# MEDIA CAMPAIGNS

**From the start, the government's anti-heroin campaign was controversial, opposed by 'experts' but favoured by politicians. Nick Dorn of ISDD's Research and Development Unit describes the background to the campaign and the evaluations of its impact, reminding those of us south of the border that a separate campaign has been underway in Scotland. This is the first in a short series comparing approaches to prevention north and south of the border.**

**Nicholas Dorn**

The English and Welsh 1985/6 mass media campaign consists of two television commercials aimed at young people, plus advertisements in the youth press and a street poster. Commercial one, code-named *Control*, is a slippery slope story about a young man's loss of control. Commercial two, *Dummy*, features cardboard cut-outs of a young girl falling backwards with a loud crash, then talking, without enthusiasm, to camera.

Some television and print material were also prepared for parents, but take-up of these by the general population has been relatively poor, so they are less significant than the youth-orientated materials.

In mounting the campaign, the government passed over opinion in the fields of health education and drug misuse. In its *Prevention* report, the Advisory Council on the Misuse of Drugs had counselled against any national mass media campaign, especially one relying on fear. The government commissioned Andrew Irving Associates, a market research firm, to see if the Advisory Council's warning was soundly based. Irving's report gave the government the go-ahead to conduct a mass media anti-heroin campaign.

Unfortunately, the research was done so fast that neither a literature review of previous research nor the compilation of a set of relevant questions was feasible. The Health Education Council had wanted more time for research — a position which the Commons Social Services Committee subsequently described as symptomatic of a "lack of urgency".

Evidently, at a political level there had developed something approaching a consensus that the various 'experts' were out of touch and a campaign was needed *soonest*.

## What sort of campaign?

According to Andrew Irving Associate's report, the aim of the English/Welsh campaign should be to build upon young peoples' existing beliefs about the "progressive decline" of the heroin user. Behind this aim lay the objective of convincing "those at risk ... of the undesirability, and dangers of heroin misuse".

Irving was, however, careful not to endorse a scare campaign, calling instead for a "a low key, honest, factual campaign". Whether this advice was followed in the development of the two TV commercials and other youth-orientated materials is a moot point.

The intended message in *Control* and *Dummy* is that heroin use leads to degradation. This degradation is presented in sex-specific ways: boys lose control, and girls lose their looks. Rough versions of the commercials were prepared by the Yellowhammer advertising agency and then tested by another firm, Cragg Ross and Dawson Research Partnership. Cragg Ross described the advertising prepared by Yellowhammer as "not low key but aims to be intrusive and compelling".

From the perspective of the general public, the government cannot fairly be described as having adopted 'scare' tactics. As all the market researchers discovered, most young people are very anti-drug in attitude, and they demand strong images and messages about heroin. For them a portrayal of heroin use is 'true to life' if it shows sunken eyes, double rings below; lank, unkempt hair; thin and wasted body; the downcast head.

A report notes that young people interviewed "spontaneously offered creative advice" to the ad-men, asking for spots and sores, pale yellowing skin, loss of possessions, and deterioration. Some of these popular stereotypes can be seen in the two English/Welsh commercials, where they serve as props to the loss of control theme. But the commercials stop short of more vivid portrayals of death and destruction.

This seems to be the balance struck between a factual approach on the one hand, and a full-blown scare approach on the other. Had the campaign followed the fantasies of the majority of adult respondents, it would have featured "youngsters injecting themselves, vomiting over themselves, shaking uncontrollably, lying in formless heaps, etc. Many youngsters believed the same thing. The popular feeling was that such images would be both unforgettable and very frightening".


**Parents' leaflets: on the left, 'straight' information; on the right, how to 'spot' drugtaking and how to cope.**

THE CAMPAIGN is not only an anti-heroin campaign as such — it is also an intended stimulus to parental and community self-help. As MP Sir David Price asked a witness before the Social Services Committee: "Could it be that the Department [of Health] have another objective — I do not know — and that is a general reassurance of the public that the government are doing something? Or would that be unfair?"

Sir David is correct, since Central Office of Information papers described one of the objectives of the campaign as: "to help convince them [the public] that heroin is, or should be, *their* concern; and to reassure them that the government is taking action". As part of the campaign there were magazine advertisements and TV commercials aimed at parents, inviting them to write off for pamphlets. *Control* and *Dummy* could be seen as helping to provide parents with sufficient interest and motivation to get involved in the national response to heroin and other drugs.

Whatever young people and parents might think of the government's campaign, it certainly caught the attention of TV programme planners (in a way that a purely parent-directed message might not have done) and generated a rush of programmes about young people and drugs. When thinking of the good or the harm that might result, one has to consider not only the government's own commercials but also the broader programming they have provoked.

## Query over outcomes

What young people will make of the campaign in the longer term, and of the rising tide of media interest in which the commercials have become a relatively minor element, is an open question.

The government commissioned Research Bureau Ltd (RBL) to carry out a 'benchmark' survey of young people just as the campaign got under way, a further sampling in Autumn 1985, and a third measure in early Spring 1986. Their reports suggest there has been a strengthening of anti-heroin attitudes and beliefs. Their work has, however, been criticised on methodological grounds by DHSS Research Liaison Group referees.

The Autumn 1985 sample was, for example, less adventurist in several ways than that drawn in the preceding Spring, and this sampling difference *may* have contributed to some of their findings about

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**Les Kay challenges drugs and preventi**
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"Since the *Prevention* report[1] of the Advisory Council on the Misuse of Drugs (ACMD) in 1984, increasing resources have been devoted to preventing drug problems. The ACMD said prevention initiatives should *either* reduce the chance of someone using drugs *or* reduce harm from this use.

To date, most efforts have targeted the first option, and the most significant have been aimed at secondary school children through personal and social education. There has also been the publicity campaign launched by government through press and television.

Failure of these approaches means effort is now being directed to alternative approaches which focus on the community rather than the school. There has also been a shift from primary (reduction of use) to secondary (harm-reduction) strategies.

In what follows I explore some issues raised by these developments, first by presenting a six-point 'Prevention Charter' which might form the basis for our work in this area, then by listing some of the new prevention options suggested by this framework.

## 1 Admit we don't know how to prevent drug use

There is no evidence to demonstrate *any* behavioural change as a consequence of *any* educational strategy for reducing drug use or drug problems.

After reviewing approaches to education about drugs for adolescents, ISDD concluded: "none of these approaches have been shown to reduce either; 1) drug/alcohol experimentation, or 2) any type of harm that may be associated with experimentation, or 3) the chances of experimentation developing into heavy use, in the British situation."[2]

In the USA, the message is the same.[3]

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.

## 2 Don't repeat mistakes

Many educational approaches have stumbled on the simplistic assumption that providing the right sort of knowledge will help restructure attitude, which in itself determines behaviour.

Behaviour is a much more complicated product of a range of factors than this model allows for. For example, it may be that behaviour can restructure attitudes, rather than the reverse.

Most smokers are aware of the harm being done to them. Probably most feel they should stop. But these views do not necessarily carry through to behaviour. Many go to an 'early' grave still holding those views *and the cigarettes*.

What is true for education in schools also holds for public education. The current advertising campaign emphasises the nastiness rather than the horror of drugs, an approach described in government circles as the 'chill factor'.

Once more psychological research has clearly demonstrated the pointlessness of these approaches based on manipulation of fear.[4] The government's own Advisory Council on the Misuse of Drugs has argued against a national campaign targeting one drug or any form of drug education that aims to scare.[5] Despite this advice, backed up by solid research, we plough on with the same old approach.

## 3 Controlled experiments only

Given the above, future attempts at preventing drug use can only be justified as innovative and carefully evaluated experiments. The main lessons we have learnt from previous evaluations have been methodological.

We realise the importance of measuring the impact of a specific programme at a number of points in time rather than just at the end. From work on smoking, we also understand the importance of the differing impact of prevention messages on different groups. Results from blanket programmes may hide what could be significant variations in their impact on these groups.

Our evaluation methods should also learn from the past and be sufficiently rigorous to produce reliable results.

## 4 Unshackle PSE from prevention

'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.

Current approaches to personal and social education (PSE) aim to enhance the power of young people to make their *own* decisions about important life events. Prevention assumes that we can set off with a set of objectives, which we can transfer to young people who will then adopt them as their own. But autonomous decision-making implies they will be able to resist not just peer group pressure, but *our* influences too.

We cannot logically demand that young people become more autonomous, *and* do what we want them to do.

Education should be about positive outcomes such as healthy lifestyles rather than narrow, negative, 'don't do it' messages. If we can unshackle PSE from prevention, teachers can get on with what they are good at, while we try to find other ways of preventing drug harm.

## 5 Expose hypocrisy

Among professionals, issues of relative harm from different forms of drug use have been adequately dealt with. Most will quickly recognise that problem drug use can embrace a wide range of substances, including legal drugs. But we are failing to translate these insights into the public arena.

For many people 'killer heroin' has assumed a demonic status. Yet harm from heroin use is miniscule compared to harm from 'killer alcohol' or 'killer tobacco'.

Rough estimates for the UK would suggest less than 150 deaths from heroin, up to 10,000 from alcohol, and about 100,000 from tobacco. Many more people drink or smoke than use heroin, but the assumption that we have 'killer heroin' and, by implication, 'safe alcohol and tobacco', bears no relation to the truth.

There are reasons why we have been hesitant to expose this hypocrisy. Most of our agencies are funded by a government which has put a relatively large amount of money into the field because of its concern about 'killer heroin'. Establishing in public that alcohol and tobacco are also major drug problems can be a risky business, threatening our continued professional survival.

Our understandable failure to confront these issues may well have become part of the problem. Turning the situation around will require consistent attention from us and a determination not to duck out of sight when the flak starts to fly.

## 6 Promote community harm-reduction

This is the element which opens up a whole new range of work. To date, we have done little to address the second of the two main objectives identified by the Advisory Council — preventing drug harm. I would argue this is because we have been bogged down pursuing the chimera of primary prevention, or prevention of the *use* of drugs. There is a vast, practically unexplored range of secondary prevention options designed to reduce *harm* from drug use.

In what follows eight such options are identified. Some of the issues and questions raised by each option are explored. One thread running throughout is the need for more useful local information on drug use,

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1. Advisory Council on the Misuse of Drugs. *Prevention*. London: HMSO, 1984. Available from ISDD, £4.25 inc. p&p.
2. ISDD Research and Development Unit. *Drugs in health education: trends and issues*. London: ISDD, 1984. Available from ISDD, £0.40 inc. p&p.
3. See for example: Moskowitz J. M. Preventing adolescent substance abuse through drug education. In: National Institute on Drug Abuse. *Preventing adolescent drug abuse: intervention strategies*. Rockville, Md: NIDA, 1983.
4. Leventhal H. Findings and theory in the study of fear communications. In: Berkowitz L. *ed. Advances in*