellent observation, this should be a series"
Group B, 25-30, Male, Scotland.

One respondent clearly had his negative view reinforced by the portrayal of therapeutic communities,

"..I realise that backsliders hang out in these places and would probably be forewarned"
Group A, 30-35, Male, Cornwall.

Grandpa Smackhead Jones

Grandpa Smackhead Jones like Tough Shit Thomas has been in every issue of the comic to date and was the second most popular page with 70% (n=280) liking the page, 4% (n=16) disliking it and 7% (n=29) unsure. Several respondents identified with Grandpa Smackhead Jones,

"Sometimes I worry that Grandpa Smackhead Jones is actually myself in 10-15 years time - what a prospect!!".
Group A, over 35, Male, Worcester.

"Grandpa Smackhead Jones is nearly as old as me, a 1942 war baby".
Group A, over 35, Male, Edinburgh.

Several respondents felt the page highlighted both the way the world views them and a need for a change in the law,

> *"Grandpa Smackhead Jones was very informative. It gives an idea of how the world perceives the 'junkie', one, which being a user, you don't see yourself. Also the prejudice to be faced. It makes you realise how limiting using can be".*
> Group A, 25-30, Female, Middlesborough.

> *"The Grandpa Smackhead Jones bit was/is apt for me as I am in HMP (name supplied) serving two years for 46 LSD. All drugs should be legalised and education should prevail and the government should encourage safer use and projects like Lifeline, keep up the good work".*
> Group B, 25-30, Male, Gwent.

Amphetamines Page

The Amphetamines Page was liked by 64% (n=255), disliked by 4% (n=17) and 11% (n=46) were unsure. Apart from the one comment on clarity already included, all the comments were complementary, without a great deal of detail,

> *"The information on Amphetamines left me more understanding of the effects of the drug".* Group B, Over 35, Female, London.

> *"Information on amphetamines was most excellent".* Group B, 16-21, Male, Essex.

Needle Exchange Page

The needle exchange page provoked no direct comment. It was liked by 55% (n=221) disliked by 3% (n=14) and 15% (n=60) were unsure.

Bob the Opinionated Barber

Bob the Opinionated Barber was the least popular page in the comic with 45% (n=180) liking it, 15% (n=62) disliking and 19% (n=76) unsure. The intentional irony was not lost on some respondents,

> *"Bob the Opinionated Barber - a great idea for information for junkies without preaching".*
> Group A, 21-25, Female, Manchester

on others it clearly was,

> *"Bob the Barber would have been killed in Newport".*
> Group B, 16-21,Male, Newport, Gwent.

Going Wild at the Zoo

This proved to be the most provocative page in the comic, although liked by 54% (n=215), disliked by 5% (n=22) with 19% (n=76) unsure, the reactions seemed to be extreme,

> *"I thought 'Dark Side of the Spoon' and 'Going Wild at the Zoo' were excellent and hilarious and having been in both situations, I've seen the attitudes portrayed many times".* Group A, 30-35, Male, Sheffield
>
> *"Going Wild at the Zoo very thought provoking, do you think it would offend anyone".*
> Group B, 30-35, Male, Hampshire
>
> *"It's no good taking the piss out of the drug user, it's better to help them stop by showing them what happens to your life if your using drugs, not telling them their animals at a zoo".*
> Group A, Over 35, Male, Salford
>
> *"Drug users are not some kind of animals, so why put them in a zoo, we're not wild, in fact a lot of drug users are really good hearted, it's just we've had a bad time. So what I'm saying is it's an insult".*
> Group A, 21-25, Male, Wigan
>
> *"..I take it (methadone) to avoid withdrawals and I am neither skinny or fat or fucking brain-dead. Think Please!!".*
> Group A, 25-30, Female, Bradford

The Man with No Bollocks

The Man with No Bollocks was liked overall by 59% (n=236) Group A 54% (n=130), Group B 74% (n=84), it was disliked overall by 12% (n=48) and 13% (n=54) were unsure. Several Group B commented favourably,

> *"More man with No Bollocks".* Group B, 16-21, Female, Penzance
>
> *"I thought the Man with No Bollocks was really funny".*
> Group B, 25-30, Female, Essex.

The Man with No Bollocks provoked several comments from Group C non-users, who worked in the drug and HIV/AIDS field,

> *"Really Excellent, perfect blend of humour, information, good graphics, well designed, right length, right format, nice mixture of old and new favourites, especially 'The Man with No Bollocks'".*
> Group C, 30-35, Male, Cambridge

"Most people found 'The Man with No Bollocks' offensive, we cannot leave the comic around the project as it creates unhelpful conversations".
Group C, Over 35, Female, London

Information

Information Needs

Asked to pick from a selection of what information contained in the comic was felt to be most useful, information on drugs themselves proved most popular with 73% ticking it overall, 72% (n=173) Group A, 78% (n=89) from Group B. Information on injecting was ticked by 41% overall, 50% (n=121) Group A, 25% (n=28) Group B, the difference in Group A and Group B is unsurprising given group A are far more involved in injecting drugs. Information on drug services was ticked by 35%, 39% (n=94) Group A, 29% (n=33) group B. Information on safer sex was disappointingly but unsurprising ticked by only 30% (n=72) Group A the figure was slightly higher with Group B with 41% (n=47). It was noticeable that several Group A respondents crossed out the safer sex option to the question and one wrote in the margin "not interested". This would seem to confirm the view that the risk of contracting HIV from sex is not taken as seriously by drug users as is the risk from injecting and sharing works.

Information Sources

The respondents were asked a multiple-choice question; where they get their information on drugs from.

Table 3 Where do you get your information on drugs from?

	Group A	**Group B**	**Group C**	**Total**
Personal experience /trial and error	210(87%)	94(82%)	19(42%)	323(81%)
Other drug users	193(80%)	87(76%)	26(58%)	306(76%)
Doctors/drug workers	141(58%)	66(58%)	32(71%)	239(60%)
TV/Newspapers/mag	47(19%)	34(30%)	12(27%)	93(23%)
Other drug leaflets	103(43%)	65(57%)	28(62%)	196(49%)
School	9(4%)	3(3%)	1(2%)	13(3%)
Smack in the Eye	132(55%)	78(68%)	26(57%)	236(59%)
Other	----------			
Textbooks	11(5%)	2(2%)	0	13(3%)
Dole office	0	1	0	1
Outreach	0	4(3%)	0	4(1%)
Non text books	1	0	0	1
E.I.G, D, U/W.H.O.	1	0	0	1
Reggae Songs	0	1	0	1

There were some differences between Groups A and B (chi-square=22.779 on 12 degrees of freedom, p>0.05). All groups relied on personal experience/ trial and error (81%) and other drug users (76%) as their main sources of information.

> *"All my information was learned by me and believe me I am wise on the subject of drugs and how to use them".* Group B, 16-21, Female, Manchester.

> "(information is obtained)..*from other drug users as they have had first hand experience of the drugs and their effects."* Group A, over 35, Male, Suffolk.

Doctors and drug workers were the next trusted source with (60%) claiming they were an information source, however, several respondents felt that doctors/drug workers was misleading as their opinions on the two differed.

> *"Sessioning with your mates teaches you most things, but drug workers always know a cleaner way."* Group A, 16-21, Male, London.

> *"Certainly <u>not</u> doctors, but many drug workers. I have ticked the box though, so judge for yourself if it should be counted, I can't understand why you put the two together."*
> Group B, 25-30, Male, Scotland.

The media in the shape of TV/Newspapers/Magazines were used as a source of information by 23%, in contrast school was seen as a source of information by only 3%, given the earlier chapter on drugs education this is unsurprising but disturbing non-the-less. Drug leaflets on the other hand were seen as a source of information by many, 'Smack in the Eye' itself cited by 59% and other leaflets by 49%, 'Smack in the Eye's' high rating is expected given the questionnaire is about the comic, however several respondents commented on the difference between 'Smack in the Eye' and some other leaflets,

> *".. I think S.I.T.E is a good source of information, but other leaflets about drugs just tell you're instantly going to become an addict and a criminal to supply your habit and catch AIDS/Hep B and the likes, instead of telling you how to use drugs safely - get your act together other leaflet writers!".*
> Group A, 16-21, Male, New age traveller.

Of the other sources mentioned only text books 3% (n=13) is worth noting, this was made up of people who mentioned specific books such as the British National Formula and MIMMS, 5% (n=11) of group A mentioned these, confirming that a proportion of drug users take drugs information very seriously.

The categories listed above, that the respondents found to provide the most accurate information is probably a more accurate guide of the information found credible and trustworthy. In this category personal experience/ trial and error again comes out top with 37% from both Group A and B listing it, overall the figure is 34% (n=137). Drug workers

are listed by 29% (n=118) overall and 'Smack in the Eye' by 26%. In this category other users is further down the list, mentioned by 16% (n=65) overall, this would suggest that whilst they are a ready source of information, the knowledge of other users is perceived to be fallible. Leaflets are mentioned by 10% (n=42) overall, TV/Newspapers/magazines by 4% (n=17) the only other note worthy mention is Textbooks with 2% (n=9). Overall the difference between group A and B is noticeable (chi square=21.642 on 11 degrees of freedom, p>0.05), Group B mention drugworkers and other users as slightly less than group A and mention written materials more.

From these figures it is possible to gain an impression of how credible 'Smack in the Eye' is for respondents as a source of information. Personal experience is as expected the most important and then two-way communications with drug workers as expected. Unexpectedly 'Smack in the Eye' is seen as a more credible than other users. Obviously this would depend on who the other user is, some individuals would be highly credible others not, but 'Smack in the Eye' occupies a pleasing and unexpectedly high position as a source of credible information in the lives of many drug users.

Behaviour

Under the general question 'Do you think SITE is likely to change any of your behaviour?' two examples are given.

Example 1: If you read in SITE that the drug you were using was likely to kill you/cause you serious harm would you…

	Group A	**Group B**	**Group C**	**Total**
Be less likely to use it	131(54%)	87(76%)	27(60%)	245(61%)
Be More likely to use it	6(2%)	1(1%)	0(0%)	7(2%)
Would use it no matter what	90(37%)	20(18%)	4(9%)	114(28%)
No Data	14(6%)	6(5%)	14(31%)	34(8%)
	(99%)	(100%)	(100%)	(99%)

In this example the difference between group A and B is highly significant (chi-square =16.852 on 2 degrees of freedom, P>0.0005). Although the majority would be less likely to use 61% overall, a much higher proportion of Group B (76%) as opposed to 54% of group A answered this way. A much higher proportion of Group A (37%) would use the drug no matter what, as compared to group B (18%). This highlights in a dramatic way the difference between the groups and the challenge for those seeking to change drug-using behaviour, for over a third of group A, drugs are more important than life. 2% (n=6) of group A and 1% (n=1) of group B would be more likely to use if they read the drug could kill them cause serious harm. This might be respondents bravado or not taking the question seriously or it may be that some of the respondents have genuinely pressed the 'self destruct button' and are actually seeking oblivion and death.

Example 2: If you read in SITE that there was a way of using the drug that you use more safely, that still allowed you to get the same effect would you..

	Group A	**Group B**	**Group C**	**Total**
More likely to use in the safer way	198(82%)	100(88%)	28(62%)	326(81%)
Be less likely to use in the safer way	3(1%)	2(2%)	1(2%)	6(1%)
It would makeno difference	32(13%)	8(7%)	1(2%)	41(10%)
No data	8(3%)	4(3%)	15(33%)	27(7%)
	(99%)	(100%)	(99%)	(99%)

With example two, the differences between the groups is not significant and the contrast with the first example is dramatic. As expected drug users are more willing to change their behaviour if the behaviour change fits into their lifestyle. This finding is particularly encouraging for those who take a harm reduction stance to drug use. Having said that, the examples are hypothetical, they do not mean drug users actually behave in this way. There are still a proportion who no matter what they read it would make no difference, as one respondent commented,

> *"Nothing will make a person change their drug habits/way they use".*
> Group A, 25-30 Male, London.

Examples of behaviour change

The respondents were asked if they could think of any examples of things in 'Smack in the Eye' that had made them change their behaviour. The more specific the answer to something that had been in the comic the more significant it would be. Forty six different categories are listed, some were very general for example 23 mentioned safer sex, 21 respondents claimed to now inject more safely,

> *"I have changed my behaviour sexually and injecting wise".*
> Group A, 21-25, Female, Manchester.

> *"..A lot of people I know inject dangerously, but once they read SITE they start injecting safely, including myself".*
> Group A, 16-21, Female, Colchester.

Some respondents were more specific, six group A respondents claimed to use less or to have stopped using lemon juice when cooking up their heroin and had switched to citric acid to avoid fungal infection,

> *"Try not to use a lemon to cook up with, only use it if no citric or Vitamin C about".*
> Group A, 16-21, Male, New Age Traveller.

Four respondents also mentioned improvements in injecting but mention the article Grandpa Smack Head Jones 'Back to Junkie School' that featured information on safer injecting (SITE issue # 7),

> *"..I learned about how dangerous it is to inject in the groin from your magazine and I've never done it since I read it, I think it was in Grandpa Smack Head Jones".*
> Group A, 25-30, Male, Bedfordshire.

A number of respondents claimed that the comic reinforced behaviour changes they had made or were thinking of,

> *"I have never injected and it has reinforced my opinion that I never will".*
> Group A, 30-35, Male, Manchester

> *"SITE articles tend to underline the 'safe' behaviour I have already adopted, e.g. works, spikes etc and sex as I am Hep B positive".*
> Group A, over 35, Male, Worcester

Many respondents mentioned specific things such as changing from injecting tap water, to water amps or fits from the use of **cyclizine** leading to recognition of a problem, one respondent mentioned the use of milk after amphetamine use,

> *"I take amphetamines regularly and now I make an effort to eat something nutritious and drink milk to replace the calcium".*
> Group A, 25-30, Male, Cleveland.

Another respondent commented,

> *"SITE told me to drink milk after using speed (amphetamines). I don't know if it works, but I do it anyway".*
> Group B, 21-25, Male, Nottingham.

This backs up the earlier findings about behaviour change fitting into lifestyle, the user wanted to use in a safer way, but didn't want to give up, drinking a glass of milk requires little effort and can not be seen to be interfering with the user's lifestyle in any way. Another example of this is sucking Methadone through a straw to avoid dental decay. This was featured in the page with Bob the opinionated Barber, the least popular character, however five respondents from Group A said they now suck their methadone through a straw. These changes to behaviour although minor do demonstrate the principle behind the comic working, making changes within the lifestyle, whilst accepting it as valid. Of more than academic interest were the comments on **Temazepam**. A page on Temazepam in the style of the amphetamines page in this issue had appeared in issue #7. Injecting Temazepam has been responsible for limb loss and death. In the page in the comic it was pointed out both the dangers of injecting the drug and describe how taken orally with a hot drink could give the same effect as an injection. This brought an amazing

response with 37 people commenting that they had changed their behaviour regarding Temazepam, six had stopped using, three now used less, thirteen now take it orally, one had been stopped from trying it and one had stopped for other reasons, thirteen had just generally mentioned Temazepam under the question on behaviour change.

> *"I have stopped injecting Temazepam mainly due to your information and trial and error".* Group A, Data missing
>
> *"I've stopped doing up pills, 'Dexys' and Temazepam. Now I swallow them, I can wait 15 minutes".* Group A, 25-30, Male, London.
>
> *"I have never injected Temazepam but have been tempted to, and after reading SITE that a cuppa does the job, I will never inject it".*
> Group A, 21-25, Female, London.
>
> *"..I stopped taking them (Temazepam) since the manufacturer's changed them to the gel making injecting likely to cause blockages in veins".*
> Group A, 25-30, Male, Manchester.
>
> *"Temazepam: experience of a friend and article in SITE has stopped me injecting them. Bad news now with new formula".*
> Group A, 30-35, Male, Cornwall.
>
> *"It (SITE) stopped me injecting Temazepam".* Group A, 16-21, Male, London.
>
> *"In that issue when you told us if you take Temazepam with a hot drink and you get the same effect, I changed my way of using it".*
> Group A, over 35, Male, Manchester.

Summary

Smack in the Eye is targeted at group A drug users, the evaluation shows that 60% of the readership are from this group, and nearly 30% from group B, many of whom are injectors and may be on the verge of type A use, the rest is made up of largely workers in the drug and HIV fields. It is often passed around, the mode being more than 5, a fair proportion of whom it is safe to assume are also drug users, some of whom may not be in contact with services. Given that the estimate of the total numbers of users of notifiable drugs in Britain is only 100,000 the 40,000 copies of Smack in the Eye distributed and passed around over the last five years, must have been seen by the majority of the target group in Britain.

It is clear from the evaluation that 'Smack in the Eye' is well liked and seen as a highly credible source of information. Behaviour change as has been stated in the earlier chapters is difficult to achieve and measure. An aim of getting drug users to stop using is unrealistic using mass media approaches, such as the comic. This is a behaviour that requires too major a change to the lifestyle of drug users. Behaviour change that fits into the drug users lifestyle is possible and when it involves very minor changes like drinking milk after using amphetamine, is achievable through credible information alone. A welcome finding of this evaluation is that drug users will change from injecting Temazepam to swallowing it with a hot drink. The reasons for this are because a credible and trustworthy source has offered an alternative that gives the same effect, whilst avoiding the perils of injecting the reformulated Temazepam eggs. It appears that for some respondents the comic reinforced a desire to act in this way, for others it seems to have been solely responsible for them changing their behaviour.

The overall aim of the comic is to halt the spread of HIV. It would appear that of the respondents most at risk, Group A are often less interested in safer sex than safer drug use. Changing peoples sexual behaviour from high risk to low risk, is a behaviour change that is not possible through text based materials alone, 'Smack in the Eye' can be seen to encourage/reinforce safer ways and keep the issue of safer sex on the agenda. Changing from sharing injection equipment to not sharing would appear to be a behaviour change of the same magnitude as changing from injecting to oral Temazepam. It is a behaviour that has so many influences that measurement is difficult. It seems likely that 'Smack in the Eye' has a significant impact on and has been the catalyst for positive behaviour change in the readership. As Stimson states,

> *"Here is a new view of motivation-the task to 'nudge' or as they say in Holland, to 'tickle' the injector through the small changes that they will accept, which may be of cumulative significance in changing individual behaviour and reducing collective risk of HIV".*
> (Stimson, 1990 p.336)

CONCLUSION

HIV/AIDS has had a dramatic impact on drug treatment services. Whilst many still aim for an abstinence in their client group, harm reduction is now often the predominant philosophy. Needle exchanges and Maintenance prescribing of oral methadone are available in many areas of Britain, although the Government still publicly express an ideal of total abstinence.

Propaganda is often passed off as drug education. There is no evidence that drug education has any impact at all on levels of drug use. Despite this there is still the belief by many people that drug education in schools and mass media campaigns with a naïve and simple message will somehow stop young people using drugs. Both government and educationalists have colluded in this myth, probably because the truth, that is that we do not know how to stop people using drugs, is far too uncomfortable or politically damaging.

The interest and contribution from health education around philosophical and practical aspects of the drug issue is noticeable by its absence. Tobacco and alcohol are seen as priorities in terms of mortality, deaths from using drugs are negligible when compared to the tens of thousands of deaths from alcohol or the one hundred thousand from tobacco. The alarming rise in recreational drug use can not be ignored however. In inner city areas of Manchester close to 50% of young people have tried an illegal drug before they leave school. Health education/Promotion units with few exceptions seem blissfully unaware of the scale and variety of drug use in the 1990's.

Both propaganda and drug education have been with us for many years, it is possible to say we know a lot about what doesn't work. A health education campaign concerning alcohol would aim for some form of sensible drinking; in other words it would be a harm reduction campaign. Trying to stop people using alcohol would be futile even if it was considered desirable; mass media campaigns that seek to stop drug use are still produced even though they at best have no impact on levels of use. Health educationilsts should not be involved in this propaganda.

Persuasive communication theory can effectively be applied to the area of harm reduction. In order for this to be effective the source, that is who the receiver of the message thinks the message comes from, must be seen as being on the side of the drug user, not warping the truth due to self interest and perceived of as having a degree of expertise, above all they must be credible.

Comics have been shown to be effective carriers of health education messages and are extremely popular with young people; they seem ideally suited to harm reduction publications.

The postal questionnaire inserted into the comic produced 400 responses, 355 from current drug users, 241 from Group A, the primary target and 114 from Group B recreational users, some of whom may be on the verge of type A use. It was in practice easy to distinguish between the two groups by the injection practices and drug use of the

respondents. The comic was clearly popular and has regular readers, more than half had seen the comic more than a year prior to the evaluation. It is usually passed around to friends and other users. Most respondents obtained their copy from drug workers.

Personal experience/trial and error was the most common way of obtaining drug information and this was felt to be the most reliable source. Other users came next, but they appeared to be viewed as a fallible source of information. Drug workers and Smack in the Eye were felt to be more accurate sources of information. Schools are not thought of as credible sources of information on drugs, only 3% of respondents obtained their information from this source.

Warnings of death/serious harm from a particular drug if they appeared in Smack in the Eye would make the majority of the respondents less likely to use the drug, but a third would use the drug no matter what. However, if the respondents read in Smack in the Eye that there was a way of using their drug more safely which allowed them to get the same effect, 90% said they would follow that advice.

The example of Temazepam backs up the previous statement. Information alone appears to have been responsible for behaviour change in a number of respondents. They had read in Smack in the Eye that swallowing the drug with a hot drink could give the same effect as injecting it, without the threat of limb loss and death and the risk of spreading and contracting HIV/AIDS.

Every society that has ever existed has always used drugs, patterns of use change but there is no reason to believe people will ever stop using drugs. An increasingly large number of young people in Britain are using a wide variety of drugs; it is approaching the point when this is the norm. The vast majority seem to be non addicted experimenters or recreational users, who, if they are provided with the right safety advice and act upon that advice, will come to little harm. The attitude and actions of the Government and society to this level of drug use are both unpredictable and beyond the control of health educators, giving credible advice is not. The evaluation of “Smack in the Eye’ has shown that giving the ‘right’ advice in a credible way, makes it possible to reduce the harm that using drugs can cause.

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QUESTIONNAIRE DATA

Criteria for groups

A: Always inject (excluding steroids) and or; daily use of: Rock Cocaine, Amphetamine, Cocaine, Heroin, Methadone, other opiates, Temgesic, LSD, Ecstasy. Daily use of Benzodiazepine/Temazepam if always inject.

B: Never inject or sometimes inject but with no daily use except cannabis. Never Inject but daily Benzodiazepine (orally) with other drug use.

C: Non users,Workers in drugs/AIDS field, Daily non injected Benzodiazepine with no other drug use, Spoilt or odd forms, grey area

Group A	**Group B**	**Group C**	**Totals**
241 (60%)	114 (29%)	45 (11%)	400

QUESTIONNAIRE

1. When did you first see a copy of SITE?

	Group A	**Group B**	**Group C**	**Total**
In last six months	94	71	17	183
More than a year ago	84	24	12	120
More than two years	60	19	16	95

2.How many issues of SITE have you seen ?

	Group A	**Group B**	**Group C**	**Total**
One only	41	37	8	86
Two	48	20	8	76
More than two	152	57	29	238

3. Where did you get this copy of SITE from?

	Group A	Group B	Group C	Total
A friend	19	26	2	47
A drug worker/Counsellor	208	66	26	300
Someone else (please give details)				
Pharmacy pack	7	0	0	7
Outreach	1	6	0	7
Prison	3	2	0	5
Rave	0	1	0	1
Health Ed Dept	0	1	0	1
Relative	0	5	0	5
Miscellaneous	1	5	3	8
Lifeline (subscription)	0	0	14	14
Youth club	0	2	0	2

4.How many people apart from yourself see your copy of SITE?

	Group A	Group B	Group C	Total
Yourself only	21	5	5	31
One other person	41	14	5	57
Two-Three people	65	27	7	99
Three-Five people	29	18	3	50
More than five	84	49	23	155

5.What information contained in SITE do you find most useful ?

	Group A	Group B	Group C	Total
Info on drug services	94	33	14	141
Info on drugs themselves	173	89	30	292
Info on injecting	121	28	16	165
Info on Safer Sex	72	47	20	139

6. Do you think the idea of a comic is a good one?

	Group A	Group B	Group C	Total
Yes	228	105	41	374
No	1	1	0	2
Unsure	6	7	2	15

7. In the copy of SITE that you got this questionnaire from (issue 8), what did you most like/dislike?

		Group A	Group B	Group C	Total
Cover					
	like	159	86	29	274
	dislike	8	3	1	12
	unsure	18	17	4	39
Letters page					
	like	133	68	28	229
	dislike	10	5	3	18
	unsure	41	25	4	70
Touh Shit Thomas					
	like	168	98	25	291
	dislike	7	4	2	13
	unsure	23	12	5	41

	Group A	Group B	Group C	Total
Dark Side of the Spoon				
like	145	76	21	242
dislike	9	13	4	26
unsure	38	18	8	64
Grandpa SmackHead Jones				
like	177	80	23	280
dislike	6	7	3	16
unsure	10	13	6	29
Amphetamines page				
like	145	82	28	255
dislike	9	5	3	17
unsure	28	12	6	46
Needle exchange page				
like	131	65	25	221
dislike	3	8	3	14
unsure	36	21	3	60
Bob the opinionated barber				
like	108	56	16	180
dislike	34	21	7	62
unsure	34	21	10	65
Going Wild at the Zoo				
like	122	72	21	215
dislike	14	5	3	22
unsure	46	20	10	76
The Man with No Bollocks				
like	130	84	22	236
dislike	34	8	6	48
unsure	39	7	8	54

8 Where do you get your info on drugs from ?

	Group A	Group B	Group C	Total
Personal experience /trial and error	210	94	19	323
Other drug users	193	87	26	306
Drs/drug workers	141	66	32	239
TV/Newspapers/mag	47	34	12	93
Other drug leaflets	103	65	28	196
School	9	3	1	13
Smack in the Eye	132	78	26	236
Other Textbooks	5	1	0	6
BNF	3	0	0	3
Dole office	0	1	0	1
Outreach	0	4	0	4
Mimms	3	1	0	4
Non text books	1	0	0	1
E.I.G,D,U/W.H.O.	1	0	0	1
Reggae Songs	0	1	0	1

9.Which of these provides the most accurate information

	Group A	Group B	Group C	Total
Personal Experience	90	42	5	137
Drug workers	73	30	15	118
SITE	63	31	23	117
Other Users	41	16	8	65
TV Newspapers	15	1	1	17
Leaflets	19	15	8	42
Mimms	4	0	0	4
BNF	3	0	0	3
Family	1	0	0	1
Dealers	1	0	0	1
Outreach	0	4	0	4
Text books	2	2	5	9
School	0	1	1	2
Prison	2	0	0	2

10. Do you think that SITE is likely to change any of your behaviour ?

Example 1. If you read in SITE that the drug you were using was likely to kill you/cause you serious harm, would you

	Group A	Group B	Group C	Total
Be less likely to use it	131	87	27	245
Be more likely to use it	6	1	0	7
Would use it no matter what	90	20	4	114

Example 2 If you read in SITE that there was a way of using the drug that you use more safely, that still allowed you to get the same effect would you..

	Group A	**Group B**	**Group C**	**Total**
Be more likely to use in the safer way	198	100	28	326
Be less likely to use in the safer way	3	2	1	6
It would make no difference	32	8	1	41

11 Can you think of any examples of things in Smack in the Eye that have made you change your behaviour (please give details)

	Group A	Group B	Group C	Total
Temazepam (total)	34	3	0	37
{Stopped using	5	1	0	6
{Use less	3	0	0	3
{Now take oral	12	1	0	13
{Stopped from trying	1	0	0	1
{General mention	12	1	0	13
{Stopped for other reasons	1	0	0	1
Injection				
Sites/veins up	2	0	0	2
Lemon juice/fungal/citric	6	0	0	6
Inject more care	17	4	0	21
Water amps instead of tap	1	0	0	1
Never inject groin	1	0	0	1
Stopped I.V Speed	0	1	0	1
Changed from I.V to I.M.	1	0	0	1
Fix less pills	1	0	0	1
Reinforced non injection	1	1	0	2
GSHJ junkie school	4	0	0	4
GSHJ Speed	1	0	0	1
Less use of speed	0	1	1	2

	Group A	Group B	Group C	Total
Drink milk after speed	1	0	0	1
Thinking of stopping speed	1	0	0	1
Disposal of works	8	1	0	9
Methadone through straw	5	0	0	5
Cut down on Methadone	3	0	0	3
Safer sex	12	8	3	23
Nothing would make change	1	0	0	1
As above but think more	3	0	0	3
Alcohol and Methadone	1	0	0	1
No	6	2	0	8
N/A as don't inject	0	2	0	2
Amphet page	0	2	0	2
Wouldn't take Heroin or Methadone	0	1	0	1
More careful	1	2	0	3
General health	0	1	0	1
Use 'E' safer	1	4	0	5
Paranoia and speed	1	0	0	1
Don't share	1	1	0	1
Reduced Cyclizine	0	0	1	1
Saw Cyclizine as problem	1	0	0	1
Needle X	0	0	1	1
Care with strong Cannabis	0	2	0	2
Dispose of works in can	2	0	0	2
Want to stop drugs since reading	1	0	0	1

No longer Mix drugs	1	0	0	1
Use less Crack	1	0	0	1
Now filters drugs	1	0	0	1

12 What Drugs if any do you use ?

	Group A	**Group B**	**Group C**	**Total**
Cannabis				
Daily	136	61	4	201
Weekly	28	15	0	43
Occas	37	35	2	74
Rock Cocaine(crack)				
Daily	13	0	0	13
Week	10	0	1	11
Occas	94	10	1	105
Amphetamine				
Daily	56	0	0	56
Week	29	18	1	48
Occas	63	47	2	112
Cocaine				
Daily	13	0	0	13
Week	9	2	0	11
occas	108	25	2	135
Heroin				
Daily	77	0	0	77
Week	32	3	2	37
Occas	72	14	0	86
Methadone				
Daily	141	0	0	141
Week	9	0	0	9
Occas	39	12	0	51
Other Opiates				
Daily	34	0	0	34
Week	14	2	0	16

Occas	82	12	1	95
	Group A	**Group B**	**Group C**	**Total**
Temazepam				
Daily	56	1	1	58
Week	17	4	0	21
Occas	96	21	2	119
Temgesic				
Daily	11	0	0	11
Week	5	0	1	6
Occas	45	4	0	49
LSD				
Daily	10	0	0	10
Week	10	13	1	24
Occas	76	47	1	124
Ecstasy				
Daily	6	0	0	6
Week	10	10	1	21
Occas	68	39	0	107
Tranquillisers (eg diazepam)				
Daily	41	1	2	44
Week	14	2	0	16
Occas	93	26	2	121
Other				
Magic mushrooms	9	3	1	13
DF118's	9	1	0	10
Alcohol	11	14	6	31
Cyclizine	4	0	1	5
Cyclimorph	1	0	0	1
Physeptone	3	0	0	3
Ketamine	2	1	0	2
Diconal	4	0	0	4
Palfium	2	0	0	2
Dihydrocodeine	3	0	0	3
Gees Linctus	3	0	0	3
Nutmeg	1	0	0	1
Solvents	5	0	0	5
DG's	1	0	0	1
Dimorphine	1	0	0	1
Poppers/Amyl nitrate	2	4	0	6
Tobacco	0	3	0	3

Mogadon	3	0	0	3
Codeine	3	0	0	3
Barbiturates	4	0	0	4
Steroids	0	1	0	1
Opium	1	1	0	2
Poppy heads	1	0	0	1
Largactil	0	1	0	1
Propranolol	0	0	1	1
Tegretol	0	0	1	1
Nitrazepam	2	0	0	2
Sennokot	1	0	0	1
DHC Continus	1	0	0	1
Amatripalin	1	0	0	1

13. Do you ever inject drugs ?

	Group A	**Group B**	**Group C**	**Total**
Always	141	1	0	142
Sometimes	72	24	5	101
Never	22	71	36	129

14.What age are you ?

U/16	2	1	3	6
16-21	42	38	2	82
21-25	47	22	2	71
25-30	66	25	13	104
30-35	41	12	5	58
over 35	43	12	16	71

15. Are you male/female

Male	172	74	24	270

Female	64	32	17	113

16.Are you employed on a regular basis ?

	Group A	**Group B**	**Group C**	**Total**
Yes	33	41	31	105
No	200	66	10	276

17.Which area of the country do you live in ?[

Aberdeen	6	1	0	7
Aldershot	1	0	0	1
Avon	0	0	1	1
Bath	2	0	0	2
Bedfordshire	8	1	0	9
Berkshire	1	0	0	1
Birmingham	4	5	1	10
Birkenhead	2	0	0	2
Blackburn (Lancs)	4	3	0	7
Bradford	0	1	0	1
Bristol	1	1	0	2
Bucks	2	1	0	3
Cardiff	4	8	1	13
Cambridge	6	5	1	12
Cambridgeshire	2	0	0	2
Cleveland	3	0	0	3
Colchester	1	0	0	1
Cornwall	9	7	1	17
Cotswolds	1	0	0	1
Crewe	1	0	0	1
Dublin	1	0	0	1
Devon	4	0	0	4
East Anglia	4	0	2	6
Essex	1	7	0	8
Exeter	1	1	0	2
Fife	0	1	1	2
Glasgow	4	3	3	10
Gloucestershire	1	0	1	2
Grampian	0	1	0	1
Grimsby	1	0	0	1
Guilford	1	0	0	1
Gwent	5	3	1	9
Hampshire	1	1	0	2
Hertfordshire	1	0	0	1
Humberside	1	0	0	1

Huntingdon	1	0	0	1
Ipswich	1	0	0	1
Ireland	0	1	0	1
Kettering	1	6	0	7
Kidderminster	1	0	1	2
Lancashire	1	0	0	1
Leeds	0	1	0	1
Leicestershire	2	3	0	5
Liverpool	1	0	0	1
London	38	5	6	49
Manchester	35	16	5	56
Merseyside	2	0	1	3
Merthyr Tydfil	0	0	1	1
Middlesborough	1	0	0	1
Middlesex	4	0	0	4
Milton Keynes	1	0	0	1
New age traveller	1	0	0	1
Newmarket	1	0	0	1
Northants	0	4	0	4
North East	0	1	0	1
North Wales	0	0	1	1
North West	0	1	0	1
Norwich	1	0	1	2
Norfolk	0	1	1	2
Nottingham	2	2	0	4
Oldham	2	0	0	2
Penzance	1	1	0	2
Peterbourough	1	1	0	2
Portsmouth	1	0	0	1
Preston	2	0	0	2
Rochdale	3	1	0	4
Salford	2	0	0	2
Scotland	1	0	2	3
Sheffield	4	2	1	7
Shropshire	3	0	0	3
Somerset	1	0	3	4
Southern England	1	0	0	1
South Wales	3	0	0	3
South West	2	1	0	3
South Yorkshire	1	0	0	1
Stockport	3	2	1	6
Suffolk	8	2	1	11
Surrey	0	1	0	1
Swansea	1	0	0	1
Wales	2	1	0	3
Watford	0	1	0	1

West Yorkshire	1	1	0	2
West country	0	0	1	1
Winchester	1	1	0	2
Wigan	1	0	0	1
Wirral	1	0	0	1
Wolverhampton	1	0	0	1
Worcester	3	0	0	3