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CITY UNIVERSITY, LONDON

# The Impact of Perceptions of Risk on Healthcare and Health Behaviours

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Submitted in fulfilment of the requirements of  
the degree

of  
Doctorate in Health  
Psychology

By

**Rhia Gohel**

**May 2016**

Psychology Department, City University London

**THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED  
FOR COPYRIGHT REASONS:**

1. Publishable Papers: Experiences of hospital admission and discharge for the homeless population of Islington in London pg. 198-279
2. Publishable Papers: PsyPAG article: Is talking to Frank doing more harm than good? Why current harm reduction campaigns for those who regularly consume are failing. Pg.280-291
3. Appendix 23: Sleep handout pg. 362-378

**THE NAMES OF SOME ORGANISATIONS INCLUDED IN THIS THESIS  
HAVE BEEN REDACTED FOR DATA PROTECTION REASONS**

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This thesis would not exist if it were not for the participants who have taken part in the competencies as well as the research. I would like to thank you all for your time, your belief in my skills, and for sharing your unique journey with me.

I would also like to say thank you to my brother, my boyfriend, my late grandfather, who would have been so proud of me, and my dearest friends. Thank you for your unconditional love, support, encouragement and pep talks. I know I haven't been the easiest person to be around, but I want you all to know I really appreciate everything you have all done.

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## **Declaration**

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## SECTION A: PREFACE

This portfolio is a documentation of how the required competencies were met in order to submit for the Professional Doctorate in Health Psychology at City University. It consists of practical examples of how I have implemented Health Psychology at both a practical and theoretical level within my academic and clinical work. The doctoral thesis within this portfolio concentrates on trying to understand the effectiveness and experiences of drugs education, and how this impacts on an individual's decision to use substances. In addition, two teaching and training case studies have been completed; with one focussing on training National Health Service (NHS) professionals on substance use, and the other focussing on training patients on psycho-social methods to manage their pulmonary conditions. The intervention competency focussed on delivering an intervention to improve sleep among a patient group who had difficulties with the maintenance of healthy sleep behaviour. A consultancy was designed for an organisation to deliver mental health awareness training for an organisation who specialise in substance use. A systematic review was also conducted to understand the effectiveness of Public Service Announcements on reducing marijuana use among the teenage population. Furthermore, a qualitative study was conducted on the experiences of hospital admission and discharge among the homeless population in Islington, London.

The '*common thread*' which links the competencies together concerns the area of risk and risk perception in relation to health and healthcare. Risk perception is an important area of research for Health Psychologists, as individuals can often misinterpret their risk of health problems through either over or under interpretation. Therefore an individual may become more susceptible to the choices they make in terms of how they view their health behaviours, how they choose to safeguard their behaviours (if at all) and whether they perceive they have the same rights as others in terms of accessing fair and equal healthcare, free from judgement or bias.

The health psychology doctorate has enabled me to grasp a solid understanding of how models of behaviour and behaviour change can be understood and utilised to facilitate

understanding and behaviour change in individuals. Throughout the conduction of this doctorate, my skills as an applied psychologist have grown. I believe that my research and evaluation skills have developed considerably, along with my critical thinking and interpretation of findings. My insight and perception of the complex interaction of health, wellbeing and health behaviours have increased dramatically, with the understanding that nothing is ever quite what it initially seems. In the future, I hope to pursue a role working within global healthcare policy, to reduce risk and inequalities in healthcare.

## SECTION B: RESEARCH

### 1. Research

**Is the United Kingdom (UK) government's current drug education strategy working? An exploratory study considering the effect of 'Talk to Frank' on perceived risk and intent to use substances, and the experiences of substance use education for young adults in London and the surrounding counties.**

#### Abstract

**Purpose:** A societal response to the existence of substance misuse fluctuates between harm minimisation and prohibition. Until recently, little attention has been paid to the importance of the individual's substance use experiences, which are vital to understanding the social and contextual reasons to understanding why someone chooses to use, and are therefore of imperative importance to facilitating the design and delivery of a substance use health promotion campaign. The purpose of this study is to investigate the efficacy of the television adverts shown as part of the previously unstudied 'Talk to Frank' intervention in relation to an individual's perceived risk of taking a substance and their intent to use substances in the future. It is also to get a better understanding of the educational experiences surrounding substance use, in order to provide information to health psychologists devising and developing health promotion campaigns concerning substance use in the future.

**Design:** A mixed-methods design was employed in order to quantitatively analyse the data collected from the study testing the efficacy of the 'Talk to Frank' intervention. To follow this, semi-structured interviews were conducted with a third of the study population to gain an understanding of their experiences of substance use education, and how this impacted their substance use experiences.

**Findings:** The 'Talk to Frank' television adverts were unsuccessful at increasing perceived risk and reducing intent to use. However, a positive correlation was found between participants' previous substance use scores and their intent to use substances in the future. The results of the qualitative analysis indicated that participants draw on a

variety of 'primary', 'secondary' and 'tertiary' learning experiences to enhance their understanding of substance use, which therefore affects their substance use behaviour.

**Originality/value:** This study calls for health psychologists and other health educators to focus on understanding the lived experiences of substance use education so that these findings can be implemented back into designing a more effective intervention.

**Keywords:** Health education, substance use, drugs, Public Service Announcements, Interpretative Phenomenological Analysis, mass media campaigns and substance misuse prevention.

## **Introduction**

Drug, alcohol and tobacco use (from hereafter will be referred to as substance use) is a common phenomenon that occurs amongst individuals, within social contexts, and at different periods throughout the life trajectory.

Substance abuse has been defined as “the harmful or hazardous use of psychoactive substances, including cigarettes, alcohol and illicit drugs” by the World Health Organisation (2015). For the purposes of this study, drug use has been defined as any substances that are used which are illegal within the country of use. It is important to note the differences in terminology that are used when discussing substance use and drug use: substance use covers the use of all substances, whether legal or illegal, whereas drug use primarily concerns the use of substances which are considered to be illegal within the country of use.

Most substance use is documented within the media and other sources as problematic. However, research suggests that the vast majority of those who use substances do so in a way that is controlled, sensible, and recreational (Measham, Newcombe & Parker, 1994; Measham & Shiner, 2009; Measham, Williams & Aldridge, 2011). This literature review aims to describe British trends in both the prevalence and patterns of substance use, along with theoretical insights into the reasons why an individual may choose to use, the effectiveness and dissemination of current substance use education, and the relevance of health psychology models on substance use patterns and prevalence.

### **Illicit drug use in the United Kingdom**

Studies of recreational drug use have revealed that those from the United Kingdom (UK) have drug consumption patterns wider in repertoire and greater in frequency than national household studies of the worldwide general young adult population (Deehan & Saville, 2003; European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2008; Ramsay, Baker, Goulden, Sharp & Sondhi, 2001). In order to understand current and emerging patterns of recreational drug use in the UK, it is important to firstly understand the rates of use; the contexts in which they are used; the reasons as to why they are used, and the place that drug use has within their lifestyle.



## The Statistics

The Crime Survey for England and Wales (CSEW; previously the British Crime Survey), is a self-reported household survey conducted annually to measure behaviours associated with crime, conducted amongst 16-59 year olds. The 2013/2014 CSEW found that 35.6% of respondents had tried illicit drugs at least once in their lives, and that this more than doubled when looking at the age subgroup of 16 to 24 year olds (18.9%). Trends from this survey indicate that overall drug use has increased between 2012/2013 and 2013/2014, with cocaine, ketamine, 3,4-methylenedioxy-methamphetamine (MDMA) and lysergic acid diethylamide (LSD) use increasing in 2013/2014 from the 2012/2013 data. The study also found that there were no statistically significant decreases in drug use from 2012/2013 to 2013/2014. Furthermore, levels of use of any illicit drug more than once a month on average in the last year were higher among men than women, among those who frequented pubs and nightclubs, and among those who lived in more deprived areas. In addition, those who went to nightclubs frequently were more likely to use drugs frequently, with levels of use of any illicit drug in the past month being 10.9% for those who went to a nightclub four or more times in the last month, compared with 2.3% of respondents who had not visited a nightclub in the last month. In particular, MDMA use was found to be 15 times higher amongst those who had visited a nightclub at least 4 times in a month (11.9%) in comparison to those who had not visited a nightclub in the past month (0.8%).

The average age of someone using an illicit drug in England and Wales has also risen, from 26.6 years in 1996 to 29.3 years in 2013/2014 (All data: The Home Office: CSEW, 2013/2014). However, whilst the CSEW provides invaluable information about trends in drug use amongst the general population, it does not provide specific information on trends in drug use amongst a population that is already using. It also does not explore the social context of drug taking, motivations behind drug use, or how drugs fit in with more general lifestyle choices (Deehan & Saville, 2003).

Cross-sectional surveys such as the CSEW are useful in producing '*trend*' data, as they allow researchers to identify population level trends in drug taking, and therefore provide indications as to whether the use of a particular drug is decreasing, increasing or remaining stable. However, they have been found to underestimate current drug use

(Gore, 1999) and capture disproportionate data on males to females (Hoare & Moon, 2010). In addition, non-response has increased over the last two decades for the British Crime Survey and CSEW, and for international social surveys (Galea & Tracy, 2007), causing concern about response bias. Furthermore, The EMCDDA (2009) has identified a falling response rate in European surveys with disproportionate non-response rates from young people, drinkers and drug users; and the lack of an internationally standardised methodology. Additionally, these types of studies do not capture data on specific populations such as those who reside in institutional settings like prisons, the homeless, and those who live busy and/or chaotic lives who simply do not have the time to participate in interviews. Therefore, they automatically exclude a large population of those who are more likely to be engaged in some form of drug use (Hoare and Moon, 2010). It has also been found that non-responders are more likely to be heavy drinkers (Hill, Roberts, Ewings & Gunnell, 1997), smokers (Vink, Willernsen, Stubbe, Middeldorp, Ligthart et al., 2004) and drug users (Cunradi, Moore, Killoran & Ames, 2005). Therefore, this suggests that there is a very real possibility that the data provided by these studies is inaccurate, and as a result, there has been increasing concern that willingness to admit to specific substance use behaviours may be changing over time, and may actually be reported by individuals in reactance to changing social, political or policy contexts (Fendrich & Vaughn, 1994) thus reducing the ability to identify any real changes in behaviour.

In addition to the above issues, these surveys do not provide information on an individual's substance use throughout a lifetime period. Longitudinal surveys such as the North West Longitudinal Survey are useful in understanding patterns of recreational use as they are able to follow an individual over their lifetime. They also ask important questions relating to the onset of their substance use, the desistance of their substance use, and any relapses that may have occurred. Furthermore, they are able to measure the nature of the use, the context in which it is most commonly used in, as well as changes in frequency and intensity of use, and how this may change in shift between occasional, recreational and more frequent or dependent use (Simpson, 2003). In particular, the North West Longitudinal Study has found that women were less likely than men to be recent drug users in their late teens and early twenties. However, by the

age of 27, they were just as likely to be recent drug users (Measham, Williams & Aldridge, 2011).

Apart from the 2013/2014 data collected, the drug use prevalence period post-2000 has shown that there have been small but regular decreases in drug taking prevalence, (CSEW, 2014). Although this may be the case, it is important to note that drug taking prevalence remains still at relatively high levels. For those who are still using, drug use appears to be entrenched within their lifestyles. The behaviour of drug users can often remain a mystery due to the illegality surrounding drug use, and for this reason, it is often difficult to study recreational drug users. Aldridge (2008) has argued that this overall downward trend could be due to the following reasons:

*Period effect:* Some individuals are actually stopping use of certain substances, and are therefore changing their health behaviour. She argues that over time, people are generally more likely to discontinue their use of drugs.

*Cohort effect:* The individuals studied are not actually changing their drug use at all, but as each year continues, the new cohort of individuals is made up of less of the '*drug-involved generation*' (Aldridge, 2008), that are now moving into the higher age bands and are therefore excluded by the study's parameters. She therefore argues that if this is the case, the expectation is that the drug taking prevalence rates may level off in the coming future, which is perhaps the indicative trend shown through the results published in this year's Crime Survey for England and Wales (CSEW, 2014).

Nevertheless, the patterns of use, including the types of drug individuals are choosing to use and the contexts in which they are choosing to use appear to be changing. The Global Drug Survey (GDS) is an annual survey conducted in partnership with Mixmag, a popular dance culture magazine in the UK that has an international following. This study aims to find out the current trends in substance use consumption at a local, national and global level, in order for data to be shared to introduce harm reduction interventions based upon its geographical substance use data (GDS, 2015). The 2014 survey had some interesting and surprising findings: one in ten UK users had taken a '*mystery white powder*', despite having no idea what this white powder was, with 80% of those reporting their behaviour indicating they were already intoxicated at the time of consumption (GDS, 2014). This in itself could pose serious health implications for the

recreational user. More worryingly, there was a sharp increase in deaths related to substance misuse of 21% in 2013 from 2012. In specific, deaths as a result of heroin and morphine use, methadone, all amphetamines (including speed and cocaine), MDMA, para-Methoxyamphetamine (PMA) / para-Methoxy-N-methylamphetamine (PMMA), novel psychoactive substances, cathinone's, mephedrone and legal benzodiazepines that are commonly misused had all risen since 2012 (Office of National Statistics, 2013).

According to Nutt, King and Phillips (2010), *"drugs including alcohol and tobacco problems are major causes of harm to individuals and society"* (2010: p. 1558). Within this paper, Nutt et al. (2010) argues that alcohol is the most harmful drug to individuals and society, followed by heroin, crack-cocaine, methamphetamine, cocaine and tobacco. Cannabis, which is a commonly used recreational substance, appears eighth in the list, and more surprisingly, drugs that are considered to be Class A under the Misuse of Drugs Act 1971 appear much lower down in the list, with MDMA and LSD appearing 17<sup>th</sup> and 18<sup>th</sup> in the list out of a possible 20. With this in mind, it raises the question as to why there has been an overall increase in deaths from MDMA use from 1995 when official figures actually suggest that drug use has declined since this period. It suggests that those that are using may not be receiving harm reduction information in relation to their drug use.

The location that substances are most commonly used in also appears to be changing. For example, MDMA (which has a reputation as a club drug) was reportedly used by 36% of drug users in the previous 12 months who do not go clubbing (GDS, 2014) This is in contradiction to the findings of the CSEW, which suggested that only 0.8% of the study population that had not visited a nightclub in the past month had used MDMA (CSEW, 2013/2014). In addition, UK respondents of this study were more likely to say they had taken cannabis than tobacco or even energy drinks at some point in their life (GDS, 2013). These figures show that substance use is constantly evolving, and as a result, any harm reduction strategies that are implemented should reflect the continual changing substance use scene.

### **Availability of recreational drugs**

A report conducted by Eurobarometer (2002) studied the use and opinions of substances among 7,687 young Europeans aged 15 to 24 from all countries in the

European Union and found that many young Europeans stated that they had found it relatively easy to obtain illegal drugs, whether that be in parties, pubs, and clubs or in school or close to their homes. Calafat, Fernandez, Juan, Anttila, Arias et al. (2003) argue that this is an indication that drug use is deeply entrenched within society and that there is a low social rejection of substances, with these buying and selling situations arising from the widespread acceptance of recreational drugs by a significant sector of young people. As a result, Calafat et al. (2003) argue that frequent drug use is occurring in recreational contexts and exists within a climate of social acceptance and normality. Taking into account the above statistical information, it is evident that frequent drug use is occurring in recreational spheres within an environment of social acceptance and normality in present day society within the United Kingdom and Europe. Therefore, it is important to give recognition to the social context of recreational drug use.

### **The Social Context – Deviant Behaviour as a Recreational Activity**

Recreational drug use seems to be more affiliated with certain activities and lifestyle choices. In particular, a number of studies examining drug use have found a strong correlation between those who frequently visit nightclubs and the recreational use of drugs (Duff, 2005; Bellis, Hughes, Bennett & Thompson, 2003; Deehan & Saville, 2003; Hunt, Bergeron & Milhet, 2011). However, other studies have also highlighted the importance of recreational drug use that takes place in the context of private spaces and social settings, as well as the health and social risks and harm that may be associated with this type of consumption (Duff, Johnston, Moore & Goran, 2007; Parker et al., 1998). Private settings are considered to have their own unique '*risk environments*' (Rhodes, 2002) in comparison to the bars, clubs and raves that have been more extensively investigated (Hunt et al., 2011). For example, a study by Race (2009) suggests that young people consume a wider range of drugs in higher quantities in private settings in comparison to a public setting. Private settings are also known for pre-loading, whereby an individual will consume alcohol before going out, which implies that a higher level of total substance use consumption is gained over the period of the night out, (McClatchley, Shorter & Chalmers, 2014; Østergaard & Skov, 2014).

## The Normalisation Debate

The proposition that the UK is experiencing the '*normalisation*' of drug use by young people has been widely noted in the literature (Hammersley, Marsland & Reid, 2003; Measham, & Aldridge, 1995; Measham, Aldridge, & Parker, 2001; Measham, Newcombe, & Parker, 1994; Measham, Parker, & Aldridge, 1998; Parker, 2005; Parker, Parker, Williams, & Aldridge, 2002; Measham & Shiner, 2009; Williams & Parker, 2001). Previously, illicit drug use was greatly attributed to individual or social pathology. However, the normalisation thesis as described most fully by Parker, Aldridge and Measham (1995) has brought to attention an unremarkable feature of young people's lives. This being that the recreational consumption of drug use incorporated into their consumer-oriented lifestyle in order to seek pleasure, excitement, and enjoyment. They argued that for many, taking drugs has '*become the norm*', and that in the future, youth non-drug users would actually be in the minority (Parker et al., 1995). Within the literature, normalisation of drug use has been conceptualised into six key dimensions which include: drug availability or offers, drug trying or lifetime prevalence, current usage, intended future use, being '*drug wise*' – regardless of individual experiences with drugs, and evidence that the drug has been culturally accommodated within society (Measham & Shiner, 2009).

In comparison to major criminological theories such as disorganisation theory, general strain theory, and the general theory of crime (i.e. control theory) which attempt to explain youth drug use (Baron, 2004; Lambert, Brown, Phillips & Lalongo, 2004; Pratt & Cullen, 2000), the normalisation argument aims to provide an alternative explanation for youth drug use, arguing that not all drug use is problematic and dysfunctional. Instead, the normalisation argument suggests that drug use by the youth may be a part of their key leisure activity (Hunt et al., 2007; Measham et al., 2001; Measham & Shiner, 2009; Rojek, 2000; Sanders, 2006; Soar, Turner & Parrott, 2006). Therefore, drug use does not necessarily negatively impair a young person's ability to function and play a contributory role within society, neither is their use stigmatised by their peers. Instead, their use is viewed as common practice that is a part of their daily, weekly or monthly routines (Sanders, 2012). Therefore, as drug use does not occur as a result of chronic pathology, the normalisation thesis argues that it instead occurs due to the value the individual places on the use of the drug, the meaning that it has for them, and the way

that it is used in context of a pleasure-seeking activity (Sanders, 2012). Use of drugs such as cannabis have moved from the fringes of youth culture to the centre of it, and Parker et al. (1998; 2002) argue that although normalisation does not necessarily refer to how drug use has become a day-to-day activity for young drug users, it is now a very common feature of the youth leisure landscape.

Critics of the normalisation thesis argue that it exaggerates the amount of illegal drug use amongst the youth population; that it did not take into consideration the context into how and where drugs were used, and that it simplifies the complex reasons why youth use them (Shiner and Newburn, 1996, 1997; 1999). They have also argued that there is a lack of empirical evidence to suggest that drugs were normalised within a particular population (Pilkington, 2007; Shildrick, 2002), including the youth in general (Shiner and Newburn, 1997; 1999). Blackman (2004) additionally argues within his paper that the normalisation thesis can be criticised for potentially implying that those who use are in more control of their drug consumption choices through their decision-making abilities. Therefore, as a result, this has led to social policies trying to advance the prohibition argument further by suggesting increased regulation and a stronger drug policy. This has been evident through the introduction of drug testing of those who have been arrested, including the youth and young adults in schools and leisure venues (Carver, 2004; McKeganey, 2005), and the reclassification of cannabis from a Class C to a Class B, even though the evidence presented by Nutt et al. (2010) would argue otherwise. It has also been shown through the expansion of the Misuse of Drugs Act 1971 to include additional psychoactive substances that are commonly used in a recreational manner such as ketamine and fresh '*magic*' mushrooms (Measham & Moore, 2008; Moore & Measham, 2008). However, others have found support for the normalisation argument and suggest that it is in agreement for *specific* illicit substances among *certain* populations (Duff, 2005; MacKenzie, Hunt & Joe-Laidler, 2005; Sanders 2005a, 2005b; Moloney, Hunt and Evans, 2008; Sanders, Lankenau, Jackson-Bloom & Hathazi, 2008). This has also been shown in other countries, with young drug users in the general United States of America (USA) population showing to have polarising attitudes about various illegal drugs, whereby some illegal substances are seen to be more harmful than others. For example, in the Monitoring the Future study conducted by Johnston, O'Malley, Miech, Bachman & Schulenberg (2015), it is suggested that

although marijuana use has declined overall in the USA, youth marijuana attitudes have moved toward greater acceptance, and as a result, perceived risk of regular cannabis use among the youth population has declined in comparison to other drugs. Cannabis use was also seen to be as less harmful and more social than other drugs (Johnston et al. 2015).

If the normalisation of drug use is occurring, it is important to consider the effects of this when designing and developing a health promotion campaign targeting drug use. This is because a harm reduction approach may make the most sense when trying to safely manage the use of recreational drugs by the population, as if drug use is seen to be an ordinary activity, then they should be provided with information which enables them to prevent or reduce the harmful consequences of taking such substances. This is in line with what would occur for harm reduction campaigns concerning alcohol consumption or being given recommendations on diet and exercise.

### **The Postmodern Society and the impact of Media**

Although the normalisation debate has moved on, there is no doubt that it remains one of the most influential in terms of the development of the understanding of drug use (Measham & Shiner, 2009). There is also no doubt that illicit drug use is becoming more accepted, discussed and normalised in mainstream culture. For example, in 2005, the British Tabloid - *The Daily Mirror* published front page photographs of fashion model Kate Moss taking cocaine. In 2009, Olympian swimmer Michael Phelps was photographed by the *News of the World* smoking from a cannabis bong. In 2010, Paris Hilton was charged with possession of cocaine. In 2013, Fashion model Cara Delevigne was pictured by paparazzi dropping a small bag with what appeared to be powdered cocaine inside it. In the same year, celebrity chef Nigella Lawson admitted in court that she had been a regular user of cocaine for 10 years. Regular and recreational drug use has also slipped into the entertainment industry, with mainstream USA films such as *Harold and Kumar Get the Munchies*, *Pineapple Express*, and more underground, gritty UK based films such as *Harry Brown*, *Shifty* and *Kidulthood*, normalising recreational drug use within them. In addition, television shows aimed at young adults such as the Channel 4 show *Skins* normalised recreational drug use among British youth population. Within these dramas, drug use is depicted as an every-day part of British youth culture



and life. The mention of recreational drug use in popular music has also seen a revival, with artists such as Miley Cyrus singing about MDMA, rapper Wiz Khalifa and popular UK grime artists such as The Newham Generals and Dizzee Rascal talking of cannabis, and Rihanna singing about cocaine.

The media provides a reflection of society, and in doing so, enables an individual to see if what they are doing is '*normal*' in comparison to the rest of the postmodern world. This world, along with its socio-political climate, has an impact upon how the media influences and constructs its ideas and informs the world. For example, when there is a time of risk or uncertainty, the media will report and frame events in a particular way. The early 21<sup>st</sup> Century has seen the rise of terrorism, in particular, extremist Islamism and the UK and USA governmental hacking of other citizens and states. The way that these events have been reported within the UK mainstream media implies that the general public are at continual risk of some form of threat. As a result, the balance of security and freedom is focussed on and governed through how we perceive crime and insecurity (Simon, 2007).

In regards to drugs use, the media is able to '*agenda-set*' in a similar way. The tone, emphasis and use of statistics within an article aim to assist a reader to make an informed choice about what they are reading, with the illusion being that through the use of statistics, the information that they are being given is '*fact*' (Mountney, 2015). In addition, this information aims to guide the reader into making a decision, as even if the media source may not be "*consciously engaged in crusading or muck-racking, their very reporting of certain 'facts' can be sufficient to generate concern, anxiety, indignation or panic*" (Cohen, 2002: 16, in Mountney, 2015: 144). By enforcing these scare tactics and horror stories, the media is able to influence the general public and is also seen to act as an agency that is able to enforce the existing will of agenda setters, in contrast to them independently forming shaping public opinion (Lancaster, Hughes, Spicer, Matthew-Simmons & Dillon, 2011). Linked to this is the work of Coomber, Morris and Dunn (2000), who argues that any drug-related issues that are reported within the British press are sensationalised and exaggerated in some way, shape or form. They suggest that representations of drug use in the media create further issues for the drug using population as if issues were reported in an unbiased and informed style; it would assist in the prevention of drug misuse.

Mountney (2015: 147) argues that the way in which the media depicts illicit drugs, drug users and its associated acts of deviance has arisen from a particular subculture to become the “*centre stage of media reports, public opinion and subsequently policy debates*”. He argues that this therefore results in the news about drugs being reported in a sensationalist way, that by using emotive language and playing on popular misconceptions, it generates headlines, sells stories, and makes for good reading (Mountney, 2015). This is further evidenced by Weisman, in Coomber et al’s., (2000) paper, whereby Weisman is quoted as “*cooking figures and using alarmist headlines and prose... to convince readers that practically everyone they know is addicted to crack, and that they too are likely to be addicted soon*” (Coomber et al., 2000: 688).

The above information is important to consider when we are thinking of the recreational drug user. It has been argued that the substance use scene of today is impacted largely by the media, including the internet, where ‘*underground*’ websites concerning the dance sub-culture, or drug sub-culture provide vast quantities of information to the individual on how to obtain, synthesise, extract, identify and ingest substances (Bogenschutz, 2001; Halpern & Pope, 2001). Although this clearly shows that there is a prevailing interest for those who wish to seek the information, more worryingly, it has been found that some of these drugs have largely not been empirically evaluated for dose range, effect, risk, or abuse liability due to the limitations sanctioned on them as a result of their illegality (Franken, 2001). This potentially means that those who are using are doing so in a way that may be putting them at risk.

In part, drug use may be further normalised to the recreational user, as they may perceive that everyone in their social cohort is consuming recreational drugs (for example, watching the television programme *Skins* may result in a young adult thinking that everyone in their cohort is a regular consumer of recreational drugs). It also may potentially further alienate them from mainstream society; they may think of their drug use as risky and deviant, and this may prevent them from seeking help and support about their recreational drug use from health agencies. Their drug use may also meet a need to belong: by becoming a part of this apparent deviant subculture as portrayed by the mass media, drug use may give an individual a sense of identity and belonging and may further involve them with drug use. The information that is provided by the media may also be biased. For example, it has been found that there are many more reports

concerning the use of ecstasy in comparison to solvent abuse, even though solvents are considered to have a proportionately higher risk of death to users (Manning, 2007). In addition, the way that the reports are conducted about ecstasy frame a ‘threat to the innocents’, with the case of Leah Betts – an 18 year old, middle class white girl, dying as a result of ecstasy use being used as an example (Manning, 2007; Murji, 1998). It does not tend to reflect the demographics of actual drug-related deaths within the community, most of whom tend to be male, multi-drug experienced, and are rarely teenagers (Graham, Matthews, Dunbar & Stoner; 2010; Office for National Statistics, 2011).

The above portrayal of recreational drug use by the mainstream media may further alienate the recreational user from the general population of those who do not use and who ‘believe’ the stories written, as the general population may learn to view the recreational user as deviant and as a victim of their use, whereas the user may view their use in an entirely different fashion, as one of recreational consumption, choice, and a consumerist, rational cost-benefit decision (Measham, 2004). This further creates a barrier between the using and non-using population and serves to encourage fear and fosters a lack of discernment between both parties and fits in with Crawford’s (2009: 97) ideas on “*living in an age of increased insecurity and uncertainty*”. According to Crawford (2009) if the media is informing a user that their use is not “*normal*” or that they will be harmed, stigmatised or discriminated against in some way, it results in an individual feeling marginalised from society, which may prevent them from seeking effective harm reduction information to save their lives.

An example of how this has currently occurred within mainstream media of late is with the previously-legal high mephedrone (Forsyth, 2012; Measham et al. 2010). A new drug of concern is considered to firstly be newsworthy if it is considered to be novel (Braden, 1973; Forsyth, 2001). If a substance is considered to be harmful and a high profile case or increased prevalence occurs, the drug is then subsequently constructed into a problem by the media (Levine and Reinerman, 1988; Young, 1973). The media raising awareness about a new drug of concern may in fact be very unhelpful, as it diverts attention away from drugs that cause more physical and societal harm such as alcohol (Nutt et al., 2010), and additionally provides free advertising; a term coined by Farrell (1989) as ‘*the oxygen of publicity*’. Mephedrone was unique in comparison to

other drug scares such as ecstasy, as it occurred in a time where the internet and social media was at the forefront of transferring information. The media were not only describing in great details the effect of mephedrone, but were also informing users or potential users about how they could get hold of it through an online source (Forsyth, 2012). Information was quick and easy to access, and could be passed from one individual to another through the re-posting of tweets on Twitter, sharing on sites such as Facebook, and through user generated content such as on blogging sites (Forsyth, 2012). Substances had now become easier to get hold of, with deliveries to their front door within the same day (Forsyth, 2012). Furthermore, along with its convenience, mephedrone fit in well with the consumerist nature of the recreational substance user as the user was able to buy it from a reputable website, with their substance of choice coming along with recommendations and testimonials left by other users. This compares their substance use to any other commodity that they require and purchase to live their day-to-day lives, (South, 2004). Therefore the recreational substance user is seen as being a consumer, who most usually have regular employment, contribute to society, and use their substance of choice to achieve a specific outcome in a specific context, which they have researched and paid for through their *'hard-earned cash'*. They see their use as relaxation, escapism, or the equivalent of a risky hobby such as playing rugby (Gossop, 2000), which is conducted to provide the individual with a temporary 'time out' from their everyday responsibilities, conducted within their control (Measham, 2004). This is in stark comparison to a high-problem drug user who funds their habit by daily involvement of crime, and who relies on dealers that have strong market and crime connections (Bennett, Holloway & Williams, 2001).

### **Risk and *'The Other'***

Although used for leisure and recreational consumption, the harm that recreational substance misuse can cause to the individual and society in general cannot be ignored by health psychologists. Studies conducted by social scientists and public health researchers on a variety of substances used recreationally, such as MDMA/ecstasy, cannabis and cocaine highlight the growing concern about the potential harm that may result if effective harm reduction interventions in the form of prevention and health education are not delivered to the user in concern (Baggott, 2002; Carlson et al. 2004; Dew, Elifson, & Sterk, 2006; Gamma, Jerome, Liechti, & Sumnall, 2005; Hall, 2015;

McElrath & McEvoy, 2002; Reid, Elifson, & Sterk, 2007; Riley & Hayward, 2004; Ruiz, Paolieri, Colzato, & Bajo, 2014; Sellaro, Hommel, & Colzato, 2014; Scholey et al. 2004; Schwingel, Zoppi & Cotrim, 2014; Theall, Elifson, & Sterk, 2006; Vonmoos, Hulka, Preller, Jenni & Baumgartner et al. 2013).

By those who use, recreational substance use has been shown in the literature to be viewed in a hierarchy of danger, with some drugs being viewed as more 'risky' to take than others. There is growing evidence to suggest that those who consume drugs clearly make a distinction between the controlled use of cannabis and the dependent use of drugs such as heroin and crack cocaine (Boys, Fountain, Griffiths, Marsden, Stillwell et al., 2000; Hart & Hunt, 1997; Perri, Jupp, Perry & Laskey, 1997; Young & Jones, 1997). Joffe (1999) within her book *'Risk and The Other'* discusses a phenomenon where an individual composes a framework of their risk in relation to how much they perceive others to be in risk. She argues that we currently live in a Risk Society (Beck, 1986/1992), or Risk Climate (Giddens, 1991) whereby although the advancement of technology has created a safer world, it has additionally created an increased sense of risk. She argues that this risk is continually depicted to the individual through the various outlets of mass media by experts in the relevant field and as a result, the individual's awareness has been heightened. In addition, she argues that these risks are often presented in a way that depicts them as statistically describable and consequently, somewhat 'predictable'. She argues that the social psychological theory of optimistic bias states that an individual will always perceive their risk to be less than that of their peer, and are unreasonably optimistic about their own susceptibility to danger. As a result, they develop a 'not me', 'not my group' and 'others are to blame' type of argument when considering their substance use in relation to others, with the rationale that someone, somewhere is always conducting in worse substance-related behaviour than they are.

Using Joffe's (1999) argument as a premise, it therefore may be considered that those who use substances do so in a way that almost explains away their use, that *'although I may smoke cannabis, at least I don't do it every-day'*, or *'I may smoke cannabis everyday but at least I don't take Class A's'*. This in itself is a dangerous phenomenon, as if substance users are continually explaining away their substance use by comparing it to *'the other'*, they may be unaware of the risks they face themselves, and therefore instead

of using a “*rational cost-benefit analysis*” to use substances in a safe manner as suggested by Measham (2004: 319), they may instead compare their already risky behaviour to those who are conducting even more riskier behaviour as a means of justifying their substance use to themselves and to others. A primary concern of health psychology is to identify risk behaviours which implement behaviour change interventions (Marks, Murray, Evans, Willig, Woodall et al., 2005). However, if risk behaviours are not fully understood, an impact to the overall significance of any intervention that is developed will be impaired.

### **Consumerism and Substance Use**

Measham (2002) argues that the manner of how recreational substances are consumed is as a result of the postmodern, consumerist society that we live in. This role of consumerism within the postmodern world is important when considering reasons why recreational substance use is conducted on such a large scale. The concept of normalisation has brought with it the idea that those who engage in substance use are doing so in order to meet a need which is otherwise unfulfilled. This is in comparison to most research and media reports and government policies, which as discussed above, are concerned with dependent, high-problem drug users who fund their use through criminal activities (Bennett et al., 2001). Nevertheless, Measham (2002) suggests that using drugs provides the otherwise responsible, law-abiding and hard-working user with a recreational activity. This ‘*controlled loss of control*’ enables the user to ‘*let go*’ of their responsibilities and worries for a short period of time and enjoy freedom away from the constraints of society and other structural constraints like gender, ethnicity, age and socio-economic class: which are themselves a product of the climate of control and surveillance that they contribute towards and live in (Measham, 2002).

Therefore, it has been argued that recreational substance users are seen to view their substance use as a ‘commodity’, which they purchase to use in a specific context, within specific environments, to achieve specific outcomes (Gossop, 2000). Murphy, Waldorf and Reinerman (1990) argue that this substance use can and does often exist alongside everyday activities that are conducted for an individual so that they are considered to be a productive member of society. They also argue that as their use of certain illicit drugs had gone on for so long, it was no longer considered a deviant act by them and

therefore, it had become normalised within their lifestyle (Murphy et al., 1990). This is in line with the work conducted by Pearson (2001) who has found that recreational substance users in London did not think of themselves as a “*drug user*” but instead just saw it as something that they did, or did not do, and that this distinction and decision was a normal part of their lives. In addition, substance use among this population is indicative of the growing commodification of young people’s leisure time, where they are choosing to buy escapism, relaxation and pleasure, to escape the pressures of the working week (de Wit, Treloar, Wilson, 2009; Lim, Hellard, Hocking & Aitken; 2008; Lim, Hellard, Hocking, Spelman & Aitken, 2009, Measham & Shiner, 2009).

As with any other type of consumer behaviour, an individual is only able to engage with it if they are able to afford it. Boys, Fountain, Marsden, Griffiths, Stillwell et al., (2000) found that specific ‘*drugs decisions*’ were made when deciding whether or not to consume a substance, and the level of consumption that would occur within a session. These drugs decisions included ‘*finances*’, where a prior decision was made about whether or not to purchase any given substance depending on an individual’s disposable income; and ‘*time*’, which influenced the use of any given substance dependent on what responsibilities the individual had (such as a work commitment) and whether their substance use would affect their ability to carry out the task in mind. This in itself is important, as it shows that the recreational substance user will only decide to engage in use if it fits in with their current lifestyle; it is a decision that is made with concern to many other factors, including finances, employment, and other commitments that may require a financial or monetary obligation.

In line with the above, and with a recent upturn in dance drug-related deaths in the UK, the contemporary significance of substance, set, and setting has shown to be evident (Zinberg, 1984). The ‘*play space*’ of dance halls and recreational spaces such as nightclubs allows for the forbidden and unpredictable to occur including recreational substance use. In these spaces, an individual is able to let go and get some ‘*headspace*’ to provide a ‘*time-out*’ to counter-balance the stressors, restrictions and performance of their work lives, and additionally momentarily escape from and rebel against “*surveillance and regulation of consumer society*” (Measham, 2004: 344).

These adult play spaces allow for curiosity, creativity, experimentation, learning and innovation to take place (Sutton-Smith, 1997). Measham (2004) argues that this is so evident within society today that the original '*play space*' of traditionally working-class, male oriented venues (such as pubs) have now moved to centrally accessible modern urban areas that are purpose-built for leisure consumption. She argues that unlicensed raves has now become culturally accommodated within mainstream culture and cater for the individuals who would have previously accessed the illegal raves of the past. Now that they are present within licensed locations, it allows for the commodification of calculated hedonistic excess to take place (Measham, 2004). It has been found that environments that foster play stimulate curiosity, and additionally, these types of environment may have benefits for mental and physical development and health (Bird, 2007; Coughlan, 2007; Goodenough, 2008; Joy, van Poortvliet & Yeowart, 2008; Milligan & Bingley, 2007). This could be argued to be the same for the recreational substance user. However, Measham (2004) argues that from a harm reduction perspective, the introduction of regulated and licensed venues has brought with it an additional set of problems, including issues with night-time related violent disorder, increased sessional consumption and an increase in dance-drug related deaths.

Although many of the large dance super clubs of the 1990's have closed, a recent resurgence in electronic music in London ensures that dance club culture continues to flourish in the nostalgic and underground scenes, where consumption of dance drugs appears to be both diversifying and intensifying (Measham, Aldridge & Parker, 2001). This is important from a health psychology perspective, as this 'movement' to the mainstream clubs has actually increased the amount of harm that may occur to the individual who chooses to recreationally consume substances. It has been found that young adults who recreationally use in modern British Society view themselves as decision making consumers with the belief that they should be able to purchase what they want, with an entitlement of knowing of and attempting to eliminate some of the risks of what they are taking (Fitchett & Smith, 2001). Harm reduction initiatives have been introduced within leisure venues, with the introduction of free water available and 'chill-out' areas for people to sit down, such as within the famous nightclub Fabric in London, as well as drug testing facilities such as within the Warehouse Project nightclub



in Manchester. However, deaths do still occur and more education does need to be provided to the individual who is choosing to consume.

### **The Pleasure Principle**

The behaviour conducted by a recreational user indicates that the existence of the postmodern climate in itself has strongly influenced and potentially exemplified the consumeristic nature of identifying, purchasing and consuming substances, as an individual is indeed sourcing a specific substance with the aims to achieve a desired goal. It is therefore largely important to recognise what pleasures an individual receives from their substance use so that a greater understanding can be made about why individuals choose to use. This will better inform those who work within harm reduction, so that effective interventions can be devised which will still meet the needs of the using individual (i.e. maintain the pleasure that an individual receives), but will reduce the amount of harm that the individual is exposed to. The pleasures of using substances in a recreational manner have not been explored in much detail within the current literature. However, it has been suggested that justifications of why public health researchers continue to focus on the potential harms of drug use are due to the fact that governments and drugs corporations provide funding to create arguments to eliminate these drugs from society in order to distance away from the pleasure as a motive for consumption, but instead to focus on the individual's pain and pathology (Moore, 2008; O'Malley & Valverde, 2004). This however is counter-intuitive as the above consumerism argument specifically suggests that those who recreationally use do so with intent, to achieve a specific desired outcome, and therefore will continue to source, obtain and use substances in a way which may cause harm if they have not been educated on minimisation techniques.

Freud (1977) argues that infantile development occurs through the derivation of satisfaction in the oral, anal and genital stages, and that an activity will only continue if it seeks to bring the individual some form of pleasure. Therefore, it has been argued that the notion of pleasure is critical to the development of an individual, from their infancy to the latest stages in their life, and additionally in order to develop successful social societies so that people can live corporately together (Valentine & Fraser, 2008). Therefore, it is argued that pleasure is fundamental for the development of the

individual, and that if an individual was to ignore its gratification for pleasure; it may result in neuroses, psychoses or other abnormalities (Freud, 1985; Lapanche & Pontalis, 1988).

In line with this, it may be important to consider the role that pleasure plays within the balance of maintaining an otherwise stressful and demanding life. If avenues of pleasure were not regularly explored by the individual, it may result in the individual being unable to effectively fulfil their otherwise non-pleasurable roles within society. The postmodern society that exists today embraces the pursuit of pleasure and markets this image as something to be desired, through a way that captivates its audience by marketing activities that derive pleasure in a fashionable, forward thinking, and attractive way. Gabriel & Lang (2006) argue that pleasure has transformed its appearance in our postmodern world: rather than it being something you attained as a result of hard work, it is now a part of the achievement of everyday life. Therefore, young people who recreationally use have made controlled hedonism as part of their everyday lifestyle, to the point of where it has become accepted by their own subculture (Measham, 2004). Experiential pleasure is seen to be a focal point to the pursuit of an altered state of consciousness, however many prevention frameworks fail to describe and take into account the sensory joys that are experienced through the enhancement of sociability, confidence or closeness (Duff, 2008). Without understanding and taking into account the role of pleasure and enjoyment, a health promotion campaign concerning substance use will not be effective (Measham, 2004).

### **Perceived Risk**

By taking the above into consideration, it is clear that the recreational user views their use as something that is part of their everyday lifestyles and is necessary for them in relation to the pressures that they experience in the postmodern world that they live in and contribute towards.

Perceptions of risk associated with substance use are considered to have important implications for drug use prevention policy, as it is considered that perceptions may influence the probability of whether or not an individual decides to initiate in use. For example, within Andersson, Miller, Beck and Chomynova's (2009) study on the prevalence's of, and perceived risks from substance use, it was concluded that if an

individual has a personal experience of the enjoyable use of a substance and has not encountered any serious damage, they will not perceive the substance to be of great harm, and will therefore have less perceived risk. Therefore, they will be more likely to use in the future, without fully considering the risks they may face. This fits in with their other findings, which show that higher rates of perceived risk exist in those who have not used the substances, which therefore results in them being less likely to use. In line with this, it has been found that adolescents tend to view experimental substance use as substantially less risky than regular use (Hibell, Andersson, Ahlstrom, Balakireva, Bjarnason, et al., 2004; Morgan, Hibbell, Andersson, Bjarnason, Kokkevi et al., 1999). This may further explain why occasional recreational users are less likely to view their use as risky in comparison to *'the other'*, as explained by Joffe (1999).

However, it is therefore equally as important to understand the ways that this recreational user views the risk of taking these substances in relation to themselves, their world and their livelihood. Tversky and Kahneman (1974) suggested that there were 2 determinants of perceived risk.

- *'Dread/non-dread risk'*: Dread was associated with the risk being greatly feared and uncontrollable, with globally catastrophic effects and an involuntary exposure to risk. Therefore non-dread was not feared, and instead is controllable, not globally catastrophic and there was a voluntary exposure to risk.
- *'Known/unknown risk'*: Known risks were defined as the risk being known to science, where it is observable and there are immediate consequences from the risk. Unknown risks are shown to be unknown to science, where the risk is not observable and there are delayed consequences from the risk.

Within their work, Tversky and Kahneman (1974) found that participants rated hazards with low dread risk and high known risk not to require any political intervention. They therefore argued that individuals should be allowed to make up their own minds on these specific issues without governmental or political intervention. As this fits the category of recreational substance use, it may explain why many recreational substance users fail to take notice of governmental campaigns concerning substance use, as they may consider the decision to be for their own making. With regards to low dread risk

and high unknown risk (for example, through the use of taking legal highs), the situation can appear even more complex, as the risks are unknown to science, and therefore there is no known way of understanding the effects of consuming such substances. If an individual perceives a legal high in a non-dread manner, where the risk is also unknown, providing harm reduction information and education can be difficult as there has not been enough empirical information collated within the literature to gain an understanding of these substances. This means that substance misuse services and organisations often provide the advice of abstinence rather than harm reduction, which could result in the recreational user distrusting the services, especially if they see others within their social circle using without any observable and immediate risk.

Early studies that concerned examining the relationship between dispositions and risk-taking mainly focussed on sensation seeking (Zuckerman, 1979), and subsequent studies have found a relationship between sensation-seeking and risk-taking in relation to making decisions about driving speed (Goldenbeld & van Schagen, 2007), dangerous sports (Zuckerman, 1983), and smoking heavily (Zuckerman, Ball and Black, 1990). More recent studies have found that risky decision-making is also associated with a broader range of personality traits (Carducci & Wong, 1998; Caspi, Harrington, Moffitt, Begg, Dickson et al., 1997; Tellegen, 1982). Katz, Fromme and D'Amico (2000) examined personality traits and outcome expectancies to explain heavy drinking, drug use and unsafe sexual behaviour. Results found that although personality and past experience were associated with the benefits and costs of engaging in a particular behaviour (i.e. the outcome expectancies), outcome expectancies and personality also independently predicted the likelihood of risk-taking behaviour. This indicates that there is indeed a complex relationship present between one's personality, their past experiences, and their risk, which perhaps may involve their perceived risk. However, it is important to note that this link has not been made yet with the recreational substance user, and although some may view drug taking as a risky activity, the literature suggests that the recreational substance user does not see their use as risky, and in fact they use within a context of control, using at specified times, in specified spaces (Measham, 2004).

Furthermore, Becker and Murphy (1988) argued that an individual can be rational in their consumption of substances within their model of rational addiction. They argue that 'consumers' take into account both past consumption experiences and consider the

future effects of current consumption when making choices. Therefore, the decision to take substances is conducted in a way that is based on present and future costs and the benefits of consumption, whereby the costs are related to the negative effects of substance use which are often realised in the future, and can include things like illness, loss of finances or employment, addiction, or even death. These perceived benefits are often instant in nature, and can include things such as stress reduction, relaxation, and enhancement of concentration or an alleviation of problems. This is in itself a significant issue for the way individuals perceive their risk towards substances, as if an individual believes that their use is under control, they may not realise when it becomes out of control and may fear accessing support or help in the community for fear of being stigmatised.

### **Curiosity and Intentions to use**

In line with the above, curiosity has additionally been shown to be a primary motivational force for influencing general human behaviour, including it being a driving force in child development, scientific discovery, and within the arts and literature (Lowenstein, 1994). In congruence with the social cognitive theories of health behaviour such as those described below, curiosity has been shown to increase brand recognition (Fazio, Herr & Powell, 1992), prompt experimentation with drugs and alcohol (Green, 1990), and be an unintended side effect of watching anti-drug Public Service Announcements (PSAs), in terms of having more curiosity about the drugs that were presented within the advertisements (Wagner & Sundar, 2008). Within his paper, Lowenstein (1994: 75) argues that curiosity exists in deviation to the rational choice-analyses of behaviour, which assumes that the value of information comes only from its ability to *“promote goals more basic than the satisfaction of curiosity”*. What is meant by this is that in terms of curiosity, an individual wants to know information about a specific situation or circumstance, whether or not it has a direct benefit to them. The drive theory of curiosity argues that curiosity produces an unpleasant sensation within the individual and as a result, this *arousal* is reduced by the individual taking part in exploratory behaviour. This unpleasant sensation is as a result of uncertainty, whereby when the individual reduces the feeling of uncertainty within them through satiating their curiosity by conducting the activity, they reduce the uncertainty. The reduction of these unpleasant feelings is in turn rewarding, and therefore the disruption that

occurred as a result of the uncertainty is regulated and restored. This is done by gathering information and knowledge, either through direct or indirect experience, to achieve understanding of the unfamiliar and achieve coherence within the mind of the individual. For example, an individual may be curious and therefore feel uncertain about how a particular substance may or may not affect them: this in itself would create an unpleasant sensation within that individual until their curiosity has been satiated, as until this has been achieved, the individual will not be completely certain how this drug will affect them.

Therefore, the curiosity is a specific internal drive that humans all possess, much like hunger or thirst and that this curiosity must be satiated by looking at new or old interests to satisfy the urge. The incongruity theory of curiosity suggests that curiosity is motivated when an individual is presented with something that does not fit into their understanding of the world. As humans view the world as being predictable and orderly, curiosity occurs when something challenges the world's order, so that we can learn to understand more about the strange phenomenon that we are faced with.

In addition, curiosity has been argued to be both internal and external in its roots, with *state* and *trait* curiosity. These theories aim to explain how individuals engage in curious behaviour. The theory of state curiosity would suggest that external objects are the reason as to what sparks an individual's curiosity, and that curiosity is therefore primarily driven by external factors. This suggests that if an individual is not already curious about something it is likely that they never will be, as curiosity about a specific situation needs to be sparked from external situations. Trait curiosity however suggests that curiosity resides within the individual and therefore if the individual is innately curious, they are therefore more likely to be experimental, have a high level of intellect and fearlessness. Kashdan and Silvia (2009) manage to amalgamate the above and suggest that curiosity acts as a force to motivate an individual to act and think in new ways and investigate, be fully immersed in and learn about the phenomenon that they are curious about. They argue that when an individual is curious, they are doing things for their own sake and are not "*controlled by internal or external pressures concerning what we should or should not do*" (Kashdan & Silvia, 2009: 368).

Furthermore, in congruence with curiosity, reactance theory states that when an individual is threatened by any perceived restrictions to their freedom, if they attempt to restore their sense of freedom, it allows for an increase in attractiveness of potentially restricted behaviour (Brehm, 1966; Brehm & Brehm, 1981). This fits in well for possibly why an individual would choose to recreationally use a substance, in contradiction to any health promotion or harm reduction messages that they are being given, and provides a problem for any substance use intervention that aims to scare, provide information, plea to adolescent morality and change personality or character are. This may be the reason as to why such 'scare-mongering' interventions have been found to be highly ineffective in comparison to social-influence-based approaches, (Cuijpers, 2002; Donaldson, Sussman, MacKinnon, Severson, Glynn et al., 1996).

### **Acceptance of 'The Norm' – who is looking after the 'good-time' user?**

Buchanan (2006) links the emergence and sudden rise in problematic drug use from the 1980s to deindustrialisation and declining opportunities for unskilled and non-academic young people. He argued that the new drug user of the 1980's was young, unemployed, single, and living at home in a socially deprived area with few to no qualifications (Buchanan & Wyke, 1987; Parker Bakx & Newcombe; Pearson, 1987). Since then, many drug prevention programmes have been aimed at targeting these 'problematic' users who belonged to 'deviant sub-cultures', with most drug services targeted at reducing problematic heroin, cocaine and alcohol use which is seen to be linked to criminal activity (Hough, 2001; Hunt & Stevens, 2004; Reuter & Stevens, 2008). For example, under the previous Labour Government, a quasi-compulsory drug treatment programme drug tested those arrested for trigger offences (such as shoplifting) and if they were found to be positive for heroin or cocaine, they were provided with treatment (Measham, Williams & Aldridge, 2011).

However, and as discussed above, the above does not include the consumption of recreational substance use that is conducted by the majority and is done in an unproblematic manner. Van Amsterdam and van den Brink (2010) argue that "*adolescents have a natural drive to investigate the unexpected, and experiencing the effects of recreational drugs, either licit or illicit, is part of that drive*" (2010: 1524). More worryingly, within this paper it is also argued that recreational substance users are

more likely to be polydrug users, and that the combined use of alcohol with other substances can lead *“in a synergistic way to very serious adverse effects”* (van Amsterdam & van de Brink, 2010: 1525). Examples cited within this paper include the use of cocaine with alcohol, which causes the toxic compound cocaethylene (Heard, Rose, Wagner, Ciarleglio & Mash, 1991: cited in van Amsterdam & van de Brink, 2010). Although services do exist for the problematic drug user whose use started off as a recreational user (such as the Club Drug Clinic by the Central and North West London NHS Foundation Trust), the only national harm reduction strategy for occasional recreational substance users that exists within the UK is Frank, a national service set up by the Department of Health to provide harm reduction advice and information to those who use or are considered at risk of using substances for recreational purposes. The vast majority of drug services in the UK are actually tailored towards systematic and regular substance users who misuse substances such as alcohol, cocaine and heroin and are claiming benefits, due to these users being much more likely to commit crime: as reported in the UK Government’s drug and alcohol strategy (Home Office, 2010). This in itself is concerning as the recreational user may feel that they are unable to access regular substance use services due to the way that these services market themselves – the recreational user is unlikely to identify themselves as ‘being of the same sort’ as a regular user of heroin or cocaine. This further argues Joffe’s (1999) research, as it suggests that the substance user creates an identity of them based upon comparing their use and their chosen substances with *‘the other’*, which can affect the way the individual chooses to engage with services available to them.

Whilst substance use among the general population is continuously being routinely monitored for public policy purposes (CSEW, 2014; Goddard & Higgins, 1999; Ramsey & Percy, 1997), the extent of the potential or actual problems experienced by substance users is not observed with the same contention (McCambridge & Strang, 2004). Official statistics highlight problems concerning legal issues, such as arrests for drug offences, as well as data for those who are willing to engage with existing drug services; however this does not take into account any data for the recreational user who does not view themselves to have a problem with their substance use. McCambridge & Strang (2004) therefore argue that *“problems that do not manifest themselves as treatment initiation thus need to be the subject of separate dedicated study”* (2004: 56). However, although it



is clear that recreational substance use is a relatively common occurrence within our post-modern society, it does not mean that it should be accepted as such, with the hope that the recreational user will become a non-user over time. Substance use, including recreational and occasional substance use still can cause health problems for the user.

Cannabis has been shown to be the most commonly used substance among British teenagers and the young adult population (CSEW, 2014). However, early illicit drug use, in particular cannabis, has been associated with a wide range of social and mental health difficulties, including mental health issues (Hall & Degenhardt, 2007), poor school performance (Lynskey & Hall, 2000), criminal activity (Block & Ghoneim, 2008) and other substance use and related problems (Skenderian, Siegel, Crano, Alvaro & Lac, 2008). The UK Government continues to be focussed towards the prohibition of cannabis, with cannabis remaining illegal in the UK and where the drug was recently reclassified from a Class C back up to a Class B drug, against the advice of professional bodies such as the Advisory Council of the Misuse of Drugs. As a result, users of cannabis may feel marginalised by society. They are still required to contend with the law regarding their use and still need to safeguard their use against those who do not use for fear of repercussions. It also leaves users of cannabis, and possibly other substances, feeling confused about the acceptance of their substance use in society, and therefore confused about the level of danger that it may pose to them as an individual.

In addition, Cunningham, Bondy & Walsh (2000) found that a relationship exists between frequency of use and related health, psychological and social consequences; therefore they argue that problems may therefore be expected to be most severe among those consuming most frequently. McCambridge and Strang (2004) found that 40-percent of their participant sample identified problems in interactions with others that they perceived to be caused by their own substance use. They also found that younger substance users were more likely to report having interactional problems, and those who reported interactional problems were smoking cannabis more frequently than those who did not. Furthermore, a positive attitude towards substance use in general was associated with more missed days from either college or work as a result of their substance use. This suggests that those who deem their use as recreational are at risk of harm. McCambridge and Strang (2004) argue that their findings suggest that even

though recreational substance use appears to be normalised within amongst British youth, it appears that the problems associated with substance use have also become normalised – as it is not suggested that the problems reported by the youth within their study are enough to warrant a clinical intervention. They however question how community-based interventions may target these issues (McCambridge and Strang, 2004).

Initially, there was found to be little information on the acute care of overdoses from popular club drugs, however protocols are now available. Traditional substance misuse services focussed on the treatment of three major substances: alcohol, heroin and cocaine. Organisations such as The Club Drug Clinic in London are also available to treat those who have a specific issue with managing their once-recreational drug use. However there seems to be a lack of evidence-based information on treating dependence of club drugs within substance misuse programs that are in existence amongst the wider community. Organisations such as DanceSafe and RaveSafe have attempted to provide harm reduction advice to recreational users by providing information at parties that concern hydration status, temperature, safe sex information, health education and pill testing (Maxwell, 2003). It has been argued that pro-rave organisations and websites make the implication that only uneducated users suffer life-threatening consequences of drug use and that proper harm-reduction behaviour will decrease addiction and risk of harm to the user. This in itself is concerning, as it suggests that the occasional recreational substance user who is uneducated about the interactions of their substances, or the correct use of the substance of their choice, could potentially be at greater risk than the regular user who only uses one substance, or has knowledge on how to consume in a way that reduces harm, due to their learned knowledge through their personal experience. It has been argued that is important that this is reflected within the scientific literature, with a focus on peer-based education that places an emphasis on the short-term dangers along with the long-term consequences of recreational substance use to prevent major public health concerns in the future (Koesters, Rogers & Rajasingham, 2002).

### **Why is the information given to recreational users not trusted?**

Drugs education has primarily held its roots in being delivered within a school setting, due to the fact that an individual's *'school career'* coincides with a formative period in

their *'health career'* (Tones & Tilford, 2001), during which substance use often begins (Parker, Aldridge & Measham, 1998). For this reason, school-based drugs education programmes that aim to improve a young person's knowledge and skills have become well established (Healy, 2004). However, trials on the effectiveness of drug education interventions have consistently found that their effects on students' behaviour are small and not generally sustained over a longer period (Faggiano, Vigna-Taglianti, Versino, Zambon, Borraccino et al., 2005). In addition, Fletcher, Bonell & Sorhaindo (2010) found that many British students reported having received little or no drugs education within the school setting. For this reason, it may be fair to concur that young adults are often left to find out information about substances themselves.

However, Hunt et al. (2007) argues that recreational users are now more sensible and informed of the choices they make when consuming substances, and often adopt harm minimisation techniques alongside their substance taking to try and encourage safe use which has been learnt from various sources, (e.g. peers, personal experience, drug forums). However, these harm minimisation techniques are often learnt as word of mouth or rumour, and are at risk of becoming dangerous and even life threatening if false information is circulated (European Monitoring Centre for Drugs and Drug Addiction, 2008).

A possible explanation into why previous intervention approaches with this demographic have failed may be because the messages provided by the programmes (i.e. abstinence from using substances) are inconsistent with the behaviours and experiences of the targeted group (Hamilton, Cross, Resnicow & Shaw, 2007). Abstinence-based approaches which emphasise refraining from use may have little relevance to those who already use, and contradicts a key component of the recreational lifestyle of both the substance experienced and inexperienced (Makhoul, Yates & Wolfson, 1998). In addition, young adults are unlikely to be persuaded not to experiment with substances in a society where many of their peers will experiment, and this experimentation is often 'condoned rather than condemned' (Parker et al., 2002, p.943).

It has also been argued by Calafat et al. (2003) that taking drugs and becoming part of drugs culture is almost a rite of passage in terms of personal maturation, due to the

complex relationship that drug use has with exploring risk behaviours, decision making, and constructing a personal identity, in addition to a need for having fun and the experience of compulsive and passive pleasure (Sissa, 2000: 896). For this reason, many recreational users may see taking substances as just “*something they do*”, and that it will be “*something they quit*” in the future. Due to this reason, an individual may be less likely to engage in official substance use education as they may feel that it is only targeted at those who may be at risk of developing a problem in later life.

## **Recreational Substance Use and the Health Psychology Models**

Many theories have been proposed to explain the adoption of health-protective behaviour. It is important to consider these theories as they emphasise beliefs about health risks and health-protective behaviours and may provide a rationale as to why an individual may consciously choose to recreationally consume a substance that they know may put their life at risk. Each of the three theories discussed below assumes that the anticipation of a negative health outcome and the desire to avoid this outcome or reduce its impact creates motivation for self-protection.

### ***The Health Belief Model***

The Health Belief Model (HBM) developed by Rosenstock (1966) argues that an individual’s readiness to take a health action is determined by four main factors: perceived susceptibility to the risk behaviour, perceived severity or seriousness of the behaviour, perceived benefits of the behaviour and perceived barriers to performing the health behaviour. Self-efficacy was additionally added to these components, which refers to an individual’s perception of their general motivation and competence to fully complete a health-related behaviour. The health belief model aims to predict health-related behaviours by accounting for individual differences in beliefs and attitudes, however it does not account for other factors that may influence health related behaviours like smoking which may occur outside an individual’s conscious decision-making process and are performed as an unconscious habit (Janz & Becker, 1984).

### ***Protection Motivation Theory***

The Protection Motivation Theory (PMT) (Rogers, 1975; 1983) proposes that an individual protects itself by basing its judgement on four factors: the perceived severity

of a threatening event, the perceived probability of the event occurring or the vulnerability of the individual of that event occurring to them, the efficacy of the recommended preventative behaviour and the perceived self-efficacy. There is continued evidence to support that the Protection Motivation Theory (PMT) (Rogers, 1975, 1983) is useful in predicting one's behavioural intention in a variety of behavioural domains (e.g. cancer prevention – Helmes, 2002; drinking and driving – Greening & Stoppelbein, 2000; smoking cessation – Maddux & Rogers, 1983; condom use – Tanner, Hunt & Eppright, 1991). Nevertheless, many researchers have levelled criticism at a rational approach to illegal and risky behaviours like drug use and have suggested that decision making in these circumstances are likely to be spontaneous or even automatic (Gibbons, Gerrard, Blanton and Russell, 1998; van der Pligt, 1998). There are also studies providing no support for PMT as a model of health behaviour (Murgraff, White & Philips, 1999).

### ***The Theory of Reasoned Action and Planned Behaviour***

The Theory of Reasoned Action (TRA) (e.g. Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980) is based upon the assumption that humans are rational in their decision-making and make use of the information that is available to them in order to make a decision related to their health. Fishbein and Ajzen (1975) state that in order for an individual to decide to perform any given behaviour, there firstly must be an intention present. Intention is where an individual makes a conscious effort to ensure that the behaviour is completed. Furthermore, attitudes (whereby an individual evaluates a particular behaviour in an overall positive or negative framework) and subjective norm (whereby the social pressure from significant others in society is taken into account) are in order for an intention to be present. According to the Theory of Reasoned Action, these attitudes and subjective norms can vary for different behaviours and populations, and therefore they have an indirect effect on the behavioural intention. Critics of the Theory of Reasoned Action argue that not all decisions are under the volitional control of the individual performing it. Therefore The Theory of Planned Behaviour (TPB) devised by Ajzen (1988) takes into account the non-volitional behaviours that exist, whereby a measure of perceived behavioural control was added as another determinant of intention. This is considered to be the amount of perceived control an individual has over performing a particular behaviour.

There has been much support within the literature for the usefulness of the TRA and the TPB for predicting behaviour regarding illegal drug use (Armitage, Conner, Loach & Willetts, 1999; Conner & McMillan, 1999; Conner, Sherlock & Orbell, 1998; Cook, Lounsbury & Fontenelle, 1980; McMillan & Conner, 2003; Umeh & Patel; 2004). For example, Conner et al., (1998) found that attitude was the single best predictor of intention to use ecstasy if participants believed that heavy ecstasy use would lead to positive outcomes, along with subjective norms and perceived behavioural control.

### **The Applications of the Models to Recreational Drug Use**

All of the above theories assume that the expected benefits in risk reduction need to be weighted against the expected costs of acting to predict changes in behaviour, whereby the costs include financial, time, inconvenience and the loss of pleasure or satisfactions that one gets from taking part in the behaviour that may detrimentally impact on their health. However, it is important to note that none of these models manage to effectively predict the amount of precautionary behaviour that an individual will engage in prior to taking part in the health risk behaviour; but instead what is predicted is *“the relative likelihood of action by different individuals or by individuals in different treatment groups”* (Weinstein, 1993: 326). This is important as it does not provide any indication of what an individual does in order to protect themselves from the risk behaviour that they may consciously choose to partake in, despite the observed risks. Furthermore, individuals are sometimes unsure in their ability to carry out specific health precautions (such as quitting recreational substance use in total) and these doubts have been argued to not be the same thing as beliefs about the cost or trouble involved. Weinstein (1993: 328) argues that *“it is one thing to ask whether the benefits of some precaution will outweigh the costs; it is something else to ask whether an attempt to carry out this precaution, because it may fail, will provide any benefits at all”*. In regards to perceived risk, the HBM and the PMT question individuals about the effectiveness of the precaution they are taking to reduce the amount of risk they are exposed to. The TRA on the other hand tends to question individuals about the likelihood and severity of harmful outcomes that may occur if they were to carry on conducting their current behaviour, and how this may differ if they were to alter their behaviour. Nevertheless, the human mind may

not be able to simply categorise risk as according to one of these models. For example, an individual may have a specific opinion about the effectiveness of waiting for a red light before they cross the road, but they may not have information available about the probability and severity of injuries for pedestrians who wait for the red light and for those who do not.

It is important to consider the above models when considering why an individual may consider taking part in a health-related behaviour that may increase or decrease their risk. Therefore these models have been considered in the planning of the below intervention.

### **Current substance use education**

International evidence suggests that most information-based substance use education fails to change behaviour, and out of those programmes that do, the effects are often small, uneven and not sustained over a long period (Aldridge, 2008). Aldridge (2008) additionally argues that substance use programmes delivered within schools are based on poorly conceived or out-dated conceptual models. She states that interventions aimed at the general population of young people are less likely to be able to address users that are problematic, and those interventions that target the specific at-risk population is also difficult due to a lack of understanding that of risk factors that are associated with those who go on to use substances in a harmful way (Aldridge, 2008). Furthermore, it has been argued that solutions for young people are not necessarily found in health education within schools or through media campaigns, but instead recognise the additional factors that influence these decisions, including poverty, deprivation and vulnerability (Pearson, 1987).

In addition, those young people that are not necessarily affected by issues that make them more susceptible or vulnerable to substance use may still display some problems with their substance use, but it is important to find the difference between what is considered to be a 'problematic' form of use versus an 'unproblematic' form of use. Measham et al. (2001) and Williams (2007) argue that low level problems are likely to be accommodated by young people, however problems of accommodation can occur

among those who struggle with their drug use among conducting other life activities including parenthood and employment. Furthermore, if normalisation of substance use continues to exist, it is important to understand the potential health implications that can occur as a result of this. Those that use in a recreational context are still at danger from their use if they have not received education on how to take substances in a controlled and sensible manner to reduce the amount of risk and harm to themselves, such as they would receive education on achieving and maintaining a healthy diet or drinking alcohol (Aldridge, 2008). Although it has been duly noted in the literature that those who do use do make adjustments to their substance use do try and mitigate for any negative consequences they may face through seeking information, if a blanket approach of *'drugs are bad'* is encouraged by governmental agencies and educational institutions, this may prevent safe harm reduction messages from being taught in an open environment. Therefore these recreational users often have no option but to seek out information from sources such as the internet that are often unregulated and do not necessarily provide a reliable source of information, or from other sources such as friends who may provide information that is not necessarily from a background of *'expert'* knowledge (e.g. Duff, 2003). Crossley (2002) argues that any future work conducted in health promotion for substance use should take into account the meaning that the individual attributes to the substance use conducted, and Duff (2003) argues that policy makers should look at the lay knowledge that substance takers utilise to see if they are effective ways of reducing harm, and to incorporate these into future policy design. Furthermore, Williams (2007) and Fox (2002) argue that risky behaviour often does not lead to actual harm and therefore risk may be one of many variables that influence an individual around substance use. Nevertheless, the effective design of a substance use education programme is vital as studies by Ellickson, Bell & McGuigan (1993), Hecht, Corman and Miller-Rassulo (1993), Lynam, Milich, Zimmerman and Novak (1999) and Needham (1999) found that there were detrimental effects from substance use education programmes including negative effects upon cigarette consumption, attitudes towards substance use, self-esteem, and problem-solving and decision-making skills. This challenges the overall assumption that health promotion can do no harm even if it does no good, and therefore underpin the requirement for ensuring that all programmes are rigorously evaluated to ensure that harm is not being caused to young people as a result.



## Public Service Announcements

A popular way of delivering harm reduction advice and information to large numbers of the general population has been through the use of Public Service Announcements (PSAs). PSAs are commercials that provide advice and/or information on a specific health concern with the aim of reducing harm among the general population (Home Office, 2006; Orwin, Cadell, Chu, Kalton, Maklan et al., 2004; Pennay, Blackmore, Milat, Stewart, Carroll et al., 2006). They can be utilised across a variety of different media sources, including the television, radio, online, print and outdoor advertising. Research conducted on the effectiveness of PSAs show that they have been very successful in reaching target audiences (Reis, Duggan, Adger & DeAngelis, 1994), getting an individual's attention (Black, 1991) and changing an individual's attitudes to be more anti-drug (Davis, 1997). However, despite their popularity, a systematic review into anti-drug PSAs revealed that only one randomised trial showed a statistically significant benefit of PSAs on intentions to reduce drug use, with two trials finding evidence for PSAs increasing intention to use drugs (Werb, Mills, DeBeck, Kerr, Montaner, et al., 2011). Indeed, this issue has been argued by other researchers, who have stated anti-drug messages used in national anti-drug campaigns may in fact increase rather than discourage interest in illegal drugs (Fishbein, Hall, Jamieson, Zimmer, von Haften & Nabi, 2002; Reinerman & Levine, 1989). When looking at the evidence together from the literature, it paints a puzzling picture, because it indicates that if PSAs are as effective as the literature suggests, then drug use should be in decline.

From the above, it is clear that researchers and academics appear to know a lot about who uses substances, when they are used, how they are used, and even *why* they are used. However, there is limited information within the literature concerning where an individual has formulated their ideas around substances, recreational use, curiosity, safety and risk. The purpose of this study is to measure the effectiveness of a current harm reduction initiative commissioned by the UK Government in relation to curiosity to use the substance, or other substances, and perceived risk from using the substance and to further explore the ideas of where an individual learns about substance use.

## **Method**

### **Aim of the study**

The primary aim of this study is to determine the effectiveness of the *'Talk to Frank'* intervention on participants' intent to use recreational substances, and whether the intervention impacts on the participants' perceived risk towards taking recreational substances.

The secondary aim of this study was to see whether previous substance use significantly affects a participant's perceived risk to themselves or intent to use substances.

The tertiary aims of this study were to gain a deeper understanding of the educational experiences the participants had in relation to recreational substances. This is to understand how the participants viewed substance use, the reasons why they may choose to use or not use substances, and to understand the role that these substances play in their personal lives and their interaction with others. By understanding these experiences, the researcher aims to develop an understanding of the role substances and substance use plays within the individual's life. If an understanding is developed of this role, a more effective harm reduction campaign can be designed that fits in with the already known educational experiences of the participants. For example, if a specific type of educational experience was experienced by participants to be more effective, a harm reduction campaign could be designed to incorporate these findings into a future intervention design.

### **A mixed methods design**

In order to explore the above, a mixed-methods sequential explanatory design was employed. This design is considered to be highly popular among researchers and is undertaken by collecting and analysing first quantitative and then qualitative data in two consecutive phases within one study (Creswell, Plano Clark, Gutmann, & Hanson, 2003; Ivankova, Creswell & Stick, 2006). By utilising a mixed methodology, the research aims to test the effectiveness of the current harm reduction strategies in place for managing substance misuse, as well as to gain a thorough understanding of why this strategy is effective, or ineffective through the derived experiences of the participants interviewed. Although the study presented is not a *'true'* mixed methodology as

described by Greene, Caracelli, and Graham (1989), the methodology will be conducted in a '*sequential*' manner. This allows for each element of the methodology to be kept separate, which allows for each adopted methodology to be true to its design requirements.

### ***An increase in data***

Studying substance use phenomena is a vast and complicated area, which often results in the phenomena that is being studied being overlooked in some areas. A mixed-methods study manages to allow for the strengths of both methodologies to provide a broader perspective on the overall issue. A mixed-methods design was employed to try and address the issue of collecting any data that would have potentially otherwise be missed, in order to make the study more comprehensive and robust. In addition, using a mixed-methods approach allows for the discussion of multiple answers, rather than focussing on one outcome for the study.

### ***Clarifying the data***

Migiro (2011) argues that a mixed-methods approach strengthens the effectiveness of the research. Due to the complex nature of the phenomena studied, it was hypothesised that through using a mixed-methods approach, the results of one study would clarify, enrich and enhance the results of another. This would allow for a more thorough understanding of the studied phenomena for the specific participants concerned by allowing for new or deeper dimensions to emerge.

### ***Interpretative Phenomenological Analysis***

It has been argued by Smith, Harre and Van Lagenhove (1995) that the IPA researcher uses ideography, which allows for an in-depth analysis of single cases before producing any general statements. This is in contrast to nomothetic principles which are considered to be the foundation for most empirical work in psychology, whereby populations are studied to understand the probability of how certain phenomena will occur under specific conditions. In addition, it is argued by Pietkiewicz and Smith (2012) that this idiographic approach is unusual even for qualitative methodologies, as the main concern for IPA is to give full appreciation to each participant's account. Although a solid theory is unlikely to develop from conducting a small-scale IPA study, the findings may at least provide some headway to understand the emergence of the

phenomena. If studies conducted on similar phenomena were compared, it may be able to provide insights into population-wide or universal patterns or mechanisms (Pietkiewicz and Smith, 2012).

## **Research question**

### **Part A - Quantitative**

In comparison with a control group (an advertisement reel without *'Talk to Frank'* adverts inserted), does the addition of *'Talk to Frank'* adverts

- Decrease the intent to use recreational substances?
- Increase participants' perceived risk towards recreational substances?

In addition, does a history of previous substance use significantly affect a participant's perceived risk towards substances or intent to use substances?

### **Part B - Qualitative**

This element will explore what experiences a participant has of learning about recreational substances and how have these experiences contributed to their own experiences of consuming or not consuming recreational substances?

## **Study Design**

### **Quantitative**

An experimental design was employed. The study used a two-group randomised controlled trial, with 1 independent variable: Experimental Condition (between subjects: 2 levels: control and intervention), 1 co-variate (previous substance use) and 2 dependent variables (intent to use substances, and perceived risk of using substances). This was to examine the effectiveness of the *'Talk to Frank'* adverts to decrease the intent to use recreational substances and increase a participants' perceived risk towards recreational substances, in comparison to a control group who were shown an advertisement reel without *'Talk to Frank'* adverts inserted within it. In addition, previous history of substance use will be examined to see if this effects a participant's perceived risk towards recreational substances, and their intent to use substances in

the future. The two groups included a control group (an advertisement reel without 'Talk to Frank' adverts inserted within it), and an experimental group (the same advertisement reel with 'Talk to Frank' adverts inserted within it).

### **Intervention Background**

The *'Talk to Frank'* intervention is funded by the UK Home Office and was developed in retaliation to the UK population viewing the existing governmental intervention (The National Drugs Helpline) as a crisis line for those in danger, rather than it being used as a general information portal. The name Frank was devised by advertising creative agency Mother, to provide the UK public who were at risk of using substances a "*wise, witty, never-hectoring*" champion who was "*a world apart from traditional anti-drugs messaging*" (Campaign, 2013). Frank aims to provide credible and accurate substance use information to young people, parents and carers through a variety of different media (including advertisements on the television, radio and print, online materials, paper materials and a website) to reach as many people as possible. It aims to change young people's behaviour and attitudes so that they see seeking substance knowledge as worthwhile, through providing credible, confidential, dependable and non-judgemental sources of information. This was so that young people were able to develop an affinity with Frank, and those who have substance-related needs are able to access the appropriate substance use services and support.

According to a report published on the EMCDDA website, 1.5 million people logged onto Frank's website in the first year of the campaign, and over 400,000 calls were received to its helpline. In addition, over 22 million printed campaign materials were distributed. The report states that both parents and young people were accessing Frank and that 73% of Frank's stakeholders believed that the service did not need improvement (all data retrieved from [http://www.emcdda.europa.eu/modules/wbs/dsp\\_print\\_project\\_description.cfm?project\\_id=6117](http://www.emcdda.europa.eu/modules/wbs/dsp_print_project_description.cfm?project_id=6117) on 21 June 2015).

Nevertheless, the campaign has received criticism and has been accused of presenting false and misleading information about substances. For example, the Transform Drug Policy Foundation (2008) criticised Frank's campaign on cocaine on the basis that the harms that were depicted were as a result of legal prohibition rather than the drug

itself. In addition, the Conservative Member of Parliament Iain Duncan Smith (2010) argued that Frank *“has proved ineffectual and even damaging, to the point of giving information as to the ‘cost’ and immediate physical effects of drugs more prominently than driving home the danger”*. As no formal studies have been conducted on the effectiveness of the Frank campaign (Sumnall & Bellis, 2007), it was decided that a study was to be conducted to test a part of this intervention’s efficacy, namely the television advertising component, to see if it had any effect on a participant’s intention to use or perceived risk. The Frank television intervention is geared towards illegal substances, although on the Frank website, there is information concerning all substances, including legal highs and alcohol. Although the Frank television intervention is directed towards illegal substances, the intervention was considered to be useful to understand the learning experience participants derived from it.

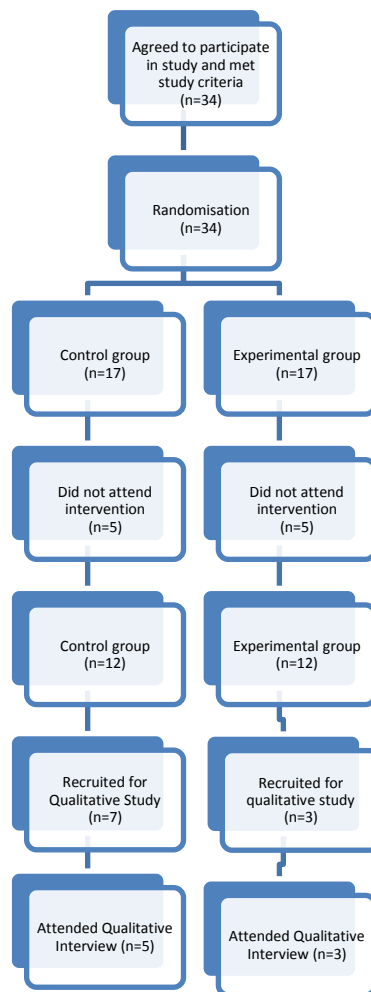
The researcher had previously directly experienced themselves the impact educational experiences on an individual in relation to substance use. The researcher herself was in a nightclub where she witnessed a group of young women in the toilet trying to look after their friend who was heavily intoxicated. They appeared confused, worried and uncomfortable within the situation, and were unsure of what to do. The researcher advised them that medical intervention may be necessary, and for them to take their friend outside of the nightclub to somewhere safe. The bouncers at the nightclub came within the toilet, however did not appear to be concerned about the girl who was unwell. Instead they lifted her up and removed her from the club. The researcher asked the girls why they had let their friend get so intoxicated, and the friend replied *“We weren’t taught how to take things in a safe way”*. This situation helped the researcher devise the concept of this particular piece of research.

### **Participants and Recruitment**

Ethical approval for the study was obtained from the City University Psychology Department Ethics Committee on 20 February 2015. Between late February 2015 and July 2015, 34 adults between the ages of 18 and 34 were screened utilising an adapted version of the Modified Telephone Interview for Cognitive Status (TICS-M) and consented to take part in the first part of the study. The TICS-M is a brief, simple to use and cost-effective screening measure for identifying the cognitive function within

adults. 10 of the participants (29%) who consented and who were randomised did not attend the intervention session. There were no recorded rates of dropout as the intervention was a one-off session. The main reason for non-attendance was other arrangements that could not be forsaken. This resulted in a total of 24 (71%) of participants taking part in the intervention study. After completion of the intervention in both the control and experimental group, participants were asked if they would like to take part in a continuing study where they would be interviewed about their experiences of the *'Talk to Frank'* intervention and other educational sources that have contributed towards their substance education. 10 participants showed interest, and were therefore contacted again and an interview was arranged with them. Out of these participants, 8 participants committed to the interview.

Figure 1. Flowchart of participants



The final sample consisted of 15 women (62.5%) and 9 men (37.5%). The mean age of the participants was 24.46 with a range of 19-33 years. The sample was ethnically diverse: 29.2% White British, 37.5% any other White background, 20.8% Indian, 4.2% Pakistani, 4.2% any other Asian background and 4.2% Black Caribbean.

Participants were recruited through poster advertisements placed around the campus of City University, London. In addition, posters were also placed in and around the researcher's place of work, at Woking Community Hospital in Surrey. Posters were displayed within male and female toilets, on notice boards, and in other prominent areas such as common rooms. Word of mouth was also used to recruit participants. For example, if a participant suggested that their friend would also like to take part in the study, the researcher encouraged the participant to inform their friend about the study and details on how to take part. All participants who showed an interest in taking part in the study were screened using the TICS-M questionnaire by the researcher. The



researcher individually screened all participants to ensure that continuity was maintained in terms of the screening process. For a copy of the TICS-M questionnaire and screening questions used, please refer to Appendix 1. This questionnaire was used to see if participants met the study criteria and held the cognitive ability and English language understanding required to take part in the study. All participants who were screened passed the screening process. After the screening process, participants were informed that they would be contacted in due course about details of the intervention time and location, and were provided with an opportunity to ask any questions that they had regarding the study. Following the successful screening, participants were randomised into the control or experimental group by the researcher, using a random number generator. Participants were then sent an email inviting them to take part in the study at a specific time and date – according to whatever intervention they had been assigned to. The intervention took place at City University, London in a classroom.

### **Inclusion and Exclusion Criteria**

Participants were not required to be currently using or have ever used any recreational substances to take part in the study. However they must not have viewed a *'Talk to Frank'* advert in the last year, be between the ages of 18-34, and be living and/or working and/or studying in London or the home counties in the UK. Participants were excluded from the study if they do not meet the above criteria and were currently receiving treatment for a substance addiction. In addition, participants were excluded if they considered themselves to be addicted to a substance. Furthermore, participants with less than a score of 20 on the TICS-M would have been excluded from the study. However, all participants exceeded this score and so were able to take part in the study.

### **Rationale**

The above criteria were selected as adults aged between 18-34 were the most active group of recreational substance users within the UK (Global Drugs Survey, 2014). In addition, the *'Talk to Frank'* intervention is targeted at this specific population. Those who considered themselves to be addicted or who were receiving treatment for a substance misuse problem were excluded from the study as the data collated from these participants may have been skewed. This is because intent to use a substance would not be a fair measure for someone who is receiving treatment for a substance misuse

problem, or for someone who considers themselves to have an addiction. Furthermore, due to the potentially sensitive nature of the study topic, participants with a score of less than 20 on the TICS-M questionnaire would have been excluded as the study topic may have evoked problematic or distressing feelings. In addition, if someone were to score less than 20 on the TICS-M, their ability to fluently speak the English language would be questioned. As the *'Talk to Frank'* intervention is delivered in English, it is important for the participants to be able to understand the English language fluently.

### **Randomisation procedure**

Participants were randomised into either the control or the experimental group by using an online random number generator. Each participant that signed up was numbered from 1-34. These numbers were then entered into the online random number generator, which produced a list of the same numbers but in a random order. Numbers 1-17 were assigned to the control group and numbers 18-34 were assigned to the experimental group.

### **Ethics**

At the intervention, all participants were asked to read a Participant Information Sheet (please see Appendix 2) which contained information about the study including the purpose of the study, the procedures and the consequences of participation. Due to the sensitive nature of the topic, participants were additionally given a verbal guarantee of confidentiality and anonymity from the researcher prior to taking part. Written consent, was gained through a signed Informed Consent Form (please see Appendix 3) and was collated from all participants who decided to take part in the study. A further copy of this form was then signed by the researcher and was provided to the participant to keep for their records. Participants were informed that they were only able to withdraw in the period of up to one month after the intervention as the data which revealed the participant's name to their unique identifying number was destroyed by the researcher, so that participants would be able to maintain full anonymity prior to the study data being analysed by the researcher. Participants were also offered an opportunity to ask questions regarding the research.

On completion of the above, participants were provided with an initial questionnaire collecting information about their demographics (Please see Appendix 4). A separate

questionnaire was then handed out and participants were asked to provide information about their current recreational substance consumption patterns, (please see Appendix 5). A pre-recorded episode of the sitcom *'Friends'* was then shown to the audience in both conditions, along with the adverts. A CD of this can be found attached to the thesis. The control group were shown the episode as aired, with the normal adverts within the reel. The experimental group however had *'Talk to Frank'* adverts edited within the reel. After the episode was shown, a third questionnaire assessing curiosity to use and perceived risk was implemented to both conditions (please see Appendix 6). The intent to use questionnaire asked participants to indicate on a scale of 0 to 10 (with 0 being no intent to use at all and 10 being extremely intending to use) how likely they are to try substances that are listed. They were asked to include substances that they have already previously used. The risk perception section on the questionnaire asked participants how concerned they would be about the listed substances negative effects specifically affecting them. This was measured using a Likert-scale.

After participants completed the final questionnaire, they were provided with a verbal debrief, as well as a written debrief sheet which detailed the purpose of the study (please see Appendix 7 for the debrief sheet provided to participants). This sheet additionally included further information on services and support regarding substance use. Additionally, participants were provided with contact details of the researcher and the researcher's supervisor in the case that they wanted their data withdrawn from the study. Following the data collection, participants were asked if they wanted to take part in an additional study to understand their experiences of the *'Talk to Frank'* intervention on their substance consumption patterns, and other educational sources of information that they use on their substance consumption patterns. The details of those who wished to take part were collated and these details were used to invite the participants to take part in a semi-structured interview at a later stage. Although no financial incentive was offered to take part in the intervention, participants were informed that if they were to take part in the interviews, they would receive a financial reimbursement for their time and travel, provided in the form of a voucher to the amount of ten British Pounds Sterling.

## **Outcome measures and questionnaire overview**

The researcher developed brief questionnaires to measure a participant's current or past substance consumption, their intent to use substances in the future, and their perceived risk towards using substances in order to generate data to measure the effectiveness of the intervention.

The design of the questionnaire took into consideration the practicalities of delivering the intervention within the given time constraints. The questionnaires were piloted with seven participants who were asked to watch an unrelated advertising reel, which was not connected to the study. This was conducted in order to check accuracy and face validity. As there is no single standard tool for measuring past and current use of recreational substances, along with intent to use and perceived risk, the questionnaires contained items to assess a participant's past and current use, their intention to use (which was determined through the use of a scoring system) and their perceived risk (which was determined through the use of a Likert-scale).

The perceived risk scores were scored by the participant marking a box on a Likert scale, from not concerned at all (scoring 1), slightly concerned (scoring 2), concerned (scoring 3), very concerned (scoring 4) and extremely concerned (scoring 5). The intent to use scores were calculated through participants subjectively attributing a score out of 10 of how much they believed they would intend to use a specific substance, with 0 being no risk at all, to 10 being extremely risky. Specific substances were not scored higher in relation to others, even if they have been considered in the literature to be more harmful. Therefore, if an individual marked intent to use cannabis as 10, this scoring of 10 would be considered to be the same if another participant scored their intent to use heroin as 10. This is because the purpose and intention of this study is not to measure intent of substance use in relation to harm, but in relation to perceived risk.

## **Methodological Issues**

Piloting the questionnaires for the quantitative part of the study was essential to identify and rectify any potential problems that may have cropped up during the administration of the intervention. The pilot highlighted no difficulties, and therefore the questionnaire was delivered as designed. Nevertheless, during delivery, some participants asked questions around filling out the forms. In particular there appeared

to be some confusion around how to mark Parent's/Caregiver's occupation on the questionnaire.

### **The interview**

In order to ensure that rich, detailed information about the first-person accounts of experiences of the phenomena were gathered, semi-structured, in-depth, one-on-one interviews were used. Participants who indicated that they wanted to take part in the interviews were contacted after completion of the study. Suitable times were arranged for the interviews. All interviews took place at City University, London within a room that provided participants with a confidential space to discuss their experiences. On arrival, participants were asked to read an additional Participant Information Sheet, highlighting the purpose of the study, the procedures and the consequences of participation. Due to the sensitive nature of the topic, participants were additionally given a verbal guarantee of confidentiality and anonymity from the researcher prior to taking part. Please see Appendix 8 for a copy of this consent form. After participants had read the sheet, an opportunity was provided for the participants to ask any questions that they may have had about the study. Participants were asked to sign a further form indicating their agreement to take part in the study, and a copy of the signed form was provided to them for their records. The semi-structured interview then commenced. This interview was audio-recorded, as the researcher transcribed the interview verbatim for analysis on completion. The interviews lasted for up to an hour. After the interview was completed, the recording was stopped, and participants were provided with a debrief sheet and a verbal debrief (please see appendix 9 for the debrief sheet provided), similar to the debrief they were provided with for taking part in the intervention. Once again the debrief included information on the study's aims and objectives, confidentiality and how to contact the researcher if they wished to have their data withdrawn from the study.

### **Constructing the interview schedule**

The purpose of the interview schedule for the Interpretative Phenomenological Analysis (IPA) was to ensure that the data captured the participants' lived experiences of substance use education. It was important for the researcher to ensure that the research questions were open-ended to allow for the researcher and the participant to engage in

a dialogue in real-time, and to also allow for space and flexibility for original and unexpected issues to arise, to enable the researcher to investigate in more detail with further questions (Willig, 2008). Furthermore, the researcher ensured that the questions asked were as free from hidden presumptions as possible. Alongside the questions, the researcher also kept a list of key words, or prompts to encourage participants in case they found the original question too vague. The interview schedule is shown in Appendix 11.

### **Study coherence**

In order to keep the study as coherent as possible, both interventions and all interviews were conducted directly by the researcher. The researcher has been working within the field of mental health and substance misuse for over 5 years and has been trained to Drug and Alcohol National Occupational Standard (DANOS). The researcher is skilled at identifying risk, and although none were disclosed, the researcher would have provided participants with adequate information on local organisations and services if she felt that a risk was present to the participant.

### **Statistical analysis**

Numerical data that was collated from the questionnaires was analysed using the Statistical Package for the Social Sciences (SPSS).

### **Statistical tests**

#### **Normality tests**

Numerical and graphical methods were employed to see if the data collated in both the control and experimental group were normally distributed. Methods included creating histograms and box plots as well as performing tests of normality, such as the Levene's test of homogeneity of variance.

### **Qualitative analysis**

Data collected from the semi-structured interviews were transcribed verbatim and were analysed using IPA. As the primary goal of IPA is to investigate how individuals make sense of their differences, this method of analysis fit well with the aims of the study. It is important to understand the lived experiences of the participants, and what

it means to them, within the reality they reside in, to experience substance use and the impact that their education has had upon this experience. It is assumed that people are '*self-interpreting beings*' (Taylor, 1985), which suggests that they are actively engaged in interpreting the objects, situations and events in their lives. Thus, the IPA researcher aims to understand what it is like to see the world from the individual's subjective experiences and social cognitions within an idiographic context. Therefore, the meanings an individual ascribes to events are of central concern but are only accessible through an interpretative process, although it must be noted that this is never completely possible as the researcher will have their own views and experiences themselves which will have some overall impact on the interpretation (Willig, 2008). It therefore facilitates an understanding of the complexity of bio-psycho-social phenomena and therefore offers an exciting possibility for adding knowledge to this area which would have been missed by applying quantitative analysis alone (Boyle, 1991). IPA will remain a dynamic process whereby the researcher plays an active role in order to access the lived experience of the participant and how they make sense of their world and the way they construct meaning (Smith & Osborn, 2008).

The process of analysis was based on that described by Willig (2008), in order to maintain a systematic approach to analysing the rich qualitative data, and to demonstrate the idiographic nature of the interpretations gathered. In order to analyse the data in the most effective way, each transcript was read once by the researcher, and then re-read with notes added to the left-hand side of the margin. These notes served as prompts to the researcher, to help the researcher recall the atmosphere of the interview and the setting in which it was conducted. Additionally, notes were made about things that may not have appeared to be obvious within the written text. For example, any metaphors used or repetitions, specific words that were chosen and initial interpretative comments. Specific distinctive phrases and emotional responses were highlighted by the researcher for further analysis. Once this was completed, the researcher placed focus on the notes made on the left hand side of the page to transform these into emerging themes. After this was completed, connections between the emerging themes were made to group them together into conceptual similarities. Some themes were disregarded at this stage as they did not have a strong enough evidence base to stay within the final analysis. Superordinate themes, along with corresponding

subthemes were constructed for each transcript. After this, a table comprising of extracts for each theme was constructed.

## Results

A total of 24 participants took part within this pilot study, all of which were randomly allocated to both the control (n=12, 50%) and the experimental (n=12, 50%) condition.

### Demographics

**Table 1: Gender between groups**

	Male (N)	Female (N)	Total (N)
<b>Watched <i>'Talk to Frank'</i></b>	2	10	12
<b>Didn't Watch <i>'Talk to Frank'</i></b>	7	5	12
<b>Qualitative Interviews</b>	5	3	8

Due to the randomisation procedure utilised for the study, the researcher was unable to control for the allocation of males and females to each condition. Another randomisation technique could have been implemented to control for this. However, there was no reason to do this as there was no obvious variation in previous literature that indicated males and females watched adverts in different ways. Additionally, it was not what the studies aims were investigating. Interestingly, although more females were recruited for the study, males were more willing to provide qualitative interviews than the females, and therefore there were more males interviewed for the qualitative component of the study.

**Table 2: Comparison of age between groups**

	N	Mean	Minimum	Maximum	Std. Deviation
<b>Watched <i>'Talk to Frank'</i></b>	12	25.08	20	33	3.965
<b>Didn't Watch <i>'Talk to Frank'</i></b>	12	23.83	19	31	4.687
<b>Qualitative Interviews</b>	8				



An independent *t*-test showed that there were no statistically significant differences in age between the control and experimental condition ( $t = -0.705$ ,  $df = 22$ ,  $p = 0.488$ , two-tailed).

**Table 3: Proportion of ethnicity between groups**

	Watched <i>'Talk to Frank'</i>	Didn't Watch <i>'Talk to Frank'</i>	Total
English/Welsh/Northern Irish/Scottish/British	3 (25%)	4 (33.3%)	7 (29.2%)
Any other White background	3 (25%)	6 (50%)	9 (37.5%)
Indian	5 (41.7%)	0 (0.0%)	5 (20.8%)
Pakistani	0 (0.0%)	1 (8.3%)	1 (4.2%)
Any other Asian Background	0 (0.0%)	1 (8.3%)	1 (4.2%)
Caribbean	1 (8.3%)	0 (0.0%)	1 (4.2%)

Although the participants were from ethnically diverse backgrounds, notably some ethnic groups were missing from the data. This was due to the nature of recruitment and as the study was conducted on a small-scale, there was no statistically significant association between ethnicity and the control and experimental condition  $\chi(5) = 9.143$ ,  $p = 0.103$ .

**Table 4: Proportion of highest held occupation in family unit between groups**

	Watched <i>'Talk to Frank'</i>	Didn't Watch <i>'Talk to Frank'</i>	Total
Executive, Administrative and Managerial Occupations	5 (41.7%)	3 (25%)	8 (33.3%)
Professional Speciality Occupations	3 (25%)	4 (33.3%)	7 (29.2%)
Service Occupations, Except Protective and Private Household	1 (8.3%)	1 (8.3%)	2 (8.3%)
Mechanics and Repairers, Construction Trades and Extractive Occupations	2 (16.7%)	1 (8.3%)	3 (12.5%)
Handlers, Equipment Cleaners, Helpers and Labourers	1 (8.3%)	0 (0.0%)	1 (4.2%)
Full Time Student	0 (0.0%)	2 (16.7%)	2 (8.3%)
Unemployed/Retired	0 (0.0%)	1 (8.3%)	1 (4.2%)

The vast majority of participants (62.5%) came from backgrounds where their primary caregiver was employed in an executive, administrative or managerial occupation, or within a professional speciality occupation. There was no statistically significant association between occupation and the control and experimental condition  $\chi(6) = 4.976, p = 0.547$ .

**Table 5: Proportion of education level among participants**

	Watched <i>'Talk to Frank'</i>	Didn't Watch <i>'Talk to Frank'</i>	Total
Higher Education & Professional/Vocational Equivalents	9 (75%)	5 (41.7%)	14 (58.3%)
A Level, Vocational Level 3 and Equivalents	2 (16.7%)	6 (50.0%)	8 (33.3%)
GCSE/O Level grade A*- C, Vocational Level 2 and Equivalents	0 (0.0%)	1 (8.3%)	1 (4.2%)
Other Qualifications, level unknown	1 (8.3%)	0 (0.0%)	1 (4.2%)

Again, the vast majority of participants (91.6%) came from higher education level backgrounds. There was no statistically significant association between Education and the control and experimental condition  $\chi(3) = 5.143, p = 0.162$ .

**Table 6: Proportion of political view held among participants**

	Watched <i>'Talk to Frank'</i>	Didn't Watch <i>'Talk to Frank'</i>	Total
Conservative	1 (8.3%)	0 (0.0%)	1 (4.2%)
Moderate	3 (25%)	2 (16.7%)	5 (20.8%)
Liberal	4 (33.3%)	2 (16.7%)	6 (25%)
Don't Know	4 (33.3%)	8 (66.7%)	12 (50%)

The political orientation was spread out, with half of all the participants indicating that they did not know their political orientation (50%). There is no statistically significant association between political orientation and the control and experimental condition  $\chi(3) = 3.200 p = 0.362$ .

## Comparison scores of drug use between groups pre-intervention

*Previous drug use scores between groups*

**Table 7: Means and standard deviations of drug use scores between participants**

	N	Mean	Std. Deviation
Watched 'Talk to Frank'	12	12.33	7.901
Didn't Watch 'Talk to Frank'	12	11.50	10.664

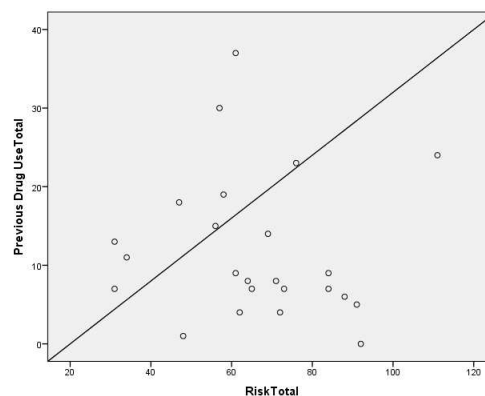
There was no significant difference in previous drug use scores between the control and experimental group ( $t = -.218$ ,  $df = 22$ ,  $p = 0.830$ , two tailed).

## Outcome data

### *Correlation analysis of previous substance use and perceived risk*

Linear regression was carried out to determine the effect of previous substance use scores on perceived risk.

Graph 1: a graph to show the correlation of previous drug use on participant's perceived risk.

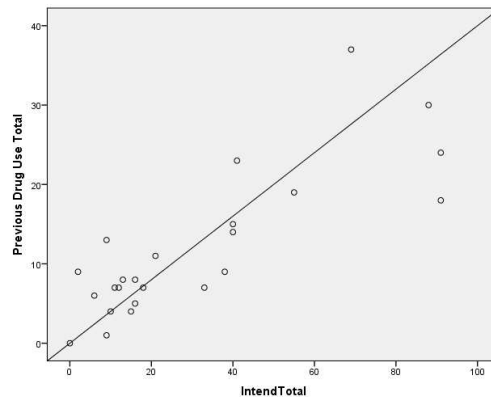


Using the enter method, the model was shown to be non-significant:  $F(1,22) = 0.088$ ,  $p < .769$ . The model explains 4.1% of the variance (Adjusted  $R^2 = -.041$ ). This indicates that previous substance use was not a significant predictor for a participant's anticipated risk.

### ***Correlation analysis of previous substance use and intent to use***

The potential correlation of a participant's previous substance use and their intent to use in the future was calculated by conducting a linear regression.

### **Graph 2: a graph to show the correlation of previous drug use on participant's intent to use**



It was found that for every score increase for the previous substance use, the intent to use score increased by 2.565, which represented .827 of a standard deviation. Using the enter method, a significant model emerged:  $F(1,22) = 47.556, p < .0005$ , showing that the results were unlikely to have arisen by sampling error. The model explains 66.9% of the variance (Adjusted  $R^2 = .669$ ).

### ***Effects of the 'Talk to Frank' intervention on participants perceived risk of drugs and intent to use drugs.***

A one-way independent ANCOVA was performed to see if the 'Talk to Frank' intervention had an effect on the participant's perceived risk of substances and intent to use substances, whilst controlling for the co-variate of previous substance use. The independent variable in this case was whether or not participants had watched the 'Talk to Frank' intervention, whilst the dependent variables were the participant's perceived risk of substances and intent to use substances. Conducting a MANCOVA in this instance would not work, due to the very low correlation with previous substance use on perceived risk. Data on the perceived risk and intent to use was collected after the intervention. This was analysed as a between groups analysis.

**Table 8: Means and standard deviations of perceived risk scores between participants**

	Means	Std. Deviation
Watched <i>'Talk to Frank'</i>	65.42	14.425
Did Not Watch <i>'Talk to Frank'</i>	66.75	24.959

The mean and standard deviations for perceived risk scores are shown in Table 9. A *t*-test was conducted to see if there was a difference in the means on the perceived risk scores between the participants. Although the data shows that there was a slight increase in perceived risk scores in those that did not watch the *'Talk to Frank'* intervention, and this difference was not statistically significant ( $t = 0.337$ ,  $df = 22$ ,  $p = 0.370$ , one-tailed).

**Table 9: Means and standard deviations of intent to use scores between participants**

	Means	Std. Deviation
Watched <i>'Talk to Frank'</i>	29.00	24.720
Did Not Watch <i>'Talk to Frank'</i>	33.00	32.838

The means and standard deviations for the intent to use scores are shown in Table 10. Once again, a *t*-test was conducted to see if there was a difference in the means on the intent to use scores between the participants. Although the data shows that there is a slight increase in scores for those who did not watch the *'Talk to Frank'* intervention, this difference was not statistically significant ( $t = 0.160$ ,  $df = 22$ ,  $p = 0.437$ , one-tailed).

After adjusting for the co-variate, the ANCOVA analysis shows that there was not a significant effect of the between subjects factor group, for those who watched the *'Talk to Frank'* intervention and their perceived risk [ $F(1, 21) = 8.932$ ,  $p = 0.887$ ], meaning that the *'Talk to Frank'* intervention had no impact on the scores of perceived risk. The analysis additionally showed that there was not a significant effect of the between subjects factor group, for those who watched the *'Talk to Frank'* intervention and their

intent to use [ $F(1, 21) = 226.474, p = 0.837$ ]], meaning that the *'Talk to Frank'* intervention had no impact on the scores of intent to use.

## Summary

Overall, the results show that there is no correlation present between the previous drug use score and a participant's perceived risk. Nevertheless, a correlation was present between previous drug use and a participant's intent to use substances in the future. The results also indicate that the *Talk to Frank* intervention had no impact on perceived risk scores or intent to use scores.

## Qualitative analysis

Participants were provided with an opportunity to be referred to with an alias in order to protect their identity. A schedule of the interview questions along with an example of the qualitative analysis conducted is also available within Appendix 11.

As the study focussed on gathering the experiences of the individual's drug education, the theme of education and acquiring information runs throughout the data collected. However, two super ordinate themes emerged from the analysed data. These were Fear and Identity. These themes emerged through the discussion of three forms of learning that the participants acquired information through. Tertiary forms of learning tended to be the initial form of gaining information about a subject area. Tertiary forms of learning occurred when participants had no direct experience of a phenomena, and therefore turned to official sources of information, such as educational resources, to gain more knowledge about the specific phenomena in question. Tertiary learning experiences also included gaining information about a phenomena from another individual who had no direct experience themselves of the given phenomena . Secondary sources of learning occurred when the participant had no direct experience of the phenomena in question, but were able to learn either through witnessing the direct experiences of others around them, or through understanding how the phenomena affected the experiences of others who had direct experience, through questioning them and through the sharing of information. Primary sources of learning occurred when participants directly experienced the phenomena themselves. This conceptualisation is novel and appears nowhere else within the literature.

A themes table has been compiled for the quotes utilised below. A more thorough themes table is available within Appendix 10.



**Table 10: Themes table**

Superordinate themes	Subthemes	Quotes
Fear	The parent's view	<ol style="list-style-type: none"> <li>1. so like maybe my dad would say, oh you know, like we'd see something on TV and he'd be like "oh there's a druggie there, look at him, he's got bad clothes, he's, he's, he's living rough, erm, he's got mood swings, etcetera". Erm, "It ruins your life; you can't do anything from it". That's what made me feel fearful of it, and I didn't wanna be in that same position (Jim; page 1, lines 30 - 35).</li> <li>2. I suppose it's your parents being, at, being, saying, trying to be a deterrent and saying that they are bad, you'll get addicted, and stuff, they er, yeah, they, they just talked about them in a really negative way and everything you heard was sort of... negative (Jenny; page 5, lines 15 - 18).</li> </ol>
Fear	Education, what education?	<ol style="list-style-type: none"> <li>1. I: What would you say is the least helpful source in your opinion and experience? S: School. I: And why would you say school is the least helpful? S: Because I don't remember anything except now that, like that was a, that was like our... social class, whatever it was, rather than, it wasn't like in health or in biology or anything. I: What do you think... was bad about it? S: Didn't exist. I: It didn't exist. S: Well I don't remember, I don't remember so either it was rubbish and I don't remember it, or it wasn't there at all (Shaznay; page 14, lines 15 - 26).</li> </ol>
Fear	Vital information isn't taught	<ol style="list-style-type: none"> <li>1. they need to educate kids, coz it's their... ignoring it is not gonna make it go away and... ignorance is not bliss, ignorance leads to death and... hospital and stomach pumping and A&amp;E and, you know, things like that. Tell these kids what is out there, what they might experience (Michael; page 17, lines 3 - 7).</li> </ol>
Fear	The worst case scenario	<ol style="list-style-type: none"> <li>1. I, find it quite powerful when you see images of people like before and after, and that's something that I've seen, in loads and loads of different places, that's always that is something quite shocking (Jenny; page 8, lines 9 - 12).</li> </ol>
Fear	Curiosity	<ol style="list-style-type: none"> <li>1. like drugs in films allow you to explore... avenues that you wouldn't usually, like...</li> </ol>

	around drugs	psychological illness, and like depression spiralling down, and like... that kind of thing, and I find that kind of thing in films quite interesting anyway, so maybe I would kind of like be more inclined to watch a film that involved drugs and stuff, and mental illness (Jenny; page 8, lines 23- 28)
Fear	Fear of the unknown	1. and then there's always like the worst case scenario, where someone's taken something and died, and that's kind of stuck with me I guess (Dave; page 2, lines 29 - 31).
Fear	The media agenda and the governmental agenda	<ol style="list-style-type: none"> <li>1. you see like programmes about like, crystal meth, and like Louis Theroux programme... you just, yeah that shows you like what happens... when you take it, which is good (Fred; page 10, lines 29 - 32).</li> <li>2. I'd trust... I'd trust government based things, so if I'm looking for something, you'll, I'll type in... like NHS after it. But you will like get the bare minimum information but... you've gotta put faith in something so... any... the sort of government backed places are the ones I'd go to first, but, or charities, usually are a good source of information, they're a bit more honest (Shaznay; page 15, lines 5 - 10 ).</li> <li>3. how education has influenced me, I mean in like the formal education institution, not much actually, coz they didn't really teach me much about it, they only told me how dangerous it was and how bad it can get which is probably their way of conditioning to say don't do it, or just you know, kind of obey the law... umm... so yeah (Sai; page 5, lines 27 - 32).</li> <li>4. just like they were advertising stuff for like on TV like 'Talk to Frank' and stuff, so obviously it gets you... umm... gets you curious, and like you start watching films and like when you get older, you start watching films and like start watching TV programmes and like obviously... you like look into it (Fred; page 3, lines 22 - 26).</li> <li>5. but I think... say on TV and in forms of video that you're more likely to see when you're younger, it's definitely negative, and a lot of the time it leads to addiction, and like spiralling downhill (Jenny; page 3, lines 30 - 34).</li> </ol>
Fear	The wise internet	1. there's this specific website called Erowid which has got really detailed information about drugs erm... coz I was worried about like school teachers and things sussing it out and maybe college teachers, so I would, I went to Erowid just to find out about, kind of half-life times and how long it would be in my system and what the effects would be so yeah (Michael; page 1, lines 13 - 18).
Fear	I don't trust the	1. I: What kinds of sites did you use?

	government's agenda	<p>J: Erowid, erm... I, I, I, had a look at 'Talk to Frank' , but... erm, I know that there's an agenda behind... sites like those.</p> <p>I: What do you mean an agenda?</p> <p>J: I would say sites like those, yes there, they, they're perceived as to inform the public about drugs and what, how, how they make you feel but at the end of the day, it's, I feel it's, it's, it's, a government led... programme so, there's always an agenda behind it, so I, I prefer to seek erm... information from unbiased sources (Jim; page 12, lines 15 - 22).</p>
Fear	The consumerism of substance education	<p>1. F: ... like you only... go to sites that you've heard of from word of mouth or are like legit. You're not gonna go to some like, page on like, 60th Google page search are you?</p> <p>I: Ok and why, why's that?</p> <p>F: Because you're obv, one it takes too long to get to the 60th page, and you just want it there and then, you don't wanna keep looking around shopping, and there's, there's pages for price comparisons sites so you can look on there, instead of just looking around for yourself.</p> <p>I: Er, er, in, would the same apply for drugs?</p> <p>F: What, what do you mean like.</p> <p>I: Like if you were find, trying to find out some information about I dunno, something to do with drugs.</p> <p>F: Yeah you'd look at a couple of websites on the first page, but that's about it. You wouldn't go to like, someone's some nine year old's made in a w, on a Windows XP (Fred; page 12, line 1 - 16).</p>
Fear	Only naughty	<p>1. ...I would say that was, the biggest kind of external influence, and just seeing it with my</p>

	kids do drugs	own eyes, like just seeing the types of people that were... doing it, they were always the ones that were always getting in trouble, and... rebellious at school at that age (Jim; page 3, lines 22 - 26).
Fear	I know what I've seen	<ol style="list-style-type: none"> <li>1. ...when I was a bit older, my friend, we'd all be at the pub, having a good time and then he'd go off into the toilet and then he'd come back a different person, so his behaviour totally changed and he'd start becoming really paranoid, erm, was on edge and not really enjoying himself, whereas when he'd had a couple of beers, he could, and we could have a laugh with him (Dave; page 1, lines 25 - 30).</li> <li>2. ... the schools just kind of said that... well if you do this, uh, it could potentially be very dangerous and highlighted on the fact of danger but umm... when I would see my experiences with my siblings and my friends, they looked like they were having a good time and they continued living healthy lives so... I didn't understand why, they were, they were able to control themselves but someone was saying something else (Sai; page 12, lines 20 - 26).</li> </ol>
Fear	They had their heads screwed on	<ol style="list-style-type: none"> <li>1. ... I think the main, the main thing that changed those views were the fact that... people that... I would mix with and erm, were like me, I would say I was, had my head screwed on and I, you know I was doing well at school, and erm... those people like that, like me, were also like that, and the fact that they were doing it and still... being like good and stuff and erm, and still attaining, made me believe that oh, maybe it's not so bad, maybe it's erm... just erm... makes you feel like... funny (laughs) or you might enjoy it for a bit (Jim; page 4, lines 5 - 14).</li> </ol>
Fear	Drugs are dangerous	<ol style="list-style-type: none"> <li>1. S: ... so I had a f, friend who nearly died and... they I think nine of them went into intensive care... erm and she nearly died, like really bad.  I: So nine of her friends who had all taken the same substance nearly died and all got taken into hospital?  S: Yeah, yeah, well I don't know how bad they all were coz they wouldn't, they didn't really tell us but yes, they all, all went to hospital, they were all like collapsing and... going... mad.  I: Ok and how did that impact on the way you saw... drugs and drug use?</li> </ol>

		S: Erm... I mean I already wasn't already really into it then, coz I was about 20 erm... but... I think it's, it's the risk I don't think it's worth the risk (Shaznay; page 5, lines 2 - 14).
Fear	A calculated risk	<ol style="list-style-type: none"> <li>1. doing anything is a risk, driving to work is a risk, but it's a risk worth taking, because I need food so... everyone makes their own decision based on risk, day in day out, you're constantly risk assessing, but you can't do it if you've not got the information (Shaznay; page 10, lines 28 - 31).</li> <li>2. MDMA really enhances music for me, and music is very important anyway, but it does give it that little edge, that's really good, and it, you, things like mushrooms, they make you know a regular, I shouldn't say a regular night out because I still enjoy being out with my friends and I don't need to do anything, but if you do 'shrooms appropriately, then they can be REALLY enhancing in, you know the things that you experience, so you just kind of unlock that potential in your brain. Yeah I mean there's always a risk of doing it for seeking that, en, enhanced experience and you can go too far, but as I've got older I've got in a far more wi, I've got far wiser in to where my limits are, and I will stop (Michael; page 3, lines 18 - 29).</li> <li>3. I think, I suppose, there's something around wanting to... not change who you are, but a certain escapism... you know which alcohol prev, previous to that would do that erm...but I think there's always something where we look for something that changes you in a manner that sort of gives you some breathing space from normal life and things like that, so I think, probably, it, it was more of a... a sort of a escapism, a change of... mode of thinking and things like that (Jason; page 2, lines 27 - 34).</li> </ol>
Fear	Of course I'm in control	<ol style="list-style-type: none"> <li>1. I mean with the knowledge I know, usually if they are very ignorant about it, saying for example don't use it, I don't listen to it because I have this kind of breadth of knowledge to say that I can control myself and that I'm not going to end up like the person in the video (Sai; page 6, lines 33 - 37)</li> <li>2. Acceptable is that everybody still has an enjoyable time with nobody specifically causing any concern to anybody else, so for me I have gone maybe too far in my limits and either my partner or one of my friends has had to deal with me in a state that I'm probably not proud of, I mean it I felt great coz my friends have looked after me but at the same time yeah, if my personal choice is having an impact on them, then I'm not very happy with it</li> </ol>

		(Michael; page 2, lines 18 - 24).
Fear	Why would I do that?	<p>1. F: ...You're not gonna take like high, class A drugs, because it has, it probably will have more of a bad effect on you then it has a good effect on you in the long run. And, and normal people know that, not to do that.</p> <p>I: So... where do you get that information from, that certain drugs are, are more detrimental to your health than.</p> <p>F: Again like from peo, like news, media, websites and stuff. And like you have your own common sense on what's good and what's bad. Like marijuana, it's not really a, it's not really a bad drug, because it's, no, nothing chemical in it. It, it's just a plant, and it grows. But like, if you take ecstasy or LSD it's all manufactured in like labs and stuff.</p> <p>I: And what makes you think that that's bad in comparison to.</p> <p>F: Because they can put anything in it, you dunno what's going, you dunno what's going on it. Even though sometimes marijuana is sprayed with stuff, or stuff like that, it's nothing, it's not gonna like, how many deaths have there been in, from marijuana use, hardly anything (Fred; page 4, lines 15 - 32).</p> <p>2. the social perception of people, heroin addicts is that they can't work, and they'd do anything to get their next score, whereas cannabis, the perception of that is that people could still smoke it and actually still function on a day to day basis (Dave; page 13, lines 26 - 30).</p>
Identity	This is who I am	<p>1. I suppose I, think to myself I'm not a very hedonistic person, I'm quite a controlled person, erm, very healthy person, erm, very conscious about my health and things like that erm... and sort of, you know, I'm quite open to trying it, so I can only sort of talk from my experience (Jason; page 6, lines 13 - 17).</p>
Identity	The societal fabric	<p>1. well I think people that don't use would view somebody who does occasionally, maybe more you know, what's the point? What's the point in risking something bad happening, people that do it a lot, people... who view, people doing it a lot I think would view them very negatively... almost irresponsible, erm... people, really. (Jason; page 4, lines 4 - 9)</p>

		<p>2. I mean people abuse alcohol all the time, they go out on Friday and binge, you know they would just binge cocaine instead! (Laughs) They would just binge on whatever else, alcohol is awful! I mean, uh, you never meet anyone on, on, you know, that had Korsikoff's syndrome and they can't even think, they can't make any new memories, no other drug does that to you but alcohol! (Michael; page 10, lines 2 - 7)</p> <p>3. I think most sensible adults know that there is risks in doing lots of things, not just drugs, but I think the fact that it's illegal makes it seem riskier but also seem... more... cool, more... daring, erm, whereas alcohol... you know if I went out and drunk a lot, people wouldn't necessarily be like "Ooh, you're so risky, I can't believe that you did that." Whereas if you went out and took... six ecstasy tablets, I probably would think that. But... at the same time, there is something exciting about somebody taking that risk. So... you might think that they're slightly cooler for their ecstasy, I wouldn't think anyone getting out, getting wasted... is cool really. It, well, I probably did when I was younger, but I think because it's, in theory, illegal, it makes it seem... seem riskier. (Shaznay; page 9, lines 29 - 39 &amp; page 10, lines 1 - 2)</p> <p>4. I've met people of that age, but, I don't think, I personally don't think they're sad, I meet people at festivals and at parties and at clubs all the time at that age that are doing it... and I think that's the thing isn't it, if you're doing drugs, you've lost your way in life and... oh and they don't know and they never made it. I've met kings of industries that do drugs, holding a job and a family, I dunno, it, it can be very private and very open but... it's got a really unfair representation.</p> <p>I: You think, in the way that, you think it's unfairly represented?</p> <p>M: They cause a lot of damage, drugs. Socially and physically and emotionally. There is, if you, if you can't accept that, then you shouldn't be doing them, in my opinion, however, you know, speak to all of my university friends and they've had perfectly fine experiences doing them. Very successful individuals, very good careers, you know, if you... if you spoke to them you'd be very impressed with the amount that they've achieved but yeah, you know, if they, if they spoke about their drug experiences to certain people, people would really start to look at them in a different way (Michael; page 13, lines 9 - 26)</p> <p>5. I'd go to the internet personally but... yeah I suppose there are helplines and stuff but... I</p>
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		<p>don't think I was really aware of them... I think I maybe was like later on in high school years but not... I, even now it's not like I first go to helplines, it seems, like, it's a helpline, like you need help, it's not something that you just wanna discuss something. It seems like it's something a little more extreme when it's like a taboo subject, like you wanna keep it more private, so you'd rather go to the internet and do it by yourself, rather than talking to someone (Jenny; page 5, lines 30 - 38).</p> <p>6. you are judged by your drug knowledge and your drug experiences. The more you know, the cooler you are. We actually had this, I had training last week. In fact, Monday and... we had a substance misuse quiz, and even then, people were showing off how much they knew. And the people that were... didn't know a lot... either sort of, said nothing, to not reveal themselves, or over the top-ly erm... exaggerated how much they didn't know "Oh I don't know anything about drugs" sort of, putting their cards on the table. So I think people's knowledge makes them... I don't know. They want to, show them they know a lot if they think it's cool or they wanna say that "this is nothing to do with me" if they think it's dangerous (Shaznay; page 9, lines 6 - 17)</p>
Identity	That's not me	<p>1. I just, I dunno, like how I've thought, I've said before really I guess... maybe I just don't have the personality that is so susceptible I don't think, I just, yeah... I am like probably more worried by the side effects than the bonuses (Jenny; page 11, lines 31 - 34).</p> <p>2. so when I was 14, the image was important, but... you would do different things to have a different image, whereas now, I want a, together adult image so... I, me, as the years have gone on I've been less and less likely to take drugs, and now I know I probably never would (Shaznay; page 5, lines 31 - 35).</p>
Identity	The friendship fabric	<p>1. if something is available in a social group, people are doing it, then it is something that you know, sort of (takes deep breath in), either you do it or you don't (Jason; page 2, lines 22 - 24)</p> <p>2. coz it feels good. It's nice to be able to relax, and I think there, there's a certain degree of social... like what we do as friends, what we've always done is like, oh lets meet up and go for a beer, so it just kind of goes, in hand and hand (Dave; page 8, lines 22 - 25).</p> <p>3. when I started drinking alcohol it was because of what I saw on TV and also because of my siblings, um I think my siblings played a really big part on how I... um, consume... these kind of mind altering substances (Sai; page 2, lines 16 - 19).</p>



		<ol style="list-style-type: none"> <li>4. it basically fitted into the lifestyle of university, you know... err, we were having so much fun, whilst being high and stuff, it, it was more of a chilled one rather than getting drunk and going out and stuff, it was, you know, you could chill with your friends, and you, you enjoy that time more to erm... like going out getting drunk and... and doing stupid stuff, like you enjoy just, just getting high and just chilling out with friends and, being in your room and just watching, si, silly things (Jim; page 6, lines 18 - 25).</li> <li>5. so the social circle I was in didn't really use drugs, and I knew people around that did use drugs but... I guess they weren't, I was aware that I suppose there was quite a negative opinion of them formed from people around me and even I suppose films and parents and teachers... They, they like, they were all a bad thing to do, and, I suppose I never felt comfortable enough with the people I knew who took drugs... it probably might've been a bit different if my friends did a whole, but I just, yeah, it just never really cropped up (Jenny; page 2, lines 11 - 19).</li> </ol>
Identity	Drug taking is an inclusive activity	<ol style="list-style-type: none"> <li>1. so the drug scene can be quite... pretentious sometimes, so people think... they're a certain way and that they're different and special sometimes, or that's how it comes across, and... so that's, that's not particularly me and it tends to be kind of like, er the music that tends to be associated with that kind of group is not for me either, erm... and the general attitudes towards certain things can be different in those groups I think (Shaznay; page 4, lines 32 - 38).</li> <li>2. you know at Uni this... couple of girls that I lived with erm... so they wouldn't come out with us so me and the, the other sort of non-drug takers, because they would go to a special drug events, so... that was and then, they kind of wouldn't be seen dead where we went, and we wouldn't be seen dead where they went, or we thought we would be seen dead there, because we would die (laughs) so... I think that's the only issue (Shaznay; page 6, lines 35 - 42).</li> <li>3. I think because there wasn't a lot of... drug taking in my group, I think if I had been more in the minority then there would be more of a need for me to, to do it. But actually there was just a couple of people in our social group that did, and that was it really (Dave; page 16, lines 30 - 34).</li> <li>4. if those nights were, full of all of my friends and full of music I loved, then I would've been there doing it (Shaznay; page 13, lines 24 - 25).</li> </ol>

Identity	I definitely know what I've felt	<ol style="list-style-type: none"> <li>1. F: I was just curious, of what it was like, then just started taking it. I: Did you think about drugs prior to that? F: Not really... just saw some people doing it. I: And who were these people? F: My sister and my cousins. I: And what did they used to do? F: They used to go in the garden, and they used to smoke it. I: And how did that make you feel? F: I was being, felt left out. That I wanted to try it. (Fred; page 2, lines 17 – 25)</li> <li>2. ... I think even my curiosity about learning about things comes into that so... you know... even, you know, I think seeing you know, friends do it, and I think that's the learning, and learning from experience, learning from my experience with drugs (Jason; page 10, lines 14 - 17).</li> </ol>
Identity	I've educated myself	<ol style="list-style-type: none"> <li>1. so, this conference that I'm going to, they're discussing, they're having a big debate on MDMA, on psychedelics, on DMT, and on all these... different drugs, and how they can be... actually beneficial, so for example MDMA can be used to treat PTSD, or um, I also watched an interview of this girl who was dying of cancer, and um, she was able to die with dignity because she... took MDMA and um, she was able to kind of die happily, and um... so I think um to be able to create some se, some kind of forum on not being, on not kind of oppressing this kind of information especially on the internet is really important to kind of spread the education about drugs and how they can actually be useful (Sai; page 5, lines 35 - 42 &amp; page 6, lines 1 - 4).</li> </ol>
Identity	My own ignorance	<ol style="list-style-type: none"> <li>1. it's what I saw, and I, I just used to think wow, I never wanna look like that, and me and my friend would, would say the same thing like, you know, so erm, yeah, it, but it was ignorant because I never researched it (Jim; page 11, lines 6 - 9).</li> </ol>
Identity	I don't need to know	<ol style="list-style-type: none"> <li>1. erm, I don't think I really have much interest in, in in, learning, it's not like I go away all the time and, I think like I said the more interest was, doing the biological psychology and just learning a bit more about how it affects our... brain chemistry, because I suppose I feel I don't need to worry about... the enduring effects coz I, I, rarely use them, so... (Jason; page 8, lines 17 - 22).</li> </ol>

## **Fear**

The theme of fear was the most prevalent amongst the data. This theme focuses primarily on the fear or lack of fear that the participant has toward substance use, where these ideas have come from, and how this impacted their learning.

### ***The parent's view***

Participants expressed that one of the first experiences they had of learning about substance was from their parents

***... so like maybe my dad would say, oh you know, like we'd see something on TV and he'd be like "oh there's a druggie there, look at him, he's got bad clothes, he's, he's, he's living rough, erm, he's got mood swings, etcetera". Erm, "It ruins your life; you can't do anything from it". That's what made me feel fearful of it, and I didn't wanna be in that same position (Jim; page 1, lines 30 - 35).***

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Participants trusted their parents' opinions and therefore were likely to believe their parents view at a younger age. The parents view was that drugs were dangerous and that they should be avoided at all costs. Participants were fearful of this description and were fearful as to what would happen if they were to experiment with drug use. As this tertiary experience was the only interaction they had of the mysterious world of substances, it was often something that they believed until they gathered experience elsewhere.

***... I suppose it's your parents being, at, being, saying, trying to be a deterrent and saying that they are bad, you'll get addicted, and stuff, they er, yeah, they, they just talked about them in a really negative way and everything you heard was sort of... negative (Jenny; page 5, lines 15 - 18).***

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The tertiary learning experience of substances simply describes the phenomena where an individual is told about substances and its effects by a source. The participant is unaware of whether this source has had any direct experience of the substance themselves, if this tertiary source is another individual. However the tertiary source can also be non-human educational sources, including the media.

### ***Education? What education?!***

In addition, all participants interviewed felt that the formal education they received from schools about substances was unmemorable, and did not leave a lasting impact:

***I: What would you say is the least helpful source in your opinion and experience?***

***S: School.***

***I: And why would you say school is the least helpful?***

***S: Because I don't remember anything except now that, like that was a, that was like our... social class, whatever it was, rather than, it wasn't like in health or in biology or anything.***

***I: What do you think... was bad about it?***

***S: Didn't exist.***

***I: It didn't exist.***

***S: Well I don't remember, I don't remember so either it was rubbish and I don't remember it, or it wasn't there at all (Shaznay; page 14, lines 15 - 26).***

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### ***Vital information isn't taught***

As a result, participants suggested that vital information was not taught within the formal education system

***...they need to educate kids, coz it's their... ignoring it is not gonna make it go away and... ignorance is not bliss, ignorance leads to death and... hospital and stomach pumping and A&E and, you know, things like that. Tell these kids what is out there, what they might experience (Michael; page 17, lines 3 - 7).***

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The importance of the formal education system to be accurate in the information that it provides is important. If participants were provided with information that was unmemorable, it may have caused participants who went on to use substances at a later stage to distrust formal forms of education, especially if the formal forms of education went against what they had learnt for themselves within their primary and secondary

learning. It may also add to the overall fear about the substance, through creating mystery around substances.

### ***The Worst Case Scenario***

Participants also said that stories which emphasised the most damaging effects of substance misuse made a powerful impact on the way that they viewed substances

***...I, find it quite powerful when you see images of people like before and after, and that's something that I've seen, in loads and loads of different places, that's always that is something quite shocking (Jenny; page 8, lines 9 - 12).***

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These worst case scenarios resonated with the individual and shaped their view on substances and how they chose to use them. It also helped them to shape their boundaries on risk, so that they put into consideration what risks were acceptable for them to take and what risks were not acceptable.

### ***Curiosity around drugs***

All participants identified that there was a curiosity around substance use. However, this curiosity was satiated in different ways. For Jenny, her curiosity was met through engaging with films which depicted drug use and its relative effects. This tertiary style of learning was a safe form of learning that she was able to do without putting herself at risk. It also further enhanced her view that drugs were dangerous and was something that she did not want to engage with

***... like drugs in films allow you to explore... avenues that you wouldn't usually, like... psychological illness, and like depression spiralling down, and like... that kind of thing, and I find that kind of thing in films quite interesting anyway, so maybe I would kind of like be more inclined to watch a film that involved drugs and stuff, and mental illness (Jenny; page 8, lines 23- 28).***

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### ***Fear of the unknown***

For those participants who had limited primary or secondary experience of drugs, this was enough to put them off from using drugs altogether

***... and then there's always like the worst case scenario, where someone's taken something and died, and that's kind of stuck with me I guess (Dave; page 2, lines 29 - 31).***

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This fear of the unknown further reinforced participants already-held meaning on substances, and helped them to differentiate between what was considered to be a risky activity and what was not. It also helped them to construct their identity of themselves and who they believed they were in relation to others behaviour.

### ***The media agenda and the governmental agenda***

Participants felt that the media was an influential source of information to society and themselves regarding the way they perceived and were educated about substance use

***... you see like programmes about like, crystal meth, and like Louis Theroux programme... you just, yeah that shows you like what happens... when you take it, which is good (Fred; page 10, lines 29 - 32).***

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This also helped participants' to understand the general consensus of the world that they lived within, in relation to understanding how substances were perceived by society. This information helped them to shape their own understanding of substances. Some participants were more likely to trust the government and charities as they perceived them to be trusted sources that were better at scrutinising the confusing and often conflicting information surrounding substances

***...I'd trust... I'd trust government based things, so if I'm looking for something, you'll, I'll type in... like NHS after it. But you will like get the bare minimum information but... you've gotta put faith in something so... any... the sort of government backed places are the ones I'd go to first, but, or charities, usually are a good source of information, they're a bit more honest (Shaznay; page 15, lines 5 - 10).***

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However, although the participants identified that the media and other institutions like the government helped shape their education and views about substances, some

participants also noted that these forms were unhelpful as they painted an inaccurate picture of what taking substances was really like, to scare or put people off from using

***... how education has influenced me, I mean in like the formal education institution, not much actually, coz they didn't really teach me much about it, they only told me how dangerous it was and how bad it can get which is probably their way of conditioning to say don't do it, or just you know, kind of obey the law... umm... so yeah (Sai; page 5, lines 27 - 32).***

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This resulted in these participants distrusting the media, and over time not believing in what they said. One participant in particular felt that the media's portrayal of substance use actually fuelled their curiosity to try

***... just like they were advertising stuff for like on TV like 'Talk to Frank' and stuff, so obviously it gets you... umm... gets you curious, and like you start watching films and like when you get older, you start watching films and like start watching TV programmes and like obviously... you like look into it (Fred; page 3, lines 22 - 26).***

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However, the above only occurred if participants had received a primary and/or secondary source of information which indicated that their specific substance use was safer than what the media or government was portraying from either through their direct experiences, or through the experiences of their family and/or friends. Primary sources of information were experiences that participants had directly through using substances, whereas secondary sources of information were experiences that participants had gathered either through watching their friends and/or family under the influence, or through talking to their friends and/or family about their experiences whilst they were under the influence.

If the participant had no primary or secondary experience from their peers indicating that substance use was 'not that bad', they then sought out information from the media or the government to collude with their already established view that was based on tertiary information from their parents and their formal education

*... but I think... say on TV and in forms of video that you're more likely to see when you're younger, it's definitely negative, and a lot of the time it leads to addiction, and like spiralling downhill (Jenny; page 3, lines 30 - 34).*

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### ***The wise internet***

Some forms of media were seen to be more trusted as sources in comparison to others. The internet seemed to be a favourite source of information for participants, as it was perceived as being a know-all information source, which was easily accessible and was private

*... there's this specific website called Erowid which has got really detailed information about drugs erm... coz I was worried about like school teachers and things sussing it out and maybe college teachers, so I would, I went to Erowid just to find out about, kind of half-life times and how long it would be in my system and what the effects would be so yeah (Michael; page 1, lines 13 - 18).*

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### ***I don't trust the government's agenda***

However, some participants were wary of the information provided by official sources like 'Talk to Frank', as they perceived them to be a biased source of information:

***I: What kinds of sites did you use?***

***J: Erowid, erm... I, I, I, had a look at 'Talk to Frank', but... erm, I know that there's an agenda behind... sites like those.***

***I: What do you mean an agenda?***

***J: I would say sites like those, yes there, they, they're perceived as to inform the public about drugs and what, how, how they make you feel but at the end of the day, it's, I feel it's, it's, it's, a government led... programme so, there's always an agenda behind***



***it, so I, I prefer to seek erm... information from unbiased sources  
(Jim; page 12, lines 15 - 22).***

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Participants' who had no prior primary or secondary experience of drug use were much more likely to believe in what the media said, without necessarily contesting the information. As they had already developed the fear of the substance in question, they sought to look for similar tertiary and secondary experiences in society which would reinforce their already held beliefs. Participants therefore felt that any individual that went against their view that taking drugs were risky were actually not educated themselves. This is in comparison to those who did use, as for those who did use felt that those who didn't use misjudged the riskiness of the substance use. This created a barrier between the population that did use in comparison to those that did not use.

### ***The consumerism of substance education***

Sites that were seen to be credible were more likely to be used by participants as they perceived these sites to be more trustworthy. Things such as the layout, how interactive the form of media was, and whether it was visually appealing was important to the participants and made them more likely to seek information from these sources over others. However, in order to visit this form of media in the first place, a recommendation from a secondary source, including the participant's own experience of what they deemed to be 'trustworthy' was required:

***F: ... like you only... go to sites that you've heard of from word of mouth or are like legit. You're not gonna go to some like, page on like, 60th Google page search are you?***

***I: Ok and why, why's that?***

***F: Because you're obv, one it takes too long to get to the 60th page, and you just want it there and then, you don't wanna keep looking around shopping, and there's, there's pages for price comparisons sites so you can look on there, instead of just looking around for yourself.***

***I: Er, er, in, would the same apply for drugs?***

***F: What, what do you mean like.***

***I: Like if you were find, trying to find out some information about I dunno, something to do with drugs.***

***F: Yeah you'd look at a couple of websites on the first page, but that's about it. You wouldn't go to like, someone's some nine year old's made in a w, on a Windows XP (Fred; page 12, line 1 - 16).***

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The experience of using a website to find information was just as important as the information itself, as for participants, the act of sourcing information required the information to be displayed in a manner that was appealing and relevant. If the participant considered either option to not meet their standards, the information was likely to be distrusted.

### ***Only naughty kids do drugs***

Participants' secondary experience of watching other substance users also played an important role in understanding substance use

***...I would say that was, the biggest kind of external influence, and just seeing it with my own eyes, like just seeing the types of people that were... doing it, they were always the ones that were always getting in trouble, and... rebellious at school at that age (Jim; page 3, lines 22 - 26).***

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This secondary experience was vital in either changing or reinforcing the participant's already held tertiary views on substances.

### ***I know what I've seen***

Depending on what participants were exposed to, their learning experience determined whether or not they would continue to use substances. Some participants learning

experiences from their parents and schools were reinforced by what they saw in society and amongst their friendship groups themselves

*...when I was a bit older, my friend, we'd all be at the pub, having a good time and then he'd go off into the toilet and then he'd come back a different person, so his behaviour totally changed and he'd start becoming really paranoid, erm, was on edge and not really enjoying himself, whereas when he'd had a couple of beers, he could, and we could have a laugh with him (Dave; page 1, lines 25 - 30).*

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However, this secondary learning experience also influenced some participants to challenge their previously held beliefs around substances and substance use that came from their initial tertiary learning

*... the schools just kind of said that... well if you do this, uh, it could potentially be very dangerous and highlighted on the fact of danger but umm... when I would see my experiences with my siblings and my friends, they looked like they were having a good time and they continued living healthy lives so... I didn't understand why, they were, they were able to control themselves but someone was saying something else (Sai; page 12, lines 20 - 26).*

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This information was often contradictory to what participants saw in their day-to-day lives through their secondary experiences. This clash of information between their tertiary and secondary experiences resulted in some participants distrusting what tertiary sources were teaching about substance use even more.

### ***They had their heads screwed on***

This influenced some participants to find out more about substances and substance use from a trusted source, their friends or family members who were seen to be sensible and “*had their heads screwed on*”

*... I think the main, the main thing that changed those views were the fact that... people that... I would mix with and erm, were like me, I would say I was, had my head screwed on and I, you know I was doing well at school, and erm... those people like that, like me, were also like that, and the fact that they were doing it and still... being like good and stuff and erm, and still attaining, made me believe that oh, maybe it's not so bad, maybe it's erm... just erm... makes you feel like... funny (laughs) or you might enjoy it for a bit (Jim; page 4, lines 5 - 14).*

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Through doing this, participants were provided with a space to explore their own feelings in relation to substance use. They were given a new perspective on substance use education and how it could personally mean something to them if they chose to use.

### ***Drugs are dangerous***

Participants also discussed how their secondary learning experiences helped them to understand that substance taking was a risky activity:

*S: ... so I had a f, friend who nearly died and... they I think nine of them went into intensive care... erm and she nearly died, like really bad.*

*I: So nine of her friends who had all taken the same substance nearly died and all got taken into hospital?*

*S: Yeah, yeah, well I don't know how bad they all were coz they wouldn't, they didn't really tell us but yes, they all, all went to hospital, they were all like collapsing and... going... mad.*

*I: Ok and how did that impact on the way you saw... drugs and drug use?*

*S: Erm... I mean I already wasn't already really into it then, coz I was about 20 erm... but... I think it's, it's the risk I don't think it's worth the risk (Shaznay; page 5, lines 2 - 14).*

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This secondary learning experience was important, as it was a more trusted source of information for the participants in comparison to the tertiary source of information

from their parents, schools and the media. This is because they had some indirect experience of how substances affected their friends, family and wider society. This personal experience resonated on a deeper level with participants rather than the stories they had heard from sources such as the media.

### ***A calculated risk***

Participants showed they were fearful of substances. However, in order for them to make a decision about whether to use or not, the information presented to them must be of good quality so that they are able to make a decision for themselves

***... doing anything is a risk, driving to work is a risk, but it's a risk worth taking, because I need food so... everyone makes their own decision based on risk, day in day out, you're constantly risk assessing, but you can't do it if you've not got the information (Shaznay; page 10, lines 28 - 31).***

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Participants have also learned from their primary or direct experiences about whether or not to take a risk, and how they mitigate for the risks they take versus the benefits they will receive if they do use

***... MDMA really enhances music for me, and music is very important anyway, but it does give it that little edge, that's really good, and it, you, things like mushrooms, they make you know a regular, I shouldn't say a regular night out because I still enjoy being out with my friends and I don't need to do anything, but if you do 'shrooms appropriately, then they can be REALLY enhancing in, you know the things that you experience, so you just kind of unlock that potential in your brain. Yeah I mean there's always a risk of doing it for seeking that, en, enhanced experience and you can go too far, but as I've got older I've got in a far more wi, I've got far wiser in to where my limits are, and I will stop (Michael; page 3, lines 18 - 29).***

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The above shows that participants use substances to achieve a specific desired outcome, however this use needs to be within their control. Therefore, their substance use was important to them as it helped them to achieve what they wanted to achieve from that situation. All participants interviewed used substances, whether legal or illegal. It was found that for all participants, their use was linked with trying to achieve a specific and desired outcome

***... I think, I suppose, there's something around wanting to... not change who you are, but a certain escapism... you know which alcohol prev, previous to that would do that erm...but I think there's always something where we look for something that changes you in a manner that sort of gives you some breathing space from normal life and things like that, so I think, probably, it, it was more of a... a sort of a escapism, a change of... mode of thinking and things like that (Jason; page 2, lines 27 - 34).***

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### ***Of course I'm in control***

This corresponded with how the participants viewed their own substance use. All participants felt that they were in control of their use, whatever the substance of choice was, and that their use was conducted with intent, but with a degree of control and restriction

***... I mean with the knowledge I know, usually if they are very ignorant about it, saying for example don't use it, I don't listen to it because I have this kind of breadth of knowledge to say that I can control myself and that I'm not going to end up like the person in the video (Sai; page 6, lines 33 - 37).***

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This control and restriction gave participants a reduction in fear and helped them to feel like they were managing the situation they were in. Participants and their friends quickly learned how to look after each other if they were at risk from substance use through the primary and secondary experiences they had, even though they were often embarrassed of their substance use if it was to the extent of where they were

intoxicated. This prevented them from wanting to repeat the experience again, for fear of it affecting their friendship

*... Acceptable is that everybody still has an enjoyable time with nobody specifically causing any concern to anybody else, so for me I have gone maybe too far in my limits and either my partner or one of my friends has had to deal with me in a state that I'm probably not proud of, I mean it I felt great coz my friends have looked after me but at the same time yeah, if my personal choice is having an impact on them, then I'm not very happy with it (Michael; page 2, lines 18 - 24).*

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Friendship within the substance use setting is important, as it is the glue that facilitates recreational substance use. Without this glue, recreational substance use would have no place within the individual's life.

#### ***Why would I do that?***

However, for substances that they did not use and had no primary or secondary experience of, the fear of the unknown was very real:

*F: ...You're not gonna take like high, class A drugs, because it has, it probably will have more of a bad effect on you then it has a good effect on you in the long run. And, and normal people know that, not to do that.*

*I: So... where do you get that information from, that certain drugs are, are more detrimental to your health than.*

*F: Again like from peo, like news, media, websites and stuff. And like you have your own common sense on what's good and what's bad. Like marijuana, it's not really a, it's not really a bad drug, because it's, no, nothing chemical in it. It, it's just a plant, and it grows. But like, if you take ecstasy or LSD it's all manufactured in like labs and stuff.*

***I: And what makes you think that that's bad in comparison to.***

***F: Because they can put anything in it, you dunno what's going, you dunno what's going on it. Even though sometimes marijuana is sprayed with stuff, or stuff like that, it's nothing, it's not gonna like, how many deaths have there been in, from marijuana use, hardly anything (Fred; page 4, lines 15 - 32).***

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Or

***... the social perception of people, heroin addicts is that they can't work, and they'd do anything to get their next score, whereas cannabis, the perception of that is that people could still smoke it and actually still function on a day to day basis (Dave; page 13, lines 26 - 30).***

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This fear of the unknown prevented participants from trying to seek out secondary sources of information that would challenge their already held view. It seems that participants who were curious would develop the means to gain some additional secondary information to help them develop a bigger picture, but their curiosity was strongly linked to how risky they perceived the activity to be. The risk was strongly linked to secondary sources of information they had already been exposed to, and whether or not they had belief in their tertiary sources of information.

## **Identity**

Identity was a strong theme that emerged throughout the data collected. Participants' identities were constructed through their decision to use or not use specific substances.

### ***This is who I am***

Participants had a clear idea about who they were and this really played into how they viewed their substance use and used substances



*... I suppose I, think to myself I'm not a very hedonistic person, I'm quite a controlled person, erm, very healthy person, erm, very conscious about my health and things like that erm... and sort of, you know, I'm quite open to trying it, so I can only sort of talk from my experience (Jason; page 6, lines 13 - 17).*

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Participants' identities were important to them. Their identity was the image they believed themselves to be, and the image they portrayed to the world. If they believed their image would be affected by substance use, they would reconsider using. Nevertheless, substance use was a private part of an individual's life and it was not something that they readily shared with others. This is because of fear of judgement.

### ***The societal fabric***

Participants discussed the importance of the fabric of society and how this fabric is fundamentally against the use of drugs. For this reason, those participants that used illegal substances felt that they had to hide their drug use from certain people

*...well I think people that don't use would view somebody who does occasionally, maybe more you know, what's the point? What's the point in risking something bad happening, people that do it a lot, people... who view, people doing it a lot I think would view them very negatively... almost irresponsible, erm... people, really. (Jason; page 4, lines 4 - 9).*

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Some participants noted that although alcohol is legal, it is still dangerous, and sometimes more dangerous than any of the illegal substances that they had tried

*... I mean people abuse alcohol all the time, they go out on Friday and binge, you know they would just binge cocaine instead! (Laughs) They would just binge on whatever else, alcohol is awful! I mean, uh, you never meet anyone on, on, you know, that had Korsikoff's syndrome and they can't even think, they can't make any new memories, no other drug does that to you but alcohol! (Michael; page 10, lines 2 - 7).*

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Michael in particular found the view that society had on substances that were not legal was hypocritical and uneducated. This may have led participants to feel alienated from mainstream society. Furthermore, using drugs gives a perception from other members of society that the individual is a risk taker. This further adds to the construction of the drug taker's perceived identity, how they control their use, and how non-drug users see the users in relation to themselves

*... I think most sensible adults know that there is risks in doing lots of things, not just drugs, but I think the fact that it's illegal makes it seem riskier but also seem... more... cool, more... daring, erm, whereas alcohol... you know if I went out and drunk a lot, people wouldn't necessarily be like "Ooh, you're so risky, I can't believe that you did that." Whereas if you went out and took... six ecstasy tablets, I probably would think that. But... at the same time, there is something exciting about somebody taking that risk. So... you might think that they're slightly cooler for their ecstasy, I wouldn't think anyone getting out, getting wasted... is cool really. It, well, I probably did when I was younger, but I think because it's, in theory, illegal, it makes it seem... seem riskier. (Shaznay; page 9, lines 29 - 39 & page 10, lines 1 - 2).*

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However, those that use illegal substances feel that society has misrepresented the recreational drug user and their ability to control their use and live a socially acceptable life

*M: ... I've met people of that age, but, I don't think, I personally don't think they're sad, I meet people at festivals and at parties and at clubs all the time at that age that are doing it... and I think that's the thing isn't it, if you're doing drugs, you've lost your way in life and... oh and they don't know and they never made it. I've met kings of industries that do drugs, holding a job and a family, I dunno, it, it can be very private and very open but... it's got a really unfair representation.*

***I: You think, in the way that, you think it's unfairly represented?***

***M: They cause a lot of damage, drugs. Socially and physically and emotionally. There is, if you, if you can't accept that, then you shouldn't be doing them, in my opinion, however, you know, speak to all of my university friends and they've had perfectly fine experiences doing them. Very successful individuals, very good careers, you know, if you... if you spoke to them you'd be very impressed with the amount that they've achieved but yeah, you know, if they, if they spoke about their drug experiences to certain people, people would really start to look at them in a different way (Michael; page 13, lines 9 - 26).***

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This further reinforced the view that those who took substances felt that their use was discriminated against by mainstream society. Participants felt judged by society, and this led to them reinforcing and protecting their own identity in regard to others who did not share their view. This judgment resulted in individuals hiding their personal drug use from others who they believed did not share the same ideas in order to protect their image.

Learning about drugs was often seen to be an embarrassing subject that could only be done within a private environment. This is because 'the societal fabric' says that drug use is bad, and therefore talking about drugs instantly means that you have a problem

***... I'd go to the internet personally but... yeah I suppose there are helplines and stuff but... I don't think I was really aware of them... I think I maybe was like later on in high school years but not... I, even now it's not like I first go to helplines, it seems, like, it's a helpline, like you need help, it's not something that you just wanna discuss something. It seems like it's something a little more extreme when it's like a taboo subject, like you wanna keep it more private, so you'd rather go to the internet and do it by yourself, rather than talking to someone (Jenny; page 5, lines 30 - 38).***

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However, knowing about drugs implies that the participant may have had previous primary or secondary experience of drugs themselves. Knowing this information added to the identity process of an individual as society then defined the individual according to a certain criteria

*... you are judged by your drug knowledge and your drug experiences. The more you know, the cooler you are. We actually had this, I had training last week. In fact, Monday and... we had a substance misuse quiz, and even then, people were showing off how much they knew. And the people that were... didn't know a lot... either sort of, said nothing, to not reveal themselves, or over the top-ly erm... exaggerated how much they didn't know "Oh I don't know anything about drugs" sort of, putting their cards on the table. So I think people's knowledge makes them... I don't know. They want to, show them they know a lot if they think it's cool or they wanna say that "this is nothing to do with me" if they think it's dangerous (Shaznay; page 9, lines 6 - 17).*

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In Shaznay's experience, it was found that certain individuals were comfortable about sharing their knowledge on substances, whereas others were not. This entirely depended on how the individual wanted to display their carefully constructed image of themselves, whether they regarded substance use as a positive construct, or whether their tertiary, secondary and perhaps primary experience had influenced them to regard substance misuse as a negative construct.

### ***That's not me***

For all of the participants, whether they used or not was irrelevant to the way that they viewed themselves in relation to others that used substances in a way that they had no primary experience of

*... I just, I dunno, like how I've thought, I've said before really I guess... maybe I just don't have the personality that is so susceptible I don't think, I just, yeah... I am like probably more*

**worried by the side effects than the bonuses (Jenny; page 11, lines 31 - 34).**

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The self-image of the participants mattered greatly to themselves within this construct

**... so when I was 14, the image was important, but... you would do different things to have a different image, whereas now, I want a, together adult image so... I, me, as the years have gone on I've been less and less likely to take drugs, and now I know I probably never would (Shaznay; page 5, lines 31 - 35).**

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### **The friendship fabric**

Whether participants used drugs, alcohol or both, the use was socially ingrained in the fabric of the friendship group

**... if something is available in a social group, people are doing it, then it is something that you know, sort of (takes deep breath in), either you do it or you don't (Jason; page 2, lines 22 - 24)**

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Substance use was often just seen as another recreational activity that the friendship group does together

**... coz it feels good. It's nice to be able to relax, and I think there, there's a certain degree of social... like what we do as friends, what we've always done is like, oh lets meet up and go for a beer, so it just kind of goes, in hand and hand (Dave; page 8, lines 22 - 25).**

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Substance use was part of the fabric that wove the friendship together. It was a commonality that the friends all shared. Strengthened by the trusted recommendations of friends, all individuals first tried substances amongst friends or siblings, after viewing their friends or siblings using the substances themselves

**... when I started drinking alcohol it was because of what I saw on TV and also because of my siblings, um I think my siblings played**

***a really big part on how I... um, consume... these kind of mind altering substances (Sai; page 2, lines 16 - 19).***

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This built trust among the friendship group and acted as an activity that was used to bond over

***... it basically fitted into the lifestyle of university, you know... err, we were having so much fun, whilst being high and stuff, it, it was more of a chilled one rather than getting drunk and going out and stuff, it was, you know, you could chill with your friends, and you, you enjoy that time more to erm... like going out getting drunk and... and doing stupid stuff, like you enjoy just, just getting high and just chilling out with friends and, being in your room and just watching, si, silly things (Jim; page 6, lines 18 - 25).***

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Additionally, the participants tended to have friends that used the same substances as them

***... so the social circle I was in didn't really use drugs, and I knew people around that did use drugs but... I guess they weren't, I was aware that I suppose there was quite a negative opinion of them formed from people around me and even I suppose films and parents and teachers... They, they like, they were all a bad thing to do, and, I suppose I never felt comfortable enough with the people I knew who took drugs... it probably might've been a bit different if my friends did a whole, but I just, yeah, it just never really cropped up (Jenny; page 2, lines 11 - 19).***

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By having shared interests with friends such as the use of specific substances, this created comradery and helped participants to feel accepted and included within their own sub-culture. The norms and ideals that they subscribed to and upheld were constructed within the friendship fabric. Although these norms and ideals were not always readily shared within their wider community for fear of being rejected by

mainstream society, within the friendship fabric, participants felt that they were able to be themselves.

### ***Drug taking is an inclusive activity***

However, there was a subculture that was associated with the use of substances, whether that was for alcohol or other recreational drugs. Some participants felt that the culture that is associated with certain types of substance use further reinforced the fact that they did not want to use certain substances

***... so the drug scene can be quite... pretentious sometimes, so people think... they're a certain way and that they're different and special sometimes, or that's how it comes across, and... so that's, that's not particularly me and it tends to be kind of like, er the music that tends to be associated with that kind of group is not for me either, erm... and the general attitudes towards certain things can be different in those groups I think (Shaznay; page 4, lines 32 - 38).***

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This subculture would also exclude non-users by the types of activity that were conducted by the users

***...you know at Uni this... couple of girls that I lived with erm... so they wouldn't come out with us so me and the, the other sort of non-drug takers, because they would go to a special drug events, so... that was and then, they kind of wouldn't be seen dead where we went, and we wouldn't be seen dead where they went, or we thought we would be seen dead there, because we would die (laughs) so... I think that's the only issue (Shaznay; page 6, lines 35 - 42).***

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Furthermore, any curiosity to use substances for participants was dampened if the substance in question was not actively part of their 'friendship fabric'

***...I think because there wasn't a lot of... drug taking in my group, I think if I had been more in the minority then there would be more***

*of a need for me to, to do it. But actually there was just a couple of people in our social group that did, and that was it really (Dave; page 16, lines 30 - 34).*

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Or

*... if those nights were, full of all of my friends and full of music I loved, then I would've been there doing it (Shaznay; page 13, lines 24 - 25).*

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This specifically showed how influential the friendship fabric was on constructing the norms for the participant. If an individual did not subscribe to the norms that were upheld by the friendship fabric, participants felt automatically excluded. Furthermore, if participants were somewhat curious about trying specific substances but their friendship fabric did not support this curiosity, they were unable to fulfil this curiosity through exploration.

### ***I definitely know what I've felt***

Nevertheless, for the remainder of the participants, the most important and useful type of education came from their personal or primary learning experiences. For the friendships that supported substance use, secondary learning experiences fuelled the curiosity to wanting to try a substance directly for the participant, by having a primary learning experience. These secondary learning experiences went against their initial tertiary learning experience from official educational sources such as schools and also parents:

***F: I was just curious, of what it was like, then just started taking it.***

***I: Did you think about drugs prior to that?***

***F: Not really... just saw some people doing it.***

***I: And who were these people?***

***F: My sister and my cousins.***

***I: And what did they used to do?***

***F: They used to go in the garden, and they used to smoke it.***

***I: And how did that make you feel?***



***F: I was being, felt left out. That I wanted to try it. (Fred; page 2, lines 17 - 25)***

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Or

***... I think even my curiosity about learning about things comes into that so... you know... even, you know, I think seeing you know, friends do it, and I think that's the learning, and learning from experience, learning from my experience with drugs (Jason; page 10, lines 14 - 17).***

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This learning experience is ingrained as part of the friendship fabric and is additionally supplemented by the information provided through their secondary sources of information, such as the experiences they have witnessed, or the described experiences of their friends or siblings. If participants were within a friendship fabric that condoned substance use and experimentation, their curiosity was fuelled by the construct of substances within their friendship fabric.

### ***I've educated myself***

Tied into the above is the supplementary learning the participants conducted to enhance their primary learning. This educational source was more useful to participants as they were able to tailor their learning to meet their specific needs and to match what they had learnt through their primary and secondary sources of information. Participants sought out information from a variety of sources including documentaries, websites and attending conferences. Participants felt that it was important to disseminate this information amongst their like-minded peers as they felt that it would enhance their understanding of the benefits and alter the way in which they used substances

***... so, this conference that I'm going to, they're discussing, they're having a big debate on MDMA, on psychedelics, on DMT, and on all these... different drugs, and how they can be... actually beneficial, so for example MDMA can be used to treat PTSD, or um, I also watched an interview of this girl who was dying of cancer, and um,***

***because she... took MDMA and um, she was able to kind of die happily, and um... so I think um to be able to create some se, some kind of forum on not being, on not kind of oppressing this kind of information especially on the internet is really important to kind of spread the education about drugs and how they can actually be useful (Sai; page 5, lines 35 - 42 & page 6, lines 1 - 4).***

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This supplementary learning helped to shape the participant's existing view on substances, and helped them to understand the context in which substance use could fit into their already crafted lives.

### ***My own ignorance***

However, some participants also freely admitted when they were not knowledgeable about certain substances. Participants held an initial tertiary view of substances, however if this tertiary view had been challenged by them gaining some primary or secondary experience of substances that went against their initial tertiary understanding, their views changed. They therefore sometimes referred to their lack of knowledge about a subject area as their own ignorance

***... it's what I saw, and I, I just used to think wow, I never wanna look like that, and me and my friend would, would say the same thing like, you know, so erm, yeah, it, but it was ignorant because I never researched it (Jim; page 11, lines 6 - 9).***

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This helped participants to better craft their identity, as it helped them to understand that sometimes they felt they had made the wrong judgement in the past. This in itself is important as it helped participants to understand that they were not necessarily knowledgeable at a previous time in their lives, even though at that time they thought they were. This meant that participants had become more open to trying novel substances where their tertiary views were challenged.

### ***I don't need to know***

Nevertheless, for those participants whose tertiary knowledge was not challenged about any specific substance, felt that they did not need to go out of their way to learn

about and understand a certain substance topic, especially if they felt that the topic held no relevance for them

*...erm, I don't think I really have much interest in, in in, learning, it's not like I go away all the time and, I think like I said the more interest was, doing the biological psychology and just learning a bit more about how it affects our... brain chemistry, because I suppose I feel I don't need to worry about... the enduring effects coz I, I, rarely use them, so... (Jason; page 8, lines 17 - 22).*

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If a participant's previously held belief was not challenged, it did not affect their judgement and therefore did not challenge their identity. No discrepancy was created in their minds toward their beliefs about a certain substance, and therefore they did not seek to challenge their previously held thoughts in order to reshape their identity.

### **Summary**

The focus of analysis shifted from trying to understand the experiences of the participants' official education around substance use, to focussing on how the participants derived meaning from many varied unofficial educational sources. It focussed on how these sources further developed and enhanced their view of substance use and the meaning that they applied to substance use. This became apparent when participants focussed on a whole range of educational sources including their personal experiences, as well as the experiences of their friends and family, and when the themes that emerged appeared to operate in layers of understanding, with some sources of information 'trumping' others. Although two super-themes emerged from the data, this format of learning penetrated both themes equally.

## **Discussion**

### **Summary of results**

The present study examined the effects of the 'Talk to Frank' intervention on a participant's perceived risk from taking a substance and their intent to use a substance. In addition, this study aimed to understand the experiences of substance use education

and how participants felt those experiences shaped their experiences of substances in the world.

For the quantitative part of the study, a total of twenty four participants aged between 18-34 were selected to take part in an intervention testing the *'Talk to Frank'* campaign, of which eight participants aged between volunteered to take part in a further qualitative study to discuss their experiences of substance use education and how this impacted on their substance use experiences.

For the quantitative aspect of the study, the main study hypothesis, being that the *'Talk to Frank'* intervention would have an impact on a participant's perceived risk of using a substance and intent to use a substance was not supported. However, a subsequent analysis showed that there was a correlation present between a participant's previous substance use score, and their intent to use substances in the future. There was no significant correlation present between a participant's previous use and their perceived risk towards use. The results indicated that the higher the participant's substance use score, the higher their intent to use substances in the future.

The qualitative results indicated that participants conducted learning through three sources of information which were graded as tertiary (including the media, their parents, and other formal educational sources, whereby those informing the participant had no direct experience of substance use themselves), secondary sources of information (including their friends who had direct experience of substance use and also experiences that were witnessed by the participants themselves of drug use) and primary sources of information (whereby participants experienced substance use for themselves).

The findings of both the quantitative study and the qualitative study complement each other. The discussion that follows will examine the possible reasons why the predicted effects in the quantitative study were not observed, and will take into account the rich qualitative data gathered from the subsequent interviews that took place from the quantitative study to explain why the findings for the quantitative study may have instead occurred. The discussion will also consider the limitations encountered within this study and will explain the possible conceptual and practical implications of this study.

## The findings

As discussed above, the quantitative findings of this study indicate that the *'Talk to Frank'* intervention was not successful at increasing participant perceived risk towards using a substance and reducing participant intention to use a substance at influencing the perceived risk and intentions to use for this particular population. However, it is important to note that due to the limited sample size, these findings cannot be generalised to the population. Although no published studies have been conducted specifically to test the effectiveness of the *'Talk to Frank'* intervention, previous research has been conducted on substance use public service announcements and substance usage intentions, however these results have not been conclusive (Gohel, 2016 – please see Systematic Review, Section D).

The quantitative findings showed that there was a positive correlation between previous substance use and the participants' intention to use a substance. This supports previous research conducted in this area, (Bachman, Johnston and O'Malley, 1998; Bachman, Johnston & O'Malley, 1990; Boys, Marsden, Griffiths, Fountain & Stillwell et al., 1999; Dunn, Mazanov & Sitharthan, 2009; Huba, Winguard & Bentler, 1979; Ojeda, Patterson, Strathdee, 2008). The results of the quantitative data need to be contextualised with the findings of other studies conducted in the same area. However, it is important to note that the population of the UK are unique in comparison to populations in other countries and therefore further research needs to be conducted on a larger scale to test the efficacy of the *'Talk to Frank'* intervention within the UK specifically.

The quantitative data from this study additionally fit in with the qualitative findings of the study, as the findings from the conducted IPA imply that learning for the participants is only validated from a tertiary source (such as the *'Talk to Frank'* adverts), if they have no secondary or primary learning experience that would discredit the tertiary source. If primary and secondary sources of information exist for the participant, the tertiary sources of information are only truly trusted and believed if they are congruent with the participant's secondary or primary learning experiences. Therefore, if a participant had indicated that they had a previous substance use history of, for example, MDMA (which would be their primary source of learning), they may be

less likely to believe the dangers highlighted about MDMA within the *'Talk to Frank'* intervention, as they would have been more likely than the non-user to have derived some direct positive experiences from their MDMA use. Therefore, they may be less likely to perceive they were at risk of consuming MDMA, and may also be more likely to use MDMA in the future, as their beliefs may be more likely to be in line with their primary experiences.

Tversky and Kahneman's (1974) work on perceived risk identified that participants rated hazards with a low dread risk and high known risk to science, to not require any political intervention. However, within the findings of the present study, it was shown that any form of learned knowledge, whether that be from a primary, secondary or tertiary source, was important to shape the understanding of the participant's view of substances. This occurred whether or not the information that was learnt was considered to be scientifically accurate, as within the participant's world, the 'science' had already occurred: the proof was conducted through their experiential learning, or the experiential learning of trusted others around them. The shaping of this understanding meant that this information would 'trump' any official scientific knowledge that was presented to the individual through a tertiary form of learning, as primary experiences will always trump secondary and tertiary forms of knowledge. In the case of scientific knowledge, the assumption is made here that scientific forms of knowledge are considered to be tertiary forms of learning, as it is unlikely that the layperson will have a robust methodology in place to conduct their own scientific studies.

If any presented scientific knowledge does not match the primary, secondary and tertiary forms of learning for the participant, then it is unlikely that the participant will consider this as true 'scientific' knowledge, and therefore may ignore messages being provided. 'Science' in the form as described by Tversky and Kahneman (1974) only became the participant's 'science' within the present study when they themselves had explored the phenomena themselves through primary learning. It was only at this point that individuals truly believed in what was being told by tertiary forms of education, as this was when they had experienced it directly, or indirectly through viewing a trusted friend in secondary learning. This may explain why within this particular study, educational programmes encouraging individuals to abstain from substance use did not

work, as for some of them, their primary and secondary sources of information went against the scientific information they were provided with. What the participants learnt through either direct use or indirect use did not match their experiential learning.

As this learned knowledge may not be 'scientifically' accurate in and lay within the definitions that were provided by Tversky and Kahneman (1974), this theory fails to take into account the value and importance of primary, secondary and tertiary experiences of learning, which may or may not be scientifically accurate on their model of perceived risk. It may be suggested that Tversky and Kahneman's (1974) theory on perceived risk should be revised to exclude the word 'science', and replaced with the broader term 'experience'.

Some participants who were interviewed had no primary experience from illicit substances. However, all participants who took part in both the quantitative and qualitative interventions had directly experienced substance use in some way, shape or form, whether this be through illicit substances or through commonly used licit substances such as alcohol or cigarettes. One participant in particular had no experience of licit substances, but had experience of illicit substances. Within the qualitative analysis, even for those participants that had only primary experiences of licit substances, the same patterns of learning were followed, although were more difficult to identify, as there were less societal constraints around licit substance use. Therefore, licit substance use was more widely accepted into '*the societal fabric*', which acted as a tertiary source of information for these participants. For these participants, this additionally fed into participant's secondary sources of information, as alcohol use was additionally widely accepted within their '*friendship fabric*'. A discussion of each theme and the meanings associated is conducted below.

### ***Fear***

The theme '*fear*' seemed to dominate much of the participants' understanding and decision making around substance use. All participants were initially provided information on both licit and illicit substances from a tertiary source, whether this was through their parents ('*the parent's view*') or through other educational sources (such as '*the media agenda and the governmental agenda*').

This tertiary view was initially trusted by the participants, and additionally served a purpose for some participants as it instilled fear of taking substances, which prevented them from wanting to take substances in the future, even if their initial tertiary view was challenged from another tertiary source. For example, Jenny mentioned that her tertiary view had developed from her parents and from what she had seen depicted in various media portrayals. However, her secondary experiences (of where she directly viewed others under the influence) allowed her to counteract for any tertiary sources of information that condoned drug use. Jenny had therefore not used any illicit substances in her life.

Bandura's (1977) Social Learning Theory posits that an individual learns through observing the behaviour of others. Therefore, if an individual had observed from a tertiary source that the specific use of a particular substance or substances is dangerous, risky, and is unacceptable behaviour within society; and if this view has been further reinforced by their secondary learning then they are less likely to conduct that behaviour themselves. For example, if an individual learnt by observing others under the influence, and the individual views the others as appearing to be out of control, deviant and careless, then this is going to reinforce their tertiary learning. This will especially occur if they have observed how those who do not use 'view' those who do use (so having a secondary experience of another's 'secondary experience'). The 'fear' of being rejected by their 'friendship fabric' and 'societal fabric' is indeed enough to put them off from using substances.

Furthermore, the Social Learning Theory is also applicable in the opposite sense. For example, if an individual had learned from tertiary sources that substance use is a dangerous, risky and unacceptable form of behaviour within society. However, their secondary learning informed them that substance use is actually something acceptable and not as dangerous or risky as the tertiary source described, then they were more likely to believe the secondary source over the initial tertiary source, and therefore negate the initial fears that were instilled from the tertiary source in relation to substance use. This is because participants were more likely to trust the information from a secondary rather than a tertiary source.



### ***The Consumerism of Drugs Education***

The above findings can be compared to the phenomena of '*word of mouth*' marketing, whereby an individual is more likely to trust a product based on a recommendation from a friend than place their trust in a marketing campaign from the product designers themselves (Marketing Weekly News, 2013). To use this analogy, the individual will need to be compared to a consumer. Although a consumer receives the majority of their information from sources that have a vested interest in selling the product to them, the most effective information is that which is received from personal sources like family, friends and neighbours (or the secondary sources of information) who have had direct experience of the '*product*', (Armstrong & Kotler, 2005). This is because although these tertiary commercial sources of information may inform a consumer about the product being advertised, the secondary or personal sources of information legitimise the products for the consumers by giving them a personal recommendation (Bae & Kim, 2013; Pruden & Vavra, 2004). Secondary sources of information are seen to have this effect as they are traditionally delivered without bias, and are therefore more 'trusted' by the consumer (or the soon-to-be drug user).

A growing body of research has indicated that credibility is one of the most important factors of a persuasive message and this alone can often influence the outcome of how persuasive an intended persuasive message actually is (Choi and Rifon, 2002; Perloff, 1993). Therefore, advertisements that lack credibility are often ignored or are avoided by consumers, which is why it is important to consider that if a change in attitude or formation is required, the advertisement must be seen as credible by the consumer. Although within the quantitative study design, there was no measure implemented on whether the participants viewed '*Talk to Frank*' as a credible source of information, participants within the qualitative analysis did discuss the lack of quality education on substance use that they received within the formal education system ('*Education? What education?!*' and '*Vital information isn't taught*'), which did not provide them with the information that they felt that they actually needed to learn around substance use. This implies that from a young age, those participants that had engaged in substance use had already learned to distrust formal sources of substance education information which related to their substance of choice. This may have made them more likely to distrust formal marketing campaigns such as '*Talk to Frank*' concerning their specific substance,

as is discussed within *'I don't trust the government's agenda'* and seek other sources of information around their particular substance of choice themselves, such as *'The wise internet'*. However, if participants had no primary or secondary experience of a specific substance, or, they had experienced the substance through a 'secondary' source and this experience correlated with the initial tertiary learning experience, then they were more likely to believe and trust in the tertiary sources of information. For example, if a participant had not used cocaine themselves, and had no secondary experiences of cocaine use, or had secondary experience of cocaine use, but this correlated with their initial tertiary learning experience of the substances then they were more likely to trust in the *'Media agenda and the governmental agenda'*, even though they recognised that the *'Media agenda and the governmental agenda'* was one that was very influential in terms of how they perceived and were educated around substance use and that it did not necessarily provide a full picture of drug use. For those who used substances, their overall trust in tertiary sources declined as their primary and secondary experiences did not match the experiences that were being described by the tertiary sources. Therefore, the tertiary sources were not seen to be credible. This phenomena is also described within the theme *'I know what I've seen'* as it depicts the participants' secondary experiences and the nature of how they influenced their perception of their tertiary education.

### ***Shocking images, the terror management theory and safety seeking behaviours***

Participants noted that shocking stories made a powerful impact on how they perceived substance use within *'The worst case scenario'*. These types of stories created fear for the participant around substance use, and although these portrayals again were from a tertiary source, if participants had no primary or secondary experience to inform them otherwise, the sources were more readily accepted to be trustworthy. However, if the participant had primary or secondary experience, these stories did not elicit the same amount of fear within them, and did not prevent them from using their substance of choice.

The Terror Management Theory (Arndt, Schimel & Goldenberg, 2003) suggests that individuals utilise various mechanisms to protect themselves from the anxiety that they get from having an awareness of their own mortality. It is argued that this awareness

can occur on two levels, a conscious or proximal level, and an unconscious or distal level. For example, if an individual fears mortality through a health behaviour that they have chosen to do, they will not attend as readily to their own defences used to lessen this experienced anxiety (i.e. through stopping the health behaviour). Instead what they do is they try and reduce their anxiety through the mediation of self-esteem (Greenberg, Solomon & Pyszczynski, 1997). Self-esteem is developed by individuals taking into account the way that they view the culture of the world they live in, and through doing this they achieve their own personal standards of value (Mandel & Heine, 1999). In addition to this, the individual also uses their own cultural worldview, which in itself contains a set of standards, to attain personal value and therefore immortality. Rosenblatt Greenberg, Solomon, Pyszczynski and Lyon et al. (1989) showed that an individual's cultural worldview and self-esteem act as buffers to continually decrease the constant anxiety they feel when faced with their own morality. This is shown through the theme '*of course I'm in control*' whereby participants rationalised their risk taking behaviour by a strong sense of self-control, which has been instilled through their '*friendship fabric*' and their self-esteem, as described above. However, if participants had no primary or secondary experience, there was no need to defend their use and for this reason they displayed anxiety towards the substances they had not used. This is shown in the theme '*Why would I do that?*'

Arndt et al., (2003) claims that individuals show defences in how they will engage in a particular behaviour, despite the mortality risks associated with it, to reinforce their self-esteem. So, by ensuring that an individual maintains a high level of self-esteem from the health behaviour activity they are conducting, they are able to keep their anxiety and fear of death suppressed (Greenberg et al., 1997). This has been shown through the theme of '*A calculated risk*', whereby when participants used a substance, they undertook specific rituals associated with validating their substance use within their friendship group, by using in a way that they deemed to be safe and appropriate, as using the substance gave them pleasure, achieved a sense of purpose, and enhanced their self-esteem.

### ***The friendship fabric***

In the same way, Greenberg et al., (1997) described that individuals use heuristics to create stability and structure in their lives, and therefore Pyszczynski, Greenberg and Solomon (1997) suggested that if an individual feels close to their own mortality as a result of their health behaviour decisions, they will use proximal (conscious) defences to distance themselves from the situation that is creating anxiety, by denying their vulnerability to the situation. This in itself creates a safety net that lessens the heightened anxiety. Therefore, to help an individual cope with the anxiety they experience when facing their own mortality, they initiate '*proximal defences*'. These can include friendship groups that validate the substance use which the individual is engaging with (such as '*the friendship fabric*'). These '*proximal defences*' provide the individual with an identity: structure, specific rules to live by, beliefs, values, and how they should behave and conduct their chosen substance use in order to be accepted by other members within the society. Therefore, specific systems are created so that individuals can engage in the substance use that they are engaging with, through the positive validation of the substance use by the groups to maintain their low anxiety levels towards the health behaviour. For the substance user, it reduces the risk that they feel when using, but it also creates an identity for the individual. This phenomena is described within the subtheme of '*They had their heads screwed on*', whereby the participants gained secondary experience from trusted friends who used substances and were still managing to live lives that were deemed acceptable lives to live by the participant.

### ***The mortality salience hypothesis***

Furthermore, those who had no primary or secondary experience of a substance tended to build their ideas based solely on the vulnerability that they felt they would face if they were to use, which was taught to them from their tertiary sources. The Mortality Salience Hypothesis suggests that individuals tend to view others who have similar beliefs, values and norms as their own, and will react negatively to those who reject their thoughts, beliefs, or threatens their world view (Greenberg, Pyszczynski, Solomon, Rosenblatt, Veeder, et al., 1990; Florian & Mikulincer, 1994). Therefore, if an individual is able to share ideas, values and thoughts and beliefs with another, a bond is created,

which is strengthened and in turn elevates their levels of self-esteem. This is also true of the opposite, whereby if an individual's ideas, values and thoughts and beliefs are rejected by another, it causes the individual in question to distance themselves from the other who is unlike them, but additionally may result in a lowering of self-esteem (Ochsmann & Mathay, 1994). Mortality Salience suggests that individuals will engage in structures that will protect them from feelings of anxiety (Pyszczynski, Greenberg & Solomon, 1999). This fits in with the themes of '*the friendship fabric*', '*the substance subculture*' and '*drug taking is an inclusive activity*' as it shows that substance users tend to gravitate towards others who use the same substances as themselves, and non-substance users tend to gravitate towards those who additionally do not use the same substances.

This is also described within the subtheme '*I know what I've seen*', where some participants described their secondary experiences of viewing trusted peers who were using drugs. This tended to always reinforce their world view, and reinforced their ideas, values and ultimately self-esteem. This was reinforced irrespective of whether their world view came from an amalgamation of tertiary sources of learning that correlated with their secondary learning, or whether their initial tertiary sources were challenged. Furthermore, the theme '*only naughty kids do drugs*' shows that those who used other substances to the substances that the participant used were viewed in a negative light by the participant. This further enhances the morality salience hypothesis as it suggests that distance was created by the participant between themselves and '*the other*' who took part in this type of substance use. Linked to this is also the theme, '*That's not me*', which shows that participants strongly identified themselves through a process of the substances that they chose to use or not use. By doing this, they created distance between themselves and those who used substances that they had no intention of using. Furthermore, they reinforced their personal identity and the way they viewed themselves in relation to others.

### ***Identity and the other***

Identity formation can be described as the development of how an individual defines and gives meaning to themselves and or other collective groups in society in relation to others and to themselves (Fornas & Xinaris, 2013). According to Erikson's (1964) life

span theory of personality development, a stable well-consolidated identity structure enables individuals to perceive a sense of self-unity over time and space through infusing their lives with a sense of personal direction, significance, and purpose. Identity emerged as a major theme within the qualitative analysis and depicted how an individual used the construction of substance use to define themselves, others, and the world around them. According to Cheek and his colleagues (Cheek, 1989; Cheek & Briggs, 1982; Cheek, Tropp, Chen & Underwood, 1994; Cheek, Underwood and Cutler, 1985), there are three main ways to explore identity. These include Personal Identity, Social Identity and Collective Identity.

Personal Identity concerns the individuality an individual reflects. This can include things like personal goals and values, self-knowledge and an individual's hopes and dreams for the future.

Social Identity concerns how an individual chooses to present themselves to the world and how they are perceived by others. This can include things like physical appearance (such as if someone is well groomed), reputation, and additionally the 'face' that they choose to show the world, through managing their impressions.

Collective Identity refers to identity characteristics that are shared with another collective group in society. This can include things like religion, nationality and ethnicity, but can also include things like shared hobbies or interests.

Within the qualitative research conducted, the participant's identity, through utilising all three of the above definitions, played into how they perceived themselves and the world. It also helped them to decide whether or not they would use a specific substance, how they viewed others using substances, and also how they viewed the substance education they received in general.

For example, within the theme '*This is who I am*', and '*That's not me*', Personal Identity was reflected. All participants had constructed a clear idea of who they were and how they defined themselves in relation to the way that they perceived their substance use, and how they chose to use substances. This was reflected through the beliefs an individual had about themselves, the values that they upheld, and through the ways that they had planned for their lives to be.

Within the theme *'the societal fabric'* and *'why would I do that?'*, Social identity was reflected. Participants that used illegal substances felt that society had in fact misrepresented the illegal substance user, and had sometimes assigned labels to them that were unfair. This often meant that those who did use substances felt that they were forced to hide their substance use from mainstream society for fear of being judged or looked down upon. For this reason, those participants felt that they had to manage who knew about their illegal substance use. In addition, the use of legal substances was also hidden from other members of society, if the participant was using at a time when they were underage to use. Furthermore, Social Identity was constructed through the behaviours someone chose to do and chose to reveal to other members of society, and through this, participants felt that society defined the individual in question with personal identifiers and characteristics that they thought defined the individual. One of the definitions provided by the participants to those that chose to use illegal substances included being a risk taker. They argued that although this could be perceived in a negative light by some in society, it also defined the individual in a more exciting and positive way, which adds to the social identity of the individual in question. This image was managed entirely by the individual in question, and was based on the amount that they chose to disclose to others in society. This social identity played an important part in the way that participants viewed drugs education, how they chose to educate themselves about substances, and how they chose to reveal their level of education around substance use, so that they were able to carefully construct a public face or identity for themselves, based on how they were choosing to be perceived by others.

Collective identity was reflected entirely through the theme *'the friendship fabric'*. Participants tended to gravitate towards others that had shared interests to themselves, and this included substances of choice. Through finding those who had similar interests, participants felt that they were able to use their substances of choice without fear of judgement. Their use also became part of the activities that they did together, and substance use was regarded as a social activity that allowed for friendships to form, and for people to bond over. Collective identity was also shown in an inverse way, whereby those who did not engage in a particular use of a substance felt marginalised by those who did, although it is important to note that those who did not engage in the use of a particular substance did not want to engage in the subculture of those who did use, as

they felt that their Personal Identity (including the way that they viewed themselves) did not match the norms and values of this specific subculture. This is shown within the theme '*Drug taking is an inclusive activity*'. Furthermore, any curiosity that participants may have had was additionally dampened if the Collective Identity of the individual did not permit the use of the substance that they were curious about.

Further research on exploring identity in relation to substance use education should be conducted to help inform Health Psychologists in order to design more effective interventions in the future.

### **Health Psychology Models**

The above data collated does seem to fit in with the health psychology models discussed within the literature review. The research falls in line with the Health Belief Model (Rosenstock, 1966), as it shows that all participants within the qualitative research considered risk and the severity and seriousness of the substance use in question by weighing out the benefits they would get from using the substance and the perceived barriers to using the substance. In addition, the Protection Motivation Theory (Rogers, 1975; 1983) was also displayed through all participants who were interviewed, as all participants decided on their use through considering how vulnerable they were as an individual to the risks associated with the particular substance in question. Participants also discussed how they aimed to minimise their risks to becoming vulnerable to the risks associated. Furthermore, the experiences of the participants within the qualitative study additionally correlated with the Theory of Reasoned Action and Planned Behaviour (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980), as participants explained the importance of accessing and utilising tertiary, secondary, and primary sources of information in order for them to make an informed decision about whether or not to use a substance. This was achieved through the constructs of attitudes and subjective norm as described in the literature review, in order to form an intention. The Theory of Planned Behaviour (Ajzen, 1988) also discusses the importance of perceived behavioural control. Control was also seen to be a theme within the qualitative analysis (*'of course I'm in control'*) and this described the participants' abilities to be able to exert a form of control over their chosen substance use, which therefore gave them



permission to carry on their use, as they felt it was something that they had control over.

### **Limitations**

This study has a number of limitations that should be recognised.

#### ***Sampling***

Although the sample fitted in with the population required to study the phenomena, recruitment for the sample only occurred through advertising at City University in London, and through word of mouth. This in itself has limitations, as only those who had a vested interest in substance use were likely to apply to take part in the study. This type of recruitment may have skewed the results towards those who are more likely to engage in substance use, and it may miss out on the population who may not identify themselves as being active substance users. In addition, the findings of the study are limited as the population studied are likely to be from a background that has supported them into further education. It therefore does not take into account those who have not come from such backgrounds. Future interventions that specifically target those who come from a background that does not involve further education need to be designed to overcome this barrier.

#### ***Sample Size***

A limitation of the present study was the small sample size. Although the researcher did aim to recruit more than the twenty four participants that were recruited for the quantitative part of the study, the researcher believes that the participant number was limited as apart from course credits, no incentive was provided to participants for taking part in this part of the study due to financial constraints. However, those that decided to take part in the qualitative part of the study were incentivised by the form of a £10 voucher to take part. Although through payment, the participant is provided with a revenue-neutral experience, whereby there is a real incentive to overcome any potential barriers the participant may experience, this in itself has its limitations, as participants may have only taken part to receive the financial contribution, therefore resulting in a skewed sample. However, it has been argued by Pietkiewicz and Smith (2012) that the true nature of an IPA is to gather the individual experiences of each

particular participant, as IPA is concerned with a detailed case exploration. Therefore, a financial incentive offered to those taking part in an IPA is not considered to be as problematic as the phenomena is still being explored by the researcher through the eyes of the participants that were interviewed. Furthermore, according to Turpin, Barley, Beail, Scaife, Slade, et. al. (1997), the Clinical Psychology doctoral programme in the UK recommend that for IPA studies, approximately six to eight participants is appropriate as this sample is a good size to examine similarities and differences between the cases, whilst also allowing the researcher to not be overwhelmed by the data gathered.

### ***The quantitative intervention design***

Within the quantitative intervention, the researcher tried to ensure that the intervention was observed in a natural environment as possible to emulate the environment in which the *'Talk to Frank'* adverts would normally be viewed, by encouraging participants to talk to each other through the viewing of the *'Friends'* episode and advert reel, and by allowing participants to do such things such as check their mobile phones and paint their nails. However, all participants that took part in the study were aware of the study's aims and objectives prior to the study taking place as it was listed on the Participant Information Sheet. Therefore, the results may have been skewed by a participant to favour one outcome over another. Furthermore, participants in both the control and the experimental group received information prior to the delivery of the intervention about the nature of the study's aims and objectives. Through simply taking part in an experimental environment, this may have been enough to affect scores in perceived risk and intent to use, and therefore it is possible that all participants may have been influenced in some way to assess their substance use intentions and perceived risk. If a future study were to be conducted, a further measure should be taken from participants not taking part in an experimental environment at all.

### ***Delivery of the quantitative intervention***

Delivery of the quantitative intervention was conducted at City University, London at a time and place which was considered to be the most accessible for participants. However, some participants dropped out of the study as they were unable to attend the intervention at the time and place advertised. Some participants were interested in

attending later evening and weekend options. Unfortunately, due to a combination of staffing and financial constraints it was not always possible to offer a participant a time that was convenient for them. This means that some participants who had passed the initial screening process were unable to take part in the testing of the intervention. If the study were to be repeated, it would be useful for the researcher to train another individual/group of individuals in delivering the experiment so that the intervention could be delivered at many different opportunities. It would also be useful for the researcher to apply for a research grant so that research could be held at other locations apart from at the University, so that it was more accessible to those attending.

### ***Memory Recall***

A measure employed within the research design involved participants trying to accurately remember their past substance use history. Simons and Chabris (2011) argue that memory in itself is a reconstructive process, which is actually much more fallible than is realised. Therefore, participants may have unwittingly over or underestimated their response to previous drug use within both parts of the study. This is seen to be less of a problem when utilising IPA as a form of analysis, as the researcher is concerned with the meanings the participants derive from their experiences. Whether or not the experiences were factually accurate is irrelevant, as the phenomena being explored is simply the participant's meanings and how this has constructed their world.

### ***Ratings***

It should be noted that ratings of any sort are very subjective. Participants were asked to rate their perceived risk and what one person finds risky, another may not. Although this could in part be down to the participant's education around substance use, it cannot be said that this is the sole reason as to why a participant may or may not find any given substance more or less risky.

### ***Social Desirability Bias***

A further problem that is common within health research is that of social desirability bias (Mitchie & Abraham, 2004). It is possible that the participants indicated lower substance use rates, and lower intent to use scores on their questionnaires, so as to give more socially-desired responses, to fit in with the normalised constraints of society

which refer to drug users as being deviant (Measham et al., 2004). As a result, this may have confounded the results of the study, (e.g. by masking the effectiveness of the *'Talk to Frank'* campaign). Nevertheless, it is relevant to point out that it is near impossible to gather data on previous substance use either than to rely on the self-reporting and memory recall of the participants concerned. Additionally, there is also evidence to suggest that self-reported substance-use behaviour is a reliable source (Napper, Fisher, Johnson, & Wood, 2010).

### ***Gender***

For reasons unknown to the researcher, many more females than males signed up to take part in the study. However, this was not considered to be an issue as there were no known reasons as to why gender would have an impact on the overall results of the quantitative study. Also, more males than females completed the qualitative interviews. If the study were to be repeated, the researcher would ensure that there would be a more equal split of male and female participants to ensure equality of the population sample, to ensure experiences from both genders were analysed.

### ***Immediate follow-up***

An immediate follow-up to test the efficacy of the intervention in itself is a limitation as it does not allow for the advert to be 'absorbed' by the individual into their *'friendship fabric'*. The importance of the *'friendship fabric'* has been discussed in more detail above, but this phenomenon seems to be crucial in understanding how participants experience drug education and how this feeds into their interaction with their peers. If the intervention was tested over a longer period such as 12 weeks, with adverts being showed to the individual over this period at specific intervals, perhaps the data would have shown the 'absorption' of the advert, in which case the results of both the quantitative and qualitative study may have differed. Furthermore, an immediate follow-up of the intervention does not allow for the exploration for other possible confounding variables that may have affected a participant's perceived risk or intent to use score. As the intervention was conducted within a 'naturalistic-test' environment, which allowed for discussion between participants, a measure should have been adopted to see if peer-influence was something that influenced the results of the study. Furthermore, this study only focuses on the intentions to use in the future and

perceived risk that an individual has. Although an individual may not intend to use a substance, it does not capture any data for those who had low intentions but went on to actually use. Any research in the future should either aim to capture this data through a follow-up questionnaire. Furthermore, research should be conducted to investigate the link between intentions and actual behaviour so that interventions aimed at substance use can be better designed in the future.

### ***Sensitivity***

A further consideration is the sensitivity or responsiveness of the questionnaire in terms of being able to measure changes over time. As discussed above, there was an issue in the study relating to its ability to measure changes of intent and perceived risk over time, as time was limited. This had an impact on the study's sensitivity to detect change in behaviour. Further research needs to be conducted in order to explore and improve the sensitivity of the current design of the intervention.

### ***Environment***

Although the quantitative intervention was delivered in a manner which allowed for the experimental environment to be as 'natural' as possible for those completing the intervention (therefore allowing participants to talk to one another during screening of the 'Friends' episode and the advert reel, permitting the checking of mobile phones during the screening, and allowing those to make comments out loud, laugh and display emotion), these in themselves could have been unintended co-variables that may have affected the overall results of the intervention outcomes. As the effects of these co-variables were not measured, this study is unable to determine whether they had an overall effect on the perceived risk and intention to use scores. Furthermore, participants were encouraged to sit wherever they liked within the room. This may have impacted the way that participants filled out their questionnaires due to the sensitive nature of the material being questioned, due to social desirability bias.

### ***Mixed-Methods***

By using a mixed-methods approach, some limitations exist, including the future replication of the study design. In order to test the model which emerged through the data, it is important to ensure that replication of a study is straightforward. However,

replication of mixed-method studies can be problematic, as “*replicating a mixed methods package, including idiosyncratic techniques, is a nearly impossible task and not likely to become a popular exercise*” (Jick, 1979: 609).

### ***Previous substance use, perceived risk and intent to use measures***

Although using self-report methods to assess previous substance use, perceived risk and intent to use is a quick and easy way of gathering data for research purposes, there are limitations associated with trying to gather information on this level. Participants may have misunderstood the measures used, and therefore may have identified themselves incorrectly. This would have skewed the overall results. In addition, the questionnaire items were kept as brief as possible to facilitate a full completion of the questionnaire. Some of the measures within the study may have affected the overall research findings as the validity and reliability of the designed questionnaires had not been established fully. In order to address this issue, any study which aims to replicate the present study should take into account the above and build this in to the design. Within the quantitative data collected, this study also failed to measure whether participant’s previous use experience was a wholly positive or negative experience. By collecting for this data, the researcher would have been able to see if there were any trends in data that accounted for positive and negative primary associations between previous substance use, and intent to use and perceived risk, as although previous substance use is an indicator of use, it is limited in that it is not a measure as to how a participant views their substance use and whether it has a positive or negative impact on their life.

### ***Methodological reflections***

Gathering data from those who respond to an advertisement about substance use patterns means that those who respond will usually have a vested interest in the field of substance use and misuse. This does mean that those who do not necessarily consider themselves to have an interest may choose to not take part in the study. The qualitative analysis of the current study raised many important sub-themes around identity, and how an individual chooses to identify themselves through the experiences and actions that they consider within the wider world. Therefore, vital documentation of the experiences of these individuals could be missed. Furthermore, in order for an

individual to take part in a qualitative study, the individual must perceive themselves to be reasonably articulate, confident and willing in their ability to talk to a stranger (the researcher) about personal experiences that may potentially be distressing.

Additionally, all participants that took part within the quantitative aspect of the study were considered to be suitable to take part in the qualitative analysis, irrespective of their previous history of substance use. This is because the researcher was trying to understand the experiences of drug education and how these experiences shaped the participants world, and their understanding of substance use. To gain a deeper understanding of those who engage in substance use versus those who do not would need the separate recruitment of both groups. This in itself may lend for further, more in depth findings on the phenomena of substance use education.

### ***Reflections on using IPA***

As the researcher has been actively researching the field of recreational substance misuse for many years, attempting to look at the qualitative data in a manner that required a fresh pair of eyes over the topic, which were separate from presuppositions and judgements, was a challenge. Although the researcher acknowledged the analysis would not be totally free from their own preconceptions, this challenge was somewhat overcome through conducting mindfulness exercises throughout the interpretation process. This ensured that the researcher stayed within the present moment. When the researcher set out to read the data for the first round, they encountered material that did not seem to fit the emerging picture. One narrative in particular was thought to be at odds with the other participants. However, on further analysis, it was found that this narrative constructed the specific forms of learning (primary, secondary and tertiary) that were identified later throughout all of the transcripts. This narrative in particular required the researcher to re-think their original interpretation, and therefore the researcher revisited earlier transcripts to understand them through the primary, secondary and tertiary framework.

## **Future research**

Future research in the area should be conducted to test the efficacy of the intervention and to get a better understanding of the how individuals experience substance use education, with the intention of improving efficacy of future substance use interventions.

### **1. Explore the impact of ‘Talk to Frank’ on different populations**

A possibility for further research would be to explore the ‘Talk to Frank’ intervention on a younger population, such as those beginning secondary school (aged 11-12). Within the qualitative analysis, participants discussed the lack of education they felt they received from official sources. As the ‘Talk to Frank’ intervention is the only UK Governmental intervention aimed at providing advice and information around substance use, a study should be designed to see if the intervention will have an effect on perceived risk and intent to use over a longer time frame than this study with a younger population. Further research is additionally required with larger samples from across the UK, including those from lower educational backgrounds and other demographic variances, including variances from those who belong to the same population as the one studied as this population in general have many variances within it such as disability, political orientation, geographical location within the UK, and sexuality that are important to consider.

### **2. Incorporate a credibility scoring component into the intervention design**

As previously mentioned, the questionnaires given to the participants did not include a section on whether the participants thought the ‘Talk to Frank’ adverts were viewed as a credible source of information by them. By including this into the questionnaire design, information can be gathered about perceived credibility of the intervention to see if that in itself has an effect on perceived risk and intent to use scores.

### **3. Explore actual use scores by conducting a longitudinal study**

As discussed earlier, the study itself did not measure actual use scores once the intervention had been administered, therefore vital data was missing.



Behavioural intentions do not necessarily lead to changes in behaviour, and this intention-behaviour gap has been highlighted by many in the literature (Conner & Armitage, 1998; Godin & Kok, 1996; Sheeran, 2002). By allowing for a longitudinal study to occur, the intention-behaviour gap in substance use can be further studied to improve the design of interventions aimed at substance use.

## **Conclusion**

This study has highlighted that the *'Talk to Frank'* intervention has no correlation with perceived risk or with intended use for the studied population in a short period. However, further research needs to be conducted to understand the effects of this intervention over a longer studied period. In order for substance use education to be effective, the effects of these programmes will need to be something that lasts for the duration of the individual's lifetime. At the very least, information should be widely publicised so that an individual is aware on how and where to seek the information if they require it.

Strategies to inform and educate young people about substance use needs to be conducted and delivered in a way that allows it to be accessible for those who have not used but are potentially at-risk, and for those who are currently using. It is important for health psychologists to assume that not all substance use is problematic and pathologic, but can occur within contexts that are occasional, episodic and sensible (Aldridge, 2008). Reactance theory predicts that people are threatened by any perceived restrictions to their freedom and the attempt to restore sense of freedom often results in increased attractiveness of potentially restricted behaviour (Brehm, 1966; Brehm & Brehm, 1981). For this reason, it is also important to support those who do use through reliable, factual and consistent educational sources that they can trust and that provides them with the information that they need to maintain their safety as young people, with their need for independence, may be more likely to react in a negative way to any forms of persuasion advocating change in their health-risk behaviour. Therefore, these expert sources of information should be presented in a way that allows the individual to feel comfortable and safe enough to access, without fear of being judged from others, or by the source that is providing them with the information.

Furthermore, it is critical to note the importance of the secondary and primary educational experiences, and the effects that this has on the individual's substance use learning experience. These experiences should be incorporated into the design of any tertiary intervention that is designed and delivered, as in doing so will provide validation of the tertiary experience to the individual which is consistent with their primary and secondary learning experiences.

Thus further research needs to be focussing on interventions that are able to capture those who do not use, those who are or may be at risk, and current users to ensure all stay safe whilst using.

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Zuckerman, M., Ball, S. and Black, J. (1990). Influences of sensation seeking, gender, risk appraisal, and situational motivation on smoking. *Addictive Behaviors*, 15, 209-220.

## Appendix 1: Screening Questions

Screening questions for Study:

- Have you ever seen a *'Talk to Frank'* Advert?
- If yes, when roughly was the last time you saw one? (If over a year, please instruct participant to not watch any *'Talk to Frank'* adverts from now, until they have taken part in the study.
- How old are you on your next birthday? (If 31, please clarify whether this is before the date of the study takes place)
- Do you currently live, work or study in London or the Home Counties area of the UK?
- Would you consider yourself to be addicted to alcohol or any substance that can be taken recreationally?
- Are you currently receiving any treatment from a healthcare professional for a substance addiction?

### Telephone Interview for Cognitive Status Interviewer

Directions: 1) Explain exam to subject. 2) Get address. 3) Be sure distractions are minimal (e.g., no T.V. or radio on, remove pens and pencils from reach.) 4) be sure sources of orientation (e.g., newspapers, calendars) are not in subject's view. 5) Care-givers may offer reassurance, but not assistance. 6) Single repetitions permitted, except for items 5 and 8.

1. **Please tell me your name?** Score one point for first name and one point for last name (2)
2. **What is today's date?** Score one point for month, date, year, day of week, and season. If incomplete ask specifics (e.g. 'What is the month?' 'What season are we in?') (5)
3. **Where are you right now?** Score one point each for house number, street, city state and zip. If incomplete ask specifics (e.g., 'What street are you on right now?') (5)
4. **Count backwards from 20 to 1.** Score two points if completely correct on the first trial; one point if the completely correct on second trial; no points for anything else. (2)
5. **I am going to read you a list of ten words. Please listen carefully and try to remember them. When I am done, tell me as many words as you can, in any order. Ready?** The words are cabin, pipe, elephant, chest, silk, theatre, watch, whip, pillow, giant. Now tell me all the words you remember. Score one point for each correct response. No penalty for repetitions or intrusions. (10)
6. **100 minus 7 equals what? And 7 from that? Etc. Stop at 5 serial subtractions.** Score one point for each correct subtraction. Do not inform the subject of incorrect responses, but allow subtractions to be made from his/her last response (e.g., 93- 85-78-71-65 would get 3 points.) (5)
7. **What do people use to cut paper?** Score one point for scissors or shears only. (1)
8. **How many things in a dozen?** Score one point for 12. (1)  
**What do you call the prickly green plant that lives in the desert?** Score one point for cactus only. (1)  
**What animal does wool come from?** Score one point for sheep or lamb only. (1)  
**Say this: 'No ifs ands or buts'. Say this: 'Methodist Episcopal'.** Score one point for each complete repetition on the first trial. Repeat only if poorly presented. (2)

**Who is the Prime Minister of the UK right now? Who is the Deputy Prime Minister?** Score one point each for correct first and last name. (2)

9. **With your finger, tap or blow 5 times on the part of the phone you speak into.**

Score two points if 5 taps are heard; one point if subject taps/blows more or less than 5 times. (2)

10. **I am going to give you a word and I want you to give me the opposite. For example, the opposite of hot is cold. What is the opposite of 'west'?** Score one point for 'east'. (1)

What is the opposite of 'generous'? Score one point for 'selfish', 'greedy', 'stingy', 'tight', 'cheap', 'mean', 'meager', 'skimpy', or other good antonym. (1)

Record Total Score Out of 41

INTERVIEWER: If Total Score is 20 or less, discontinue interview at this time. If total score is between 20 and 28, interviewer may need to consider whether proceeding through the interview will yield reliable information.

Adapted from Brandt, J., Spencer, M. and Folstein, M. (1988). The Telephone Interview for Cognitive Status. *Neuropsychiatry, Neuropsychology and Behavioral Neurology* 1, 2, 111-117.

## Appendix 2: Participant Information Sheet



### **Title of study: Is ‘Talk to Frank’ impacting on drug consumption patterns? An exploratory study considering the effect of television social marketing techniques on an individual’s perceived risk and intent to use recreational substances**

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

#### **What is the purpose of the study?**

To date, there have not been any studies conducted on the effectiveness of ‘Talk to Frank’ adverts, and whether they have an impact on drug consumption patterns. The aim of this study is to see whether a series of ‘Talk to Frank’ adverts has an impact on an individual’s risk perception and curiosity to use recreational substances.

#### **Why have I been invited?**

You have been invited to take part in the study as you meet the following criteria:

- You have not have viewed a ‘Talk to Frank’ advert in the last year
- You are between the ages of 18-30
- You are living/working/studying in London or the Home Counties in the United Kingdom

You also:

- Are not currently receiving treatment for a substance addiction
- Do not consider yourself to be addicted to a substance
- Do not have gross cognitive impairment that would make participation in the study problematic or distressing.

#### **Do I have to take part?**

Participation in the project is voluntary, and you can choose not to participate in part or the entire project. You can withdraw at any stage of the project without being penalised or disadvantaged in any way. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

#### **What will happen if I take part?**

- You will be required to give up approximately an hour and 15 minutes of your time and attend a session where you will be asked to watch a popular TV programme and answer a series of questionnaires.
- The study in itself will last for around an hour and 15 minutes
- You will meet the researcher once, at the location of the session

- At the session you will be asked to answer a variety of questions about yourself (demographic information), your current and previous drug use and your attitudes towards drug use. You will also be asked to watch a TV programme. The data collected from the study will be analysed using a quantitative form of analysis.
- The research will take place at a classroom within City University, Northampton Square, London.

### **Expenses and Payments**

- You will be provided with course credits for taking part in this study.

### **What do I have to do?**

You will be required to give up approximately an hour and 15 minutes of your time. Please arrive to the session 5 minutes before the session is due to start. Late comers will not be allowed to take part within the study. You will be required to answer some questions about yourself and your current drug use. You will then be asked to watch a popular TV programme. You will then be asked to answer questions about your attitudes towards drug use.

### **What are the possible disadvantages and risks of taking part?**

A potential risk to you is that your attitudes towards using recreational substances may be altered. You will be offered information at the end of the study on how to access support for substance misuse.

### **What are the possible benefits of taking part?**

Benefits of taking part in the study may be that you are more informed about recreational drug use, and the effects it has on you.

### **What will happen when the research study stops?**

Your data will be anonymised. This will be done by labelling each participant with a unique number through using a random number generator. Once this has been done, only the researcher will know which individual has been assigned which number. When the study stops, all your information will be stored confidentially in a locked filing cabinet at City University up until the research has been submitted and approved. As the research that is being carried out is aiming to be published in a peer-reviewed journal, the data will be kept for a period of 5 years in the way described above. This is to meet the needs of the journal that the paper will be submitted to. All electronic information will be stored on the City University network under a password protected file. Only the Researcher and her supervisor will have access to this information during this period. After this 5 year period, all hard copy information will be destroyed using a confidential paper waste service. All electronic files will be permanently deleted by the researcher.

### **Will my taking part in the study be kept confidential?**

- Only the researcher and her supervisor will have access to any information that is provided to the study prior to the information being anonymised. Once the information has been anonymised, your data will be published, however, there will be no personal information published that will enable anyone reading the study to trace it back to you.

- You are free to withdraw from the study for one month after you have taken part. After this, the information that you have provided will be completely anonymised, and therefore the researcher will not be able to distinguish your unique responses from the other data.
- All personal and identifiable information will only be accessible by the researcher and her supervisor. If this information is to be used in the final study write-up, the information will be anonymised so that it will be untraceable back you to as an individual.
- The study is confidential and the researcher will maintain this confidentiality in complete. Anything you disclose will not be passed onto anyone else, including the police. If the researcher feels that you may benefit from additional support, she will provide you with details of other organisations which will be able to provide this. The only time your confidentiality will be broken is if the researcher considers you to be a risk to others. This includes things like wanting to harm others or conducting an activity considered to be terrorist in nature, or wanting to end another's life.
- All hard copy records will be stored within a locked filing cabinet at City University, London. All soft copy records will be stored on the City University computer network under a password protected file.

### **What will happen to the results of the research study?**

The results will be used to be part of a wider thesis being submitted for a DPsych in Health Psychology, being conducted by the researcher, at City University, London. The research conducted will additionally be written up with aims for publication within a Health Psychology/Substance Misuse/Health Promotion academic journal. Full participant anonymity will be maintained for any subsequent write-up or publication. If you would like to receive a copy of any subsequent publications, please email the researcher at [REDACTED]

### **What will happen if I don't want to carry on with the study?**

If for any reason you would like to withdraw from the study, you are free to at any time. This can happen without providing an explanation or reason, and you will not be penalised in any way.

### **What if there is a problem?**

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone [REDACTED]. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: *Is 'Talk to Frank' impacting on drug consumption patterns? An exploratory study considering the effect of television social marketing techniques on an individual's perceived risk and curiosity to use recreational substances.*



You could also write to the Secretary at:  
Anna Ramberg  
Secretary to Senate Research Ethics Committee  
Research Office, E214  
City University London  
Northampton Square  
London  
EC1V 0HB  
Email: [REDACTED]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

### **Who has reviewed the study?**

This study has been approved by City University London Psychology Research Ethics Committee, Reference: PSYCH(P/F) 14/15 112

### **Further information and contact details**

Rhia Gohel (Researcher)

Dr. Tiece Turnbull (Supervisor)

**This study will involve questions about illegal recreational drugs, such as cannabis, Ecstasy/MDMA and cocaine. Neither City University London, nor the researchers undertaking this study, condone the use of illicit drugs. Taking part in this study should therefore not be seen as providing any support or encouragement for the use of illegal drugs.**

**Thank you for taking the time to read this information sheet.**

# Appendix 3: Quantitative Consent Form



CITY UNIVERSITY  
LONDON

Title of Study: *Is 'Talk to Frank' impacting on drug consumption patterns? An exploratory study considering the effect of television social marketing techniques on an individual's perceived risk and curiosity to use recreational substances*

Please initial box

1.	<p>I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.</p> <p>I understand this will involve</p> <ul style="list-style-type: none"><li>• Filling out questionnaires asking about demographic information and attitudes towards drugs</li><li>• Watching a TV programme</li></ul>	
2.	<p>This information will be held and processed for the following purpose:</p> <ul style="list-style-type: none"><li>• To analyse any data collected to find out if there are any significant trends</li></ul> <p>I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.</p>	
3.	<p>I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.</p>	
4.	<p>I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.</p>	
5.	<p>I agree to take part in the above study.</p>	

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

When completed, 1 copy for participant; 1 copy for researcher file

## Appendix 4: Demographic Form



Please complete the following to the best of your knowledge and ability

1) Date of Birth:

2) Gender:

Male  Female

3) How long have you been living in the UK for? (Years and months)

\_\_\_\_\_ Years \_\_\_\_\_ Months

4) Are you a native English speaker?

Yes  No

5) If no, how long have you been speaking English?

\_\_\_\_\_ Years \_\_\_\_\_ Months

6) Where in London/Home Counties do you live? (Please indicate town e.g. Hackney)

\_\_\_\_\_

7) Please tick the highest level of educational attainment that you have achieved so far:

- Higher Education & professional/vocational equivalents
- A levels, vocational level 3 and equivalents
- GCSE/O Level grade A\*-C, vocational level 2 and equivalents
- Qualifications at level 1 and below
- Other qualifications: level unknown (including foreign qualifications)
- No qualifications

8) What is your profession? (Please describe using chart overleaf)

\_\_\_\_\_

9) What is/was the occupation of the head of household during the most of their working career when you were a child? (Please describe using chart below)

**Occupation Chart**

Managerial and Professional Speciality Occupations

- 01. Executive, Administrative, and Managerial Occupations
- 02. Professional Speciality Occupations
- 03. Writers, Artists, Entertainers and Athletes

Technical, Sales, and Administrative Support Occupations

- 04. Technicians and Related Support Occupations
- 05. Sales Occupations
- 06. Administrative Support Occupations, Including Clerical

Service Occupations

- 07. Private Household Occupations
- 08. Protective Service Occupations
- 09. Service Occupations, Except Protective and Private Household

Farming, Forestry and Fishing Occupations

- 10. Farm Operators and Managers
- 11. Other Farming, Forestry, and Fishing Occupations

Precision Production, Craft and Repair Occupations

- 12. Mechanics and Repairers, Construction Trades, Extractive Occupations, Precision Production Occupations

Operators, Fabricators and Labourers

- 13. Machine Operators, Assemblers, and Inspectors
- 14. Transportation and Material-Moving Occupations
- 15. Handlers, Equipment Cleaners, Helpers and Labourers

Other

- 16. Armed Services
- 17. Disabled
- 18. Housewife/Homemaker
- 19. Never Worked
- 20. Full Time Student
- 21. Unemployed/Retired

10) Please describe your religious belief.

- No religion
- Catholic
- Protestant
- Jewish
- Muslim
- Hindu
- Buddhist
- Any other religion (Please indicate) \_\_\_\_\_

11) What describes your political orientation?

- conservative
- moderate
- liberal
- don't know

**END OF QUESTIONNAIRE. PLEASE BEGIN THE SECOND QUESTIONNAIRE**

## Appendix 5: Substance Use Information



Please complete the following to the best of your knowledge and ability.

12) For each substance named, please indicate if you have used it. Then, if you have tried it, please indicate how often you typically use it. Please consider only drugs taken without prescription from a healthcare professional; for alcohol, don't count just a few sips from someone else's drink

	Never Used	Tried But Quit	Several Times a Year	Several Times a Month	Week-ends only	Several Times a Week	Daily	Several Times a Day
<b>Alcohol</b>	0	1	2	3	4	5	6	7
<b>Tobacco</b>	0	1	2	3	4	5	6	7
<b>Cannabis</b>	0	1	2	3	4	5	6	7
<b>MDMA/Ecstasy</b>	0	1	2	3	4	5	6	7
<b>Cocaine</b>	0	1	2	3	4	5	6	7
<b>Speed</b>	0	1	2	3	4	5	6	7
<b>Mephedrone</b>	0	1	2	3	4	5	6	7
<b>Magic Mushrooms</b>	0	1	2	3	4	5	6	7
<b>LSD</b>	0	1	2	3	4	5	6	7
<b>Heroin</b>	0	1	2	3	4	5	6	7
<b>Benzodiazepines</b>	0	1	2	3	4	5	6	7
<b>Nitrous Oxide</b>	0	1	2	3	4	5	6	7
<b>Ketamine</b>	0	1	2	3	4	5	6	7

	<b>Never Used</b>	<b>Tried But Quit</b>	<b>Several Times a Year</b>	<b>Several Times a Month</b>	<b>Week-ends only</b>	<b>Several Times a Week</b>	<b>Daily</b>	<b>Several Times a Day</b>
<b>Research Chemicals or legal highs (including synthetic white powders and synthetic cannabis)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>Poppers</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>Ritalin</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>Electronic Cigarettes</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>Electronic THC</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>Crack Cocaine</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>Glue/Aerosols</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>Crystal Meth</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>Khat</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>Opiates and Synthetic Opiates (such as Codeine or Tramadol)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>

**END OF QUESTIONNAIRES. PLEASE RAISE YOUR HAND TO INDICATE YOU HAVE COMPLETED AND THE RESEARCHER WILL COLLECT YOUR FORMS.**

## Appendix 6: Perceived Risk and Intent to Use



Please complete the following to the best of your knowledge and ability

Please indicate whether you intend to use the below drug in the future by scoring either 0 (no intent to use at all) to 10 (extremely intending to use). Please indicate why you have scored this in the column next to it.

Substance	Intent to use
Alcohol	
Tobacco	
Cannabis	
MDMA	
Cocaine	
Speed	
Mephedrone	
Magic Mushrooms	
LSD	
Heroin	
Benzodiazepines	
Nitrous Oxide	
Ketamine	
Research Chemicals or legal highs (including synthetic white powders and synthetic cannabis)	
Poppers	
Ritalin	
Electronic Cigarettes	
Electronic THC	



<b>Crack Cocaine</b>	
<b>Glue/Aerosols</b>	
<b>Crystal Meth</b>	
<b>Khat</b>	
<b>Opiates and Synthetic Opiates (such as Codeine or Tramadol)</b>	
<b>Others (please indicate)</b>	

2) If you were to take the following drugs, please rate how concerned you would be about the below drugs negative effects *specifically affecting you* by marking the appropriate box.

<b>Substance/Effect</b>	<b>Not concerned at all</b>	<b>Slightly concerned</b>	<b>Concerned</b>	<b>Very concerned</b>	<b>Extremely concerned</b>
<b>Alcohol</b>					
<b>Tobacco</b>					
<b>Cannabis</b>					
<b>MDMA</b>					
<b>Cocaine</b>					
<b>Speed</b>					
<b>Mephedrone</b>					
<b>Magic Mushrooms</b>					
<b>LSD</b>					
<b>Heroin</b>					
<b>Benzodiazepines</b>					
<b>Nitrous Oxide</b>					
<b>Ketamine</b>					
<b>Research Chemicals or legal highs (including synthetic white powders and cannabis)</b>					

<b>Poppers</b>					
<b>Ritalin</b>					
<b>Electronic Cigarettes</b>					
<b>Electronic THC</b>					
<b>Crack Cocaine</b>					
<b>Glue/Aerosols</b>					
<b>Crystal Meth</b>					
<b>Khat</b>					
<b>Opiates and Synthetic Opiates (such as Codeine or Tramadol)</b>					
<b>Others (please indicate)</b>					

**End of study. Please raise your hand so that the researcher can collect your paper.**

**Thank you for your participation.**

## Appendix 7: Debrief Form



### **Is 'Talk to Frank' impacting on drug consumption patterns? An exploratory study considering the effect of television social marketing techniques on an individual's perceived risk and intent to use recreational substances**

#### **DEBRIEF INFORMATION**

Thank you for taking part in this study! Now that it's finished we'd like to explain the rationale behind the work. The research that you have taken part in today is aiming to see if watching the 'Talk to Frank' adverts has an impact on a person's perceived risk on taking drugs. It also aims to see if it has an impact on a person's curiosity to use drugs, or curiosity to use drugs that they have not already tried. Demographic information was also collated to see if there was a relationship present between any of the demographic variables and risk or curiosity.

Information about you and your current drug use was collected at the beginning of the study. This was to see what your current use was. After this, an episode of Friends was shown to you. You as an individual were assigned to one of two groups. Group A were shown this episode with no 'Talk to Frank' adverts within the advert reel. Group B were shown the same episode of Friends, but with 'Talk to Frank' adverts inserted within the reel. After this, both groups were asked to fill out a series of questions that measured curiosity to use future substances and their perceived risk towards using substances. The data will be compared by the researcher to see if there is a difference. Your data will remain confidential, and if published, any data you provided will be anonymised.

All psychoactive drugs may be harmful to health and well-being, including legal substances such as alcohol and nicotine. For further information about the effects of drugs, we advise you to visit the 'Frank' website ([www.talktofrank.com](http://www.talktofrank.com)). Furthermore we advise all drug users to quit using drugs, or at least to limit their consumption. If you would like any more information about drug use, or feel that you need some support around your current drug use, you can contact the below services for more information. Alternatively, please contact your GP.

Talk to Frank  
<http://www.talktofrank.com/>  
0300 123 6600

Adfam  
<http://www.adfam.org.uk/>  
020 7553 7640

NHS Club Drug Clinic  
<http://clubdrugclinic.cnwl.nhs.uk/>  
0203 315 6111

Drinkline  
<http://www.drinksarter.org/>  
0800 7 314 314

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Rhia Gohel (Researcher)

Dr. Tiece Turnbull (Supervisor)

## Appendix 8: Qualitative Consent Form



Title of Study: *Is 'Talk to Frank' impacting on drug consumption patterns? An exploratory study considering the effect of television social marketing techniques on an individual's perceived risk and curiosity to use recreational substances*

Please initial box

1.	<p>I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.</p> <p>I understand this will involve:</p> <ul style="list-style-type: none"> <li>• being interviewed by the researcher</li> <li>• allowing the interview to be audiotaped</li> </ul>	
2.	<p>This information will be held and processed for the following purpose(s):</p> <ul style="list-style-type: none"> <li>• To analyse the data and see if there is a statistical significance present among the data collated</li> <li>• The data will be held for a maximum period of 5 years in accordance with the submission guidelines for a peer-reviewed journal.</li> <li>• All data will be held securely. Only the researcher will have access to this data.</li> </ul> <p>I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.</p>	
3.	<p>I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.</p>	
4.	<p>I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the</p>	

	University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

\_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_  
Name of Participant                      Signature                      Date

\_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_  
Name of Researcher                      Signature                      Date

When completed, 1 copy for participant; 1 copy for researcher file.

---

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

## Appendix 9: Qualitative Debrief



**Is 'Talk to Frank' impacting on drug consumption patterns? An exploratory study considering the effect of television social marketing techniques on an individual's perceived risk and intent to use recreational substances**

### DEBRIEF INFORMATION

Thank you for taking part in this study! Now that it's finished we'd like to explain the rationale behind the work.

The research aims to find out more about the experiences of 'Talk to Frank' on the way that people understand drugs, use drugs, and view drugs personally.

You were interviewed to provide your experiences on the above topics. The interview was audio recorded so that the researcher is able to specifically analyse the words that you used to describe your experiences. Your data will remain confidential, and if published, any data you provided will be anonymised.

If you would like any more information about drug use, or feel that you need some support around your current drug use, you can contact the below services for more information. Alternatively, please contact your GP.

'Talk to Frank'  
<http://www.talktofrank.com/>  
0300 123 6600

Adfam  
<http://www.adfam.org.uk/>  
020 7553 7640

NHS Club Drug Clinic  
<http://clubdrugclinic.cnwl.nhs.uk/>  
0203 315 6111

Drinkline  
<http://www.drinksarter.org/>  
0800 7 314 314

All psychoactive drugs may be harmful to health and well-being, including legal substances such as alcohol and nicotine. For further information about the effects of drugs, we advise you to visit the 'Frank' website ([www.talktofrank.com](http://www.talktofrank.com)). Furthermore we advise all drug users to quit using drugs, or at least to limit their consumption.

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Rhia Gohel (Researcher)

Dr. Tiece Turnbull (Supervisor)

## Appendix 10: Themes Table

Superordinate themes	Subthemes	Quotes
Fear	The parent's view	<p>3. so like maybe my dad would say, oh you know, like we'd see something on TV and he'd be like "oh there's a druggie there, look at him, he's got bad clothes, he's, he's, he's living rough, erm, he's got mood swings, etcetera". Erm, "It ruins your life; you can't do anything from it". That's what made me feel fearful of it, and I didn't wanna be in that same position (Jim; page 1, lines 30 - 35).</p> <p>4. probably a lot around parents so I think mainly, probably my mum, erm I think you know, she would be very disappointed in the first place but also probably drummed in, you know, it's not, it's not good to take drugs (Jason; page 1, lines 31 - 34)</p> <p>5. I always really beat myself up if I go too far, coz I don't like it in my family and the stress it puts on my mum I mean imagine if.. sh, she found out I was doing it, I do worry about that (Michael; page 4, lines 18 - 21)</p> <p>6. I suppose it's your parents being, at, being, saying, trying to be a deterrent and saying that they are bad, you'll get addicted, and stuff, they er, yeah, they, they just talked about them in a really negative way and everything you heard was sort of... negative (Jenny; page 5, lines 15 - 18).</p> <p>7. We all brought spare clothes because we were paranoid about smelling because my parents wouldn't have been happy (Shaznay; page 2, lines 13 - 15)</p>
Fear	Education, what education?	<p>2. I: What would you say is the least helpful source in your opinion and experience?  S: School.  I: And why would you say school is the least helpful?  S: Because I don't remember anything except now that, like that was a, that was like our... social class, whatever it was, rather than, it wasn't like in health or in biology or anything.  I: What do you think... was bad about it?  S: Didn't exist.  I: It didn't exist.  S: Well I don't remember, I don't remember so either it was rubbish and I don't remember it, or it wasn't there at all (Shaznay; page 14, lines 15 - 26).</p>

		<p>3. I: What was it about Talk to Frank that used to stick out for you that you really didn't like  J: Just their adverts, like their visual advertising because they... always make out the end of the adverts that, oh it's bad and... erm... you know they, they'll... they instil fear into people which I don't think is right because its up to the person to make their own judgement (Jim; page 22, lines 24 - 29)</p> <p>4. what they taught me was limited, even if they taught me very early (Sai; page 12, lines 15 - 17)</p> <p>5. I don't remember having very much really, but yeah, I may have had a talk at some point, I can't really remember, it wasn't really like very prominent though, could've probably had more (Jenny; page 5, lines 6 - 9)</p> <p>6. I: Can you remember any other types of education that you might've got?  F: Umm... no can't really remember anything. Maybe... in secondary school, they had a couple... but that's about it really (Fred; page 8, lines 4 - 7)</p> <p>7. I think it's been very limited. I can't remember being at school and learning about it. Not to say that we didn't but it wasn't anything that stuck in my mind. And perhaps if I knew more about it, then it would be less worries and stuff involved, or more, I dunno. (Dave; page 4, lines 18 - 21)</p> <p>8. No, no way, I mean you know, for example, you get sex education, there needs to be drug education, and do you know what, if it leads, leads to some kinds doing it then fine, do it, but fucking hell they'll know about it (Michael; page 16, lines 13 - 16)</p> <p>9. with the alcohol in comparative to drugs, I think it's a really good comparison because one is socially acceptable, the other isn't socially acceptable and you know by, buy that means, it is talked about in a different way and we are educated in a different way about it (Jason; page 7, lines 1 - 5)</p>
Fear	Vital information isn't taught	<p>2. they need to educate kids, coz it's their... ignoring it is not gonna make it go away and... ignorance is not bliss, ignorance leads to death and... hospital and stomach pumping and A&amp;E and, you know, things like that. Tell these kids what is out there, what they might experience (Michael; page 17, lines 3 - 7).</p> <p>3. I think that's something actually just thinking, you know that's something that could easily be, sort of incorporated into sort of looking at the impact of the body, and that's something that could be very interactive (Jason; page 8, lines 5 - 8)</p>



		<p>4. I guess how addictive it is would be one, erm... how safe they are, what changes in the brain, those sorts of things (Dave; page 5, lines 2 - 3)</p> <p>5. if you're gonna tell everyone that drugs are bad, then everyone's gonna be like, oh I just wanna try it anyway (Fred; page 4, lines 6 -7)</p> <p>6. because I think it's important for people to know... umm... about how drugs can actually be beneficial, like how marijuana has changed the life of americans, so yeah (Sai; page 6, lines 12 - 15)</p> <p>7. I think they just said something like "If you've got... concerns then talk to us" which is fine, but, if you've got an audience there... you could do more with it in terms of educating, I mean you have a specific campaign for something that's a problem, erm... I mean... theres a lot in the media about legal highs, but it's not educational (Shaznay; page 15, lines 15 - 20)</p>
Fear	The worst case scenario	<p>2. I, find it quite powerful when you see images of people like before and after, and that's something that I've seen, in loads and loads of different places, that's always that is something quite shocking (Jenny; page 8, lines 9 - 12).</p> <p>3. we'd see something on TV and he'd be like "Oh that's a druggie there, look at him, he's got bad clothes, hes, hes, hes living rough" erm "He's got mood swings, ectera" erm "it ruins your life, you cant do anything from it". That's what made me feel fearful of it, and I didn't wanna be in that same position (Jim; page 1, lines 31 - 35)</p> <p>4. I had a f, friend who nearly died and... they had I think 9 of them went into intensive care... erm and she nearly died, like really bad (Shaznay; page 5, lines 2 - 4)</p> <p>5. I: he explained certain drugs were bad, erm... did you think drugs were bad from that initial explan, explanation? F: Yeah but we were 10 then so we could believe, we would believe anything (Fred; page 3, lines 12 - 16)</p> <p>6. I guess it would be more helpful if there was a balanced... if you were taught a balanced argument to... why people want it legal, why people don't want it legal, and then you can make a more informed choice, whereas you just hear worst case scenarios all the time and it... clouds the whole, the whole perception (Dave; page 11, lines 28 - 32)</p>
Fear	Curiosity around drugs	<p>2. like drugs in films allow you to explore... avenues that you wouldn't usually, like... psychological illness, and like depression spiralling down, and like... that kind of thing, and I find that kind of thing in films quite interesting anyway, so maybe I would kind of like be</p>

		<p>more inclined to watch a film that involved drugs and stuff, and mental illness (Jenny; page 8, lines 23- 28).</p> <ol style="list-style-type: none"> <li>3. I think curiosity, erm Curiosity, probably you know, again, you know social groups, if something is available in a social group, people are doing it, then it is something that you know, sort of (takes deep breath in), either you do it or you don't. Erm... er, but I think predominantly, curiosity... (Jason; page 2, lines 21 – 25)</li> <li>4. kind of a weak analogy but after 9/11, like more and more people converted to Islam after 9/11 than ever before so... if you're putting information out there people will get intrigued and wanna do it (Michael, page 15, lines 31 – 34)</li> <li>5. I know they've done, like programmes, documentaries and stuff, BBC3 I think. They're quite beneficial coz you do get to learn about the drug and people take them on telly and stuff and you can see... what happens so you're more informed erm... and yeah I guess sit still backs up the point that I'd still be less likely to take it, through watching a TV programme or seeing something in the news. (Dave; page 9, lines 10 – 15)</li> <li>6. F: I was just curious, of what it was like, then just started taking it I: Did you think about drugs kind of prior to that? F: Not really... just saw some people doing it I: And who were these people? F: My sister and my cousins? (Fred; page 2, lines 17 – 21)</li> <li>7. now it's more of a kind of, uh kind of a curiosity on how these things kind of, these things work because obviously they have a really big impact on how you perceive things in your mind (Sai; page 1, lines 27 – 29)</li> <li>8. a mixture of my own research, and curiosity, and the fact that people that were close to me had done it, and erm, their experiences they've had on it (Jason; page 17, lines 18 – 20)</li> </ol>
Fear	Fear of the unknown	<ol style="list-style-type: none"> <li>2. and then there's always like the worst case scenario, where someone's taken something and died, and that's kind of stuck with me I guess (Dave; page 2, lines 29 - 31).</li> <li>3. I mean, within life, just, if people talk about them in conversation it's more likely to be in a negative form or something, and that, a lot of the time the word addict comes up, and that's also a big deterrent (Jenny; page 3, lines 21 – 23)</li> <li>4. It just puts you off like if someone dies from it, then it like, it, actually puts you off (Fred; page 10, lines 18 – 20)</li> </ol>

Fear	The media agenda and the governmental agenda	<ol style="list-style-type: none"> <li>6. you see like programmes about like, crystal meth, and like Louis Theroux programme... you just, yeah that shows you like what happens... when you take it, which is good (Fred; page 10, lines 29 - 32).</li> <li>7. I'd trust... I'd trust government based things, so if I'm looking for something, you'll, I'll type in... like NHS after it. But you will like get the bare minimum information but... you've gotta put faith in something so... any... the sort of government backed places are the ones I'd go to first, but, or charities, usually are a good source of information, they're a bit more honest (Shaznay; page 15, lines 5 - 10 ).</li> <li>8. how education has influenced me, I mean in like the formal education institution, not much actually, coz they didn't really teach me much about it, they only told me how dangerous it was and how bad it can get which is probably their way of conditioning to say don't do it, or just you know, kind of obey the law... umm... so yeah (Sai; page 5, lines 27 - 32).</li> <li>9. just like they were advertising stuff for like on TV like 'Talk to Frank' and stuff, so obviously it gets you... umm... gets you curious, and like you start watching films and like when you get older, you start watching films and like start watching TV programmes and like obviously... you like look into it (Fred; page 3, lines 22 - 26).</li> <li>10. but I think... say on TV and in forms of video that you're more likely to see when you're younger, it's definitely negative, and a lot of the time it leads to addiction, and like spiralling downhill (Jenny; page 3, lines 30 - 34).</li> <li>11. Talk to Frank for example, I think that there's... always an agenda behind their adverts, they instil a lot of fear into the advertisements, erm, even though they actually try to come across as... giving you information on... a drug... like the pros and cons and stuff (Jim; page 20, lines 3 - 6)</li> </ol>
Fear	The wise internet	<ol style="list-style-type: none"> <li>2. there's this specific website called Erowid which has got really detailed information about drugs erm... coz I was worried about like school teachers and things sussing it out and maybe college teachers, so I would, I went to Erowid just to find out about, kind of half-life times and how long it would be in my system and what the effects would be so yeah (Michael; page 1, lines 13 - 18).</li> <li>3. J: and my views on it weren't as bad because I was educated more on it, I did my own research on it and erm I: And where did you go out to seek this information?</li> </ol>

		<p>J: The internet  I: What kinds of sites did you use?  J: Erowid (Jim; page 12, lines 10 - 15)</p> <p>4. now because of the internet obviously, I get to uh, watch a lot of videos (Sai; page 5, lines 10 - 11)</p> <p>5. I'd go to the internet personally but... yeah I suppose there are helplines and stuff but... I don't think I was really aware of them... (Jenny; page 5, lines 30 - 31)</p> <p>6. I: And what would you say out of all of those is the most trusted source?  S: Probably the internet, even though it doesn't give me what I want. (Shaznay; page 15, lines 2 - 5)</p> <p>7. I: Ok, and when do you think your beliefs started changing?  F: Probably in secondary school, when you, when you open up to more stuff, or when the internet comes into your... life you start looking at stuff don't you? (Fred, page 3, lines 17 - 20)</p> <p>8. I guess the internet has probably played a bit of a part coz obviously if you need to research something then that's the main source that I would use anyway. (Dave, page 9, lines 11 - 13)</p>
Fear	I don't trust the government's agenda	<p>2. I: What kinds of sites did you use?</p> <p>J: Erowid, erm... I, I, I, had a look at 'Talk to Frank' , but... erm, I know that there's an agenda behind... sites like those.</p> <p>I: What do you mean an agenda?</p> <p>J: I would say sites like those, yes there, they, they're perceived as to inform the public about drugs and what, how, how they make you feel but at the end of the day, it's, I feel it's, it's, it's, a government led... programme so, there's always an agenda behind it, so I, I prefer to seek erm... information from unbiased sources (Jim; page 12, lines 15 - 22).</p> <p>3. Also how it's portrayed in terms of the media regularly, you know theres often, drugs, drugs are quite negatively, most times (Jason; page 10, lines 27 - 29)</p> <p>4. But anything in the news, it's masked isn't it compared to what's... potentially really going</p>

		<p>on... so yeah I think they can make it as one sided as they want to coz... they, they had to sell papers and stuff like that (Dave; page 7, lines 36 – 37, page 8, lines 1-2)</p> <p>5. F: you cant believe everything the media says. I: And why do you feel you cant believe everything the media says? F: Because they just like to exaggerate and stuff (Fred; page 5, lines 20 – 22)</p> <p>6. I think... say on TV and in forms of video that you're more likely to see when you're younger, it's definitely negative, and a lot of the time it leads to addiction, and like spiralling downhill and like... because that's how TV over dramatizes things (Jenny; page 3, lines 31 – 34)</p> <p>7. Well with adverts I feel like adverts always have an incentive in the end its for profit, and umm.. or, or their own selfish interests so which Is why I, I don't really in general I don't really listen to advertisements that much. (Sai; page 10, lines 31 – 34)</p>
Fear	The consumerism of substance education	<p>2. F: ... like you only... go to sites that you've heard of from word of mouth or are like legit. You're not gonna go to some like, page on like, 60th Google page search are you?</p> <p>I: Ok and why, why's that?</p> <p>F: Because you're obv, one it takes too long to get to the 60th page, and you just want it there and then, you don't wanna keep looking around shopping, and there's, there's pages for price comparisons sites so you can look on there, instead of just looking around for yourself.</p> <p>I: Er, er, in, would the same apply for drugs?</p> <p>F: What, what do you mean like.</p> <p>I: Like if you were find, trying to find out some information about I dunno, something to do with drugs.</p> <p>F: Yeah you'd look at a couple of websites on the first page, but that's about it. You wouldn't go to like, someone's some nine year old's made in a w, on a Windows XP (Fred; page 12,</p>

		<p>line 1 - 16).</p> <ol style="list-style-type: none"> <li>3. It's so accessible, very easy for all people to put on their experiences, erm... I know I keep mentioning erowid, that site, but erm it had a forum in it, people talking about stuff, people talking about mixing different drugs, what they experienced, people making new things (Michael; page 15, lines 1 - 4)</li> <li>4. There has to be like a disclaimer or something, you, you know. Just like all drugs, erm... they can mess you up in the long run for example, er just like something written you know, erm it should just be informational, solely informational, no need for like visuals, adverts, and stuff like that, it, that's that's what it should be, er that's my personal view of it anyway (Jim; page 21, lines 24 - 29)</li> <li>5. if someone is very influenced by the media and they, they kind of consider the media their lifeline, they're likely to consider it but if you question the media and you que, and you question its incentives then that will play a part... (Sai; page 11, lines 21 - 24)</li> <li>6. I'd hope that was reliable, I certainly see it as a reliable source with it being a campaign, it's a government campaign or something, so yeah, I'd trust that information was correct. With films... I suppose yeah you do like put a lot of trust in them, thinking that the things they are saying are correct, maybe there is that... element of doubt if something... I just, you're just you're knowledge that you've already gained and comparing it to the film, and if there's something that doesn't match up then maybe you doubt it but... id say probably do trust in films, quite a lot (Jenny; page 17, lines 17 - 25)</li> <li>7. I'd trust government based things, so if im looking for something, you'll, I'll type in... like NHS after it. But you will like get the bare minimum information but... you've gotta put faith in something so... any... the sort of government backed places are the ones id go to first, but, or charities, usually are a good source of information, they're a bit more honest (Shaznay; page 15, lines 5 - 10)</li> <li>8. So if I was gonna search, I'd... use the websites that we'd use at work, so I know they're kind of... as legitimate as they can be I guess. (Dave; page 6, lines 11 - 13)</li> <li>9. I think now they're trying to... appeal to the younger generation, definitely in terms of erm advertising like in terms of erm.. erm, Frank, Talk to Frank and erm, other things in terms of their, their advertising erm and you know using, er, younger people, and trying to make a bit of a... joke around it but with a serious message, erm... (Jason; page 9, lines 28 - 33)</li> </ol>
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Fear	Only naughty kids do drugs	<ol style="list-style-type: none"> <li>2. ...I would say that was, the biggest kind of external influence, and just seeing it with my own eyes, like just seeing the types of people that were... doing it, they were always the ones that were always getting in trouble, and... rebellious at school at that age (Jim; page 3, lines 22 - 26).</li> <li>3. at 13 there were some kids that were a little bit older so my f, brothers friends. And they used to take drugs, and I could never really see the point of them to be honest, their behaviour changed and it was all a bit... weird (Dave; page 1, lines 20 - 23)</li> <li>4. I think that meow meow drug, ages ago, err, someone died from it, so... I did, I wasn't really interested in it, I just thought they were stupid for taking it really (Fred; page 10, lines 25 - 27)</li> <li>5. I suppose not... that highly really, like... maybe like... wasters sort of thing like... they were the sort of people who were skipping school and... yeah, and, weren't doing so well... in life. There was never like, they were particularly cool or anything, they just, yeah I suppose there was more of a negative association (Jenny; page 3, lines 7 - 11)</li> <li>6. me and that particular sister were kind of the black horses of the family anyway (Michael; page 1, lines 24 - 26)</li> </ol>
Fear	I know what I've seen	<ol style="list-style-type: none"> <li>1. ...when I was a bit older, my friend, we'd all be at the pub, having a good time and then he'd go off into the toilet and then he'd come back a different person, so his behaviour totally changed and he'd start becoming really paranoid, erm, was on edge and not really enjoying himself, whereas when he'd had a couple of beers, he could, and we could have a laugh with him (Dave; page 1, lines 25 - 30).</li> <li>2. the schools just kind of said that... well if you do this, uh, it could potentially be very dangerous and highlighted on the fact of danger but umm... when I would see my experiences with my siblings and my friends, they looked like they were having a good time and they continued living healthy lives so... I didn't understand why, they were, they were able to control themselves but someone was saying something else (Sai; page 12, lines 20 - 26).</li> <li>3. it's caused so many problems in her family, my cousin's in jail for it, my uncles dying from it, uh, an uncle and alice, her sister died from it, so shes got a very extreme reaction to what they do, she would never have an appreciation for... what I've experienced through it. And even if I said to them look, I've done it many times, I've always been, main, mainly, very</li> </ol>

		<p>controlled and I've always had a great time... she, she wouldn't be able to see that I don't think. (Michael; page 5, lines 2 - 9)</p> <ol style="list-style-type: none"> <li>4. Erm... coz they're enjoying... the positives from it... erm everyone else probably isn't taking them because they're thinking of the negatives erm... it's also like, you, you just think theres so much naivety there, that they're taking them, and, they're not weighing up the risks... and everyone else, they prob, they just come across as stupid sometimes erm.. so yeah (Jenny; page 16, lines 28 - 33)</li> <li>5. so I had a f, friend who nearly died and... they had I think 9 of them went into intensive care... erm and she nearly died, like really bad (Shaznay; page 5, lines 2 - 4)</li> <li>6. No they didn't force me to do it or nothing, they were just, I just used to see them doing it and they used to be like all funny, so then I, I, felt like I felt like I wanted to feel like that. See what it fe, felt like (Fred; page 7, lines 31 - 33)</li> <li>7. I think just the fact that friends, were you know doing it and, seemed to be enjoying it, erm.. I think that's the main thing (Jason; page 5, lines 25 - 26)</li> <li>8. from what I know about it, from my experiences from a person myself, seeing people on it, seeing the impact it's had on their lives, that's why I... you know, those drugs are just erm bad. (Jim; page 25, lines 1 - 4)</li> </ol>
Fear	They had their heads screwed on	<ol style="list-style-type: none"> <li>1. I think the main, the main thing that changed those views were the fact that... people that... I would mix with and erm, were like me, I would say I was, had my head screwed on and I, you know I was doing well at school, and erm... those people like that, like me, were also like that, and the fact that they were doing it and still... being like good and stuff and erm, and still attaining, made me believe that oh, maybe it's not so bad, maybe it's erm... just erm... makes you feel like... funny (laughs) or you might enjoy it for a bit (Jim; page 4, lines 5 - 14).</li> <li>2. if you're around people even if you're not doing it, it normalises more, of, taking a drug, and seeing an effect of a drug, just... you know erm.. you know the irony of all this is probably that alcohol is er, you know, the biggest economic cost, in terms of, you know, a drug and yet... because it's legal, it's fine, and no one will look down on it, comparative to drugs which, having that illegal title, is erm given such a bad reputation (Jason; page 4, lines 16 - 23)</li> <li>3. She just was like... try it but, you can do it but just don't take too much of it, do it in</li> </ol>



		<p>moderation. And make sure you're with someone... that's done it before (Fred; page 3, lines 1 - 3)</p> <ol style="list-style-type: none"> <li>4. when I was about thirteen, that's like when we would, like talk more about it because her brother sort of talked to us about it mostly (Shaznay; page 1, lines 17 - 19)</li> <li>5. with dosing it comes with advice from friends, friends that you trust and friends that you... know have taken it (Sai; page 7, lines 38 - 40)</li> <li>6. actually my sister found out, got a bit annoyed and then actually became my dealer just because she wanted me to take... safe drugs (Michael; page 1, lines 10 - 11)</li> </ol>
Fear	Drugs are dangerous	<ol style="list-style-type: none"> <li>1. S: ... so I had a f, friend who nearly died and... they I think nine of them went into intensive care... erm and she nearly died, like really bad.</li> </ol> <p>I: So nine of her friends who had all taken the same substance nearly died and all got taken into hospital?</p> <p>S: Yeah, yeah, well I don't know how bad they all were coz they wouldn't, they didn't really tell us but yes, they all, all went to hospital, they were all like collapsing and... going... mad.</p> <p>I: Ok and how did that impact on the way you saw... drugs and drug use?</p> <p>S: Erm... I mean I already wasn't already really into it then, coz I was about 20 erm... but... I think it's, it's the risk I don't think it's worth the risk (Shaznay; page 5, lines 2 - 14).</p> <ol style="list-style-type: none"> <li>2. I mean I do drink too much, generally anyway, but erm especially with, coz I do like the feeling and so addiction is always, and so anyway maybe that's why I think I always have that very rigid social "I do it socially, not individually", but I again have seen it within my family, I got um, a you know, uncle who's a heroin addict, my auntie dies of alcoholism, my you know, two of, one of my uncles died of alcoholism so (Michael; page 4, lines 6 - 12)</li> <li>3. if people talk about them in conversation it's more likely to be in a negative form or something, and that, a lot of the time the word addict comes up, and that's also a big deterrent (Jenny; page 3, lines 21 - 23)</li> <li>4. If you're gonna take a... Class A drug, like LSD or something, its gonna, it makes you hallucinate so... I dunno you could see like... stuff that you shouldn't see which could end</li> </ol>

		<p>up you... falling off a cliff or something. (Fred; page 10, lines 5 – 8)</p> <ol style="list-style-type: none"> <li>5. there was always this side of what if I get addicted to it, and I didn't want that to happen. (Dave; page 2, lines 15 – 16)</li> <li>6. I think I'm more conscious of the long term impacts that, you know, potentially, regular drug use can take (Jason; page 10, lines 33 – 34)</li> <li>7. I've had a, I had an older cousin, he used to be... pretty addicted to cocaine, when... I was a teenager and er, I was told that, you know by other cousins and stuff that, look, you don't wanna tur, turn into that and... and stuff so you know, that was my own view of it (Jim; page 10, lines 1 – 5)</li> </ol>
Fear	A calculated risk	<ol style="list-style-type: none"> <li>1. doing anything is a risk, driving to work is a risk, but it's a risk worth taking, because I need food so... everyone makes their own decision based on risk, day in day out, you're constantly risk assessing, but you can't do it if you've not got the information (Shaznay; page 10, lines 28 - 31).</li> <li>2. MDMA really enhances music for me, and music is very important anyway, but it does give it that little edge, that's really good, and it, you, things like mushrooms, they make you know a regular, I shouldn't say a regular night out because I still enjoy being out with my friends and I don't need to do anything, but if you do 'shrooms appropriately, then they can be REALLY enhancing in, you know the things that you experience, so you just kind of unlock that potential in your brain. Yeah I mean there's always a risk of doing it for seeking that, en, enhanced experience and you can go too far, but as I've got older I've got in a far more wi, I've got far wiser in to where my limits are, and I will stop (Michael; page 3, lines 18 - 29).</li> <li>3. I think, I suppose, there's something around wanting to... not change who you are, but a certain escapism... you know which alcohol prev, previous to that would do that erm...but I think there's always something where we look for something that changes you in a manner that sort of gives you some breathing space from normal life and things like that, so I think, probably, it, it was more of a... a sort of a escapism, a change of... mode of thinking and things like that (Jason; page 2, lines 27 - 34).</li> <li>4. some friends used to be like "Oh why you smoking on your own, that's a bit, bit like crackheady isn't it like" just like, just smoke with people or something. It was yeah, so it... that kind of made me feel bad like "ohh, yeah I shouldn't really be smoking on my own" but</li> </ol>

		<p>I really enjoyed the effects of it, and sometimes I just, just wanna get like high and just be al, just be alone and just relax on my own, without having to you know (Jim; page 7, lines 23 – 29)</p> <p>5. I don't drink anymore but, um when I did it was mainly so that I could socialise with people and that was usually... the reason why people would and why the media also portrays it. (Sai; page 2, lines 29 – 31)</p>
Fear	Of course I'm in control	<p>1. I mean with the knowledge I know, usually if they are very ignorant about it, saying for example don't use it, I don't listen to it because I have this kind of breadth of knowledge to say that I can control myself and that I'm not going to end up like the person in the video (Sai; page 6, lines 33 - 37)</p> <p>2. Acceptable is that everybody still has an enjoyable time with nobody specifically causing any concern to anybody else, so for me I have gone maybe too far in my limits and either my partner or one of my friends has had to deal with me in a state that I'm probably not proud of, I mean it I felt great coz my friends have looked after me but at the same time yeah, if my personal choice is having an impact on them, then I'm not very happy with it (Michael; page 2, lines 18 - 24).</p> <p>3. as ive got older... I less and less wanna be out of control, so even with drinking... I find more now that I don't, I don't wanna feel that way, whereas I would've done, and... I think when you're younger you're happy to just let, like the night or whatever take you wherever, whereas now youre more cautious about... what you're doing and what that means and whats happening tomorrow or whatever (Shaznay; page 5, lines 15 – 21)</p> <p>4. But I know I can stop at any time, I've done it... in the past before (Fred; page 14, lines 10 – 11)</p> <p>5. When I did drink with my friends, I would try not to get drunk. So I'd drink a lot, but then I'd have this... persona that actually I wasn't drunk at the time (Dave; page 4, lines 6 – 8)</p> <p>6. I from experience... know, I'm controlled (Jason; page 5, line 11)</p> <p>7. I think with all drugs they have to... you have to be responsible with them. You can't abuse them, whatever drug it is you cant abuse it, just like everything is in moderation... you know you have to have it in moderation, it's the same with drugs. (Jim; page 21, lines 15 – 18)</p>

Fear	Why would I do that?	<p>1. F: ...You're not gonna take like high, class A drugs, because it has, it probably will have more of a bad effect on you then it has a good effect on you in the long run. And, and normal people know that, not to do that.</p> <p>I: So... where do you get that information from, that certain drugs are, are more detrimental to your health than.</p> <p>F: Again like from peo, like news, media, websites and stuff. And like you have your own common sense on what's good and what's bad. Like marijuana, it's not really a, it's not really a bad drug, because it's, no, nothing chemical in it. It, it's just a plant, and it grows. But like, if you take ecstasy or LSD it's all manufactured in like labs and stuff.</p> <p>I: And what makes you think that that's bad in comparison to.</p> <p>F: Because they can put anything in it, you dunno what's going, you dunno what's going on it. Even though sometimes marijuana is sprayed with stuff, or stuff like that, it's nothing, it's not gonna like, how many deaths have there been in, from marijuana use, hardly anything (Fred; page 4, lines 15 - 32).</p> <p>2. That's what made me feel fearful of it, and I didn't wanna be in that same position (Jim; page 1, lines 34 - 35)</p> <p>3. Er, my dad's... can't give up alcohol. So he's not an alcoholic as such... erm so he doesn't drink during the day, but at night he will drink, so I guess, so it's kind of mixed in with that, so it's seeing him get dependant on it and I didn't wanna... be the same (Dave; page 3, lines 32 - 35)</p> <p>4. I do think to some extent, well, quite a large extent, taking legal highs is stupid. (Shaznay; page 12, lines 23 - 25)</p> <p>5. they say it'll ruin your life and it will be more difficult, and you won't carry on with college or if you, you know its like, it is definitely something that, that's how they would deter you by saying and impact your life later (Jenny; page 15; lines 32 - 35)</p> <p>6. I dunno whether those limitations come from, I just wouldn't do them. I mean I'm intrigued, I'm totally intrigued about the heroin because it, it is euphoria in its purest form... but yeah just the addiction, it's just... just fucks over so many factors in your life as</p>
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		well... like people who are addicted to cocaine can generally function as well, in life, people addicted to heroin cannot function... (Michael; page 7, lines 18 - 23)
Identity	This is who I am	<ol style="list-style-type: none"> <li>1. I suppose I, think to myself I'm not a very hedonistic person, I'm quite a controlled person, erm, very healthy person, erm, very conscious about my health and things like that erm... and sort of, you know, I'm quite open to trying it, so I can only sort of talk from my experience (Jason; page 6, lines 13 - 17).</li> <li>2. I'm sure when I have kids and they get married, I'm gonna be smashing it. Just because why not, I think it would be funny! Go against the stereotype, I know, I've met, I've met people of that age, but, I don't think, I personally don't think they're sad (Michael; page 13, lines 7 - 10)</li> <li>3. I think that experience in particular umm... influenced me highly on how I perceive and live my day-to-day life and it's the same with MDMA because um with MDMA you can feel very happy and euphoric and um, that also kind of makes you reflect on um like, why am I happy now, and um, let's say in my sober life I can't be this happy, we um, we actually try to, we, we, I, I try, I made my friend try MDMA for the first time and he was very depressive, he was ve, he, he had you know, suicidal thoughts and didn't really like how he was living but, the first time that he took it he, he, didn't realise how happy he could be, so um... in that sense it can change your life when you're off it because um, you remember that moment and you remember how you were capable of doing that (Sai; page 4, lines 28 - 40)</li> <li>4. I think personality plays a role... like it does with everything. I think people that are maybe more... thrillseekers, are maybe, more inclined to, you know like risk takers, that plays a big role, but... yeah, yeah, personality definitely plays a role I: And, and how would you describe your personality? J: Erm... I'm just quite laid back... erm I don't know, I guess... like, im not a particularly like... risk... taker, like, I'd, I wouldn't like, I'm not gonna seek out like a thrill or something, like maybe some people would, erm... yeah, maybe quite level headed (Jenny; page 13, lines 8 - 16)</li> <li>5. more responsibility, and... boredom of that like... not... er... yeah just the sort of relaxed, let's just see what happens kind of thing, I think is, is, more boring... and... wanting to know what im doing, things like reputation, erm, stuff that's going on facebook, what you look like if you're... out, not like pretty I mean like not on the floor (Shaznay; page 6, lines 23 -</li> </ol>

		<p>28)</p> <p>6. Well if I, if I get a job and, obviously, if, if I get, er like a proper job, no like... a job where they drug test, then obviously im gonna stop. If something in my life... comes in between that smoking, or it puts like something else first, before, before the smoking, coz smoking's just something, that, just, it's just there, might as well do it, what's the point, you're not gon, why you saving it for ano, another time in your life? Might die tomorrow (Fred; page 14, lines 21 – 27)</p> <p>7. I just wanted it, I just wanted to be high, like myself for my experience, and do my own thing coz... im quite a creative person and I, I, you don't not all, not all the time do you just wanna be high and just be... doing something with friends and stuff, although that, what. That's what it was at first. It became more of a thing where I was starting to really enjoy the effects it was giving me personally and erm what... the way it used to make me feel personally inside my head (Jim; page 7, line 40, page 8, lines 1 – 7)</p>
Identity	The societal fabric	<p>1. well I think people that don't use would view somebody who does occasionally, maybe more you know, what's the point? What's the point in risking something bad happening, people that do it a lot, people... who view, people doing it a lot I think would view them very negatively... almost irresponsible, erm... people, really. (Jason; page 4, lines 4 - 9)</p> <p>2. I mean people abuse alcohol all the time, they go out on Friday and binge, you know they would just binge cocaine instead! (Laughs) They would just binge on whatever else, alcohol is awful! I mean, uh, you never meet anyone on, on, you know, that had Korsikoff's syndrome and they can't even think, they can't make any new memories, no other drug does that to you but alcohol! (Michael; page 10, lines 2 - 7)</p> <p>3. I think most sensible adults know that there is risks in doing lots of things, not just drugs, but I think the fact that it's illegal makes it seem riskier but also seem... more... cool, more... daring, erm, whereas alcohol... you know if I went out and drunk a lot, people wouldn't necessarily be like "Ooh, you're so risky, I can't believe that you did that." Whereas if you went out and took... six ecstasy tablets, I probably would think that. But... at the same time, there is something exciting about somebody taking that risk. So... you might think that they're slightly cooler for their ecstasy, I wouldn't think anyone getting out, getting wasted... is cool really. It, well, I probably did when I was younger, but I think because it's,</p>

		<p>in theory, illegal, it makes it seem... seem riskier. (Shaznay; page 9, lines 29 – 39 &amp; page 10, lines 1 - 2)</p> <p>4. I've met people of that age, but, I don't think, I personally don't think they're sad, I meet people at festivals and at parties and at clubs all the time at that age that are doing it... and I think that's the thing isn't it, if you're doing drugs, you've lost your way in life and... oh and they don't know and they never made it. I've met kings of industries that do drugs, holding a job and a family, I dunno, it, it can be very private and very open but... it's got a really unfair representation.</p> <p>I: You think, in the way that, you think it's unfairly represented?</p> <p>M: They cause a lot of damage, drugs. Socially and physically and emotionally. There is, if you, if you can't accept that, then you shouldn't be doing them, in my opinion, however, you know, speak to all of my university friends and they've had perfectly fine experiences doing them. Very successful individuals, very good careers, you know, if you... if you spoke to them you'd be very impressed with the amount that they've achieved but yeah, you know, if they, if they spoke about their drug experiences to certain people, people would really start to look at them in a different way (Michael; page 13, lines 9 - 26)</p> <p>5. I'd go to the internet personally but... yeah I suppose there are helplines and stuff but... I don't think I was really aware of them... I think I maybe was like later on in high school years but not... I, even now it's not like I first go to helplines, it seems, like, it's a helpline, like you need help, it's not something that you just wanna discuss something. It seems like it's something a little more extreme when it's like a taboo subject, like you wanna keep it more private, so you'd rather go to the internet and do it by yourself, rather than talking to someone (Jenny; page 5, lines 30 - 38).</p> <p>6. you are judged by your drug knowledge and your drug experiences. The more you know, the cooler you are. We actually had this, I had training last week. In fact, Monday and... we had a substance misuse quiz, and even then, people were showing off how much they knew. And the people that were... didn't know a lot... either sort of, said nothing, to not reveal themselves, or over the top-ly erm... exaggerated how much they didn't know "Oh I don't know anything about drugs" sort of, putting their cards on the table. So I think people's knowledge makes them... I don't know. They want to, show them they know a lot</p>
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		<p>if they think it's cool or they wanna say that "this is nothing to do with me" if they think it's dangerous (Shaznay; page 9, lines 6 - 17)</p> <p>7. Alcohol was not really looked down upon coz it's accepted in today's society and stuff I: Why do you think that is? J: Erm first of all it's legal so straight away the... erm... the bad implications of it are kind of thrown away, straight away, so... so I would say that's the first thing. Secondary I would say because my family drink, and most of my cousins drink ectera, so it's not really a thing that's frowned upon (Jim; page 2, lines 24 - 31)</p>
Identity	That's not me	<p>1. I just, I dunno, like how I've thought, I've said before really I guess... maybe I just don't have the personality that is so susceptible I don't think, I just, yeah... I am like probably more worried by the side effects than the bonuses (Jenny; page 11, lines 31 - 34).</p> <p>2. so when I was 14, the image was important, but... you would do different things to have a different image, whereas now, I want a, together adult image so... I, me, as the years have gone on I've been less and less likely to take drugs, and now I know I probably never would (Shaznay; page 5, lines 31 - 35).</p> <p>3. And I wasn't really around it much so there wasn't really... a lot of people talking to me about it, but it was just one of those things, from an early age, you know I was never a kind of... never gonna be involved in it (Jim; page 2, lines 13 - 16)</p> <p>4. I: Have you ever used drugs on your own before? J: Er, no I: So... why have you not done that, is it a choice that you've made? Or... J: Erm... its because I don't know why I would want to use drugs on my own (Jason; page 3, lines 29 - 34)</p> <p>5. Coz, it doesn't... I can't, I dunno, just, im happy with... what I take and that's it. I don't wanna... buy that stuff, its just, its not, you don't know whats in it basically, you dunno what you're taking... (Fred; page 6, lines 28 - 30)</p> <p>6. so the drug scene can be quite... pretentious sometimes, so people think... theyre a certain way and that they're different and special sometimes, or that's how it comes across, and... so that's, that's not particularly me and it tends to be kind of like, er the music that tends to be associated with that kind of group is not for me either, erm... and the general attitudes</p>



		<p>towards certain things can be different in those groups I think. I mean obviously you can take whatever you want with whomever you want but socially that tends to be how I see it (Shaznay; page 4, lines 32 – 38, page 5, lines 1 – 2)</p> <p>7. yeah it put me off big time, and heroin I'd never do coz my uncle... and crack cocaine, just, yeah... the addicted nature of it (Michael; page 7, lines 12 – 14)</p>
Identity	The friendship fabric	<ol style="list-style-type: none"> <li>1. if something is available in a social group, people are doing it, then it is something that you know, sort of (takes deep breath in), either you do it or you don't (Jason; page 2, lines 22 - 24)</li> <li>2. coz it feels good. It's nice to be able to relax, and I think there, there's a certain degree of social... like what we do as friends, what we've always done is like, oh lets meet up and go for a beer, so it just kind of goes, in hand and hand (Dave; page 8, lines 22 - 25).</li> <li>3. when I started drinking alcohol it was because of what I saw on TV and also because of my siblings, um I think my siblings played a really big part on how I... um, consume... these kind of mind altering substances (Sai; page 2, lines 16 - 19).</li> <li>4. it basically fitted into the lifestyle of university, you know... err, we were having so much fun, whilst being high and stuff, it, it was more of a chilled one rather than getting drunk and going out and stuff, it was, you know, you could chill with your friends, and you, you enjoy that time more to erm... like going out getting drunk and... and doing stupid stuff, like you enjoy just, just getting high and just chilling out with friends and, being in your room and just watching, si, silly things (Jim; page 6, lines 18 - 25).</li> <li>5. so the social circle I was in didn't really use drugs, and I knew people around that did use drugs but... I guess they weren't, I was aware that I suppose there was quite a negative opinion of them formed from people around me and even I suppose films and parents and teachers... They, they like, they were all a bad thing to do, and, I suppose I never felt comfortable enough with the people I knew who took drugs... it probably might've been a bit different if my friends did a whole, but I just, yeah, it just never really cropped up (Jenny; page 2, lines 11 - 19).</li> <li>6. the drug doesn't make it big but it will be like I'm going out, with friends, either out for a night in like Manchester, or down here and I know it's gonna be a long night (Michael, page 6; lines 33 – 36)</li> </ol>

		<p>7. my friendship group when I was at uni and my current friendship group is mixed of all people with different drug use levels so, I do, I don't think it affects things like that, except nights out, so if you've got a group of friends that wanna go on a night out, they'll wanna do different stuff whether it's different places, or drug involvement or not (Shaznay; page 6, lines 29 - 34)</p>
Identity	Drug taking is an inclusive activity	<p>1. so the drug scene can be quite... pretentious sometimes, so people think... they're a certain way and that they're different and special sometimes, or that's how it comes across, and... so that's, that's not particularly me and it tends to be kind of like, er the music that tends to be associated with that kind of group is not for me either, erm... and the general attitudes towards certain things can be different in those groups I think (Shaznay; page 4, lines 32 - 38).</p> <p>2. you know at Uni this... couple of girls that I lived with erm... so they wouldn't come out with us so me and the, the other sort of non-drug takers, because they would go to a special drug events, so... that was and then, they kind of wouldn't be seen dead where we went, and we wouldn't be seen dead where they went, or we thought we would be seen dead there, because we would die (laughs) so... I think that's the only issue (Shaznay; page 6, lines 35 - 42).</p> <p>3. I think because there wasn't a lot of... drug taking in my group, I think if I had been more in the minority then there would be more of a need for me to, to do it. But actually there was just a couple of people in our social group that did, and that was it really (Dave; page 16, lines 30 - 34).</p> <p>4. if those nights were, full of all of my friends and full of music I loved, then I would've been there doing it (Shaznay; page 13, lines 24 - 25).</p>
Identity	I definitely know what I've felt	<p>1. F: I was just curious, of what it was like, then just started taking it.  I: Did you think about drugs prior to that?  F: Not really... just saw some people doing it.  I: And who were these people?  F: My sister and my cousins.  I: And what did they used to do?  F: They used to go in the garden, and they used to smoke it.</p>

		<p>I: And how did that make you feel?  F: I was being, felt left out. That I wanted to try it. (Fred; page 2, lines 17 – 25)</p>
		<p>1. ... I think even my curiosity about learning about things comes into that so... you know... even, you know, I think seeing you know, friends do it, and I think that's the learning, and learning from experience, learning from my experience with drugs (Jason; page 10, lines 14 - 17).</p>
Identity	I've educated myself	<p>1. so, this conference that I'm going to, they're discussing, they're having a big debate on MDMA, on psychedelics, on DMT, and on all these... different drugs, and how they can be... actually beneficial, so for example MDMA can be used to treat PTSD, or um, I also watched an interview of this girl who was dying of cancer, and um, she was able to die with dignity because she... took MDMA and um, she was able to kind of die happily, and um... so I think um to be able to create some se, some kind of forum on not being, on not kind of oppressing this kind of information especially on the internet is really important to kind of spread the education about drugs and how they can actually be useful (Sai; page 5, lines 35 – 42 &amp; page 6, lines 1 – 4).</p> <p>2. I think seeing you know friends do it, and I think that's the learning, and learning from experience, learning from my experience with drugs, learning about... you know, obviously, its very... portay, well portrayed, the social impact of drugs, but erm, you, for my... business degree we looked at sort of the economics of drugs and you know the economics of legalising drugs and why that would be better, why, you, know not just for... economic terms but also, making it safer in terms of for other people so... erm... I suppose, I, I have an awareness of a, a, number of different ways of looking at a drugs and that's been influenced by... social experiences, erm, friends, personal experiences, just by using myself, and also... you know looking more... academically and, in terms of economically but also how its portrayed in terms of the media (Jason; page 10, lines 15 – 28)</p> <p>3. that's when I started to smoke a lot of weed as well on my own and I just used to do these things like err, just used to research a lot of stuff on the internet... used to erm... yeah, I, I, felt like I really grew, in that stage of my life, and that's what kind of... further reinforced my use of my erm, my use of smoking weed because I, it, it made, it made me erm, it didn't make me but it... it accompanied the... natural... kind of interest I had in things and it. (Jim;</p>

		<p>page 14, lines 4 – 11)</p> <ol style="list-style-type: none"> <li>4. I think personal experience is the main thing but I did try and... learn as much as I can about... so for example I knew about half life of drugs, like so, way before any of my friends did, coz I just like looked it up (Michael; page 11, lines 2 – 5)</li> <li>5. S: I think maybe once you understand what the risks are more by experimenting yourself you then understand it better but I think a lot of people don't go through that proper experimental phase so they stay on the scared side, which is probably where I am I: I see, so you think, personal experience would actually help to mitigate a lot of people's fears towards drug use S: Yeah but their own personal drug use, not seeing other people necessarily, coz once you know what it's like, if, if something's really scary, you know if you do a bungee jump for the first time, you can see somebody do it and it looks scary still and then once you do it, you then know what you're doing, and what it's like, so I think its whether you, you push through that phase or not (Shaznay; page 15, lines 29 – 39, page 16, lines 1 – 2)</li> <li>6. F: you have to... you just have to do research, because you can't just always believe one thing, it's like shopping innit, you're not gonna... like... just because you've bought something from that website before it doesn't... necessarily mean it's gonna be cheaper on that website. I: So... doing research is, is very much like shopping around I guess F: Yeah (Fred; page 15, lines 6 – 12)</li> </ol>
Identity	My own ignorance	<ol style="list-style-type: none"> <li>1. it's what I saw, and I, I just used to think wow, I never wanna look like that, and me and my friend would, would say the same thing like, you know, so erm, yeah, it, but it was ignorant because I never researched it (Jim; page 11, lines 6 - 9).</li> <li>2. I think it's brought a lot to my life. I, I don't I mean, people worry about the health benefits coz I did a lot but if it has damaged my health a bit, ok yeah maybe I should've thought about that but when I'm young, that's not what I'm thinking about but... God the experiences and friends that it's given me, I'd trade... 5 years of that... happily (Michael; page 12, lines 2 – 8)</li> <li>3. I think that's the thing that you need to know, whether this drug or this experience would suit you, and the only way that you can find that out is if you try it yourself and... that is</li> </ol>

		probably the most reliable thing, the most reliable indicator of whether one drug would suit you, or whether this experience would suit you, because you feel that it's right, it's not because someone else is telling you that you should do it (Sai; page 17, lines 9 – 15)
Identity	I don't need to know	<ol style="list-style-type: none"> <li>1. erm, I don't think I really have much interest in, in in, learning, it's not like I go away all the time and, I think like I said the more interest was, doing the biological psychology and just learning a bit more about how it affects our... brain chemistry, because I suppose I feel I don't need to worry about... the enduring effects coz I, I, rarely use them, so... (Jason; page 8, lines 17 - 22).</li> <li>2. a lot of people have probably been influenced... and er, exposed to it earlier than that, er, although I hadn't really been, it was more, it was still something that was quite distant by that age and something that you see on TV, so... for me... it was fine, but for others I suppose it would be quite late. (Jenny; page 4, lines 17 – 21)</li> <li>3. I think it would be beneficial to learn about the different types of drugs and how they benefit, or not benefit you. But its not something that I sit down and think, oh I've got a bit of time on my hand, lets go and do some research (Dave; page 14, lines 15 – 18)</li> <li>4. If you, if you're that hard up against doing something, why would you learn about it, and they need to learn about it. They should. And you know they might experience, they might have fun. (Michael; page 11, lines 8 – 10)</li> <li>5. I: How do you feel when you're reading about stuff in the media about... legal highs and stuff like that S: Not really interested if I'm honest (Shaznay; page 12, lines 21 – 23)</li> </ol>

# Appendix 11: Interview Questions & Analysis Example

## Interview questions

2. What are your general opinions on drugs?
3. Where have your ideas of drugs come from/where did you learn about drugs initially?
4. What were these experiences made up of?
5. What did it teach you?
6. What did you find useful about x experience? What was not useful? Why?
7. What do you use? Why? What made you decide to use in the first place? Why?
8. What do you not use? Why?
9. Where do you get your information about substances now?
10. How do you make sure your use is safe? Where did you learn this from?
11. In what context do you use (alone, with people, if with people, what people, why those people and not other people)
12. How do you view others that use? (Others that use substances they use as well as others who use substances they don't use)
13. Discussion of FRANK and other substance misuse campaigns – have they seen any? Did any work for them? What stood out? What didn't work so well? How did this impact on their substance use?
14. Were there any other factors that influenced them? Media/friends/family/formal education system/popular culture etc.? How did these other factors influence them?
15. Taking into account their experience, how do they think that substance misuse education could be improved?

## Analysis Example

	1	I: Erm... ok, erm so, these views came from your parents, you, you	
	2	mentioned elder family members, who	
	3	J: Yeah parents, older cousins, erm... yeah mainly, mainly family	
	4	I: Ok and what did your older cousins used to say?	
<i>drugs are bad "idea has been reinforced by other family members too</i>	5	J: Er it wasn't as much from older cousins but... erm I think they	<i>the parent's view</i>
	6	would say stuff like, yeah you know when your in, in school, "don't	
	7	do naughty things like that. Stay away from bad, the bad group"	
	8	basically "You don't wanna mix with the wrong people"	
	9	I: And you got told this around 10 years old would you say?	
<i>because I was told they were bad - I didn't want to do bad things!</i>	10	J: Er nn, that would be a bit later I'd say. My parents, I, s, I would say,	<i>the parents view</i>
	11	8 to 10 years old was more my parents, err, school time, I would	
	12	probably say secondary school, so maybe like, fou, fourteen, th,	
	13	thirteen, fourteen. Yeah. And I wasn't really around it much so there	
	14	wasn't really... a lot of people talking to me about it, but it was just	<i>that's not me</i>
	15	one of those things, from an early age, you know I was never a kind	
	16	of... never gonna be involved in it	
	17	I: And... as you grew older, do you think your views of drugs	
	18	changed?	
	19	J: It definitely changed, yeah.	
	20	I: Why do you think they changed and how do you think they	
	21	changed?	
<i>Alcohol is ok as its accepted in society</i>	22	J: Well... first substance I tried was alcohol, now I must've been	<i>I know how it's societal fabric</i>
	23	around... erm... what, 15-16? When I fi, first properly got drunk and	
	24	felt the effects of it. Alcohol was not really looked down upon coz	
	25	it's accepted in today's society and stuff	
	26	I: Why do you think that is?	
<i>legal status of drugs because others do it, it's ok - others don't do drugs so there is a fear of "the unknown" - "I started rebelling" - "drug use is a normal rebellious, risky activity - not doing drugs means you're sensible" "innocent to the world" but he got "corrupted"</i>	27	J: Erm first of all it's legal so straight away the... erm... the bad	<i>societal fabric the parent's view societal fabric only naughty kids do drugs</i>
	28	implications of it are kind of thrown away, straight away, so... so I	
	29	would say that's the first thing. Secondary I would say because my	
	30	family drink, and most of my cousins drink ectera, so it's not really a	
	31	thing that's frowned upon, erm, and yeah, that's why I think that,	
	32	but yeah in regards to drugs like, cannabis and things like that, I	
	33	think that was more of a... as I grew up I kind of... just started	
	34	rebelling a bit and erm... probably around 16, se, seventeen I	
	35	thought I'd just try it because a couple of friends tried it... but... prior	
	36	to that when I was younger, I would, I was in a different kind of	
	37	frame of mind, I was, you know, more sensible and I was... er...	
	38	quite innocent to the world and stuff I'd say, so I didn't really	

drug users are a certain type of person

1 wanna... mix with people that did that back in the day because I  
2 could see what kind of people they were and... they weren't people  
3 I'd wanna be around

I wasn't naughty, I was obedient & wanted to do well  
"I had my head screwed on" - this meant my dad & mom not

4 I: What kind of people were they? Why were they different to you?

5 J: Erm they were, they were, they were different because, so this is...  
6 I'd say from secondary school, around year 7, erm... the people that  
7 used to smoke weed then, they were naughty, they were always  
8 getting into trouble, they were... they weren't people I'd chill with  
9 anyway... erm... they weren't, my, my group basically, th, they, and...  
10 my group were pretty... pretty, they had their heads screwed on,  
11 they did their work... and erm... I didn't wanna mix in with that  
12 crowd because they used to smoke and... do bad things which I  
13 thought were bad back then

only naughty kids do drugs  
they had my head screwed on

14 I: What do you think made you think it was bad back then?

the drugs made ppl bad

15 J: Erm... the fact that they, the people that were doing it were bad  
16 themselves, so I thought that the drugs... possibly made them that  
17 way, or... made it easier for them to be like that

only naughty kids do drugs

18 I: Do you think your thoughts were reinforced in any other, in any  
19 way, by other external influences?

why wouldn't he trust his parents? They told him the truth, & life experiences reinforced this  
But then his life experience changed his view again because it wasn't just the "naughty" people doing it anymore... it had become a part of his friendship fabric

20 J: Err, I would say, just the fact that I was told from a young age that  
21 drug are bad and that people that do them normally... kind of turn  
22 out bad... erm... I would say that was, the biggest kind of external  
23 influence, and just seeing it with my own eyes, like just seeing the  
24 types of people that were... doing it, they were always the ones that  
25 were always getting into trouble, and ... rebellious at school at that  
26 age. But what I thought... changed my mind in regards to it was that  
27 the fact that people that were like me were doing it as well, but they  
28 were still ok, and that's what kind of made me think, ooh lets  
29 actually give it a try, coz obviously it hasn't messed these guys up.  
30 These are people that are like me, so erm... lets just give it a try

I know what I've seen  
my naughty but so cool  
they had their heads screwed on

31 I: Was it your friends that were using?

they also had their heads screwed on  
this facilitated curiosity - "it can't be that bad"  
got tempted as it became part of his friendship fabric

32 J: Yep. When I was older, I'd say, the first time I did it, the first time I  
33 smoked cannabis was... when I was... in year 12, which I would've  
34 been, what, 16 - 17? Yeah. And erm yeah. The. My friends would,  
35 would doing it then and they were you know, they had their head  
36 screwed on, they were doing well at school and stuff, and I thought,  
37 lets just try it. And plus I was older and erm... erm it was just yeah,  
38 just more of a temptation kind of thing, just try it, like, as in, just for  
39 jokes. Yeah.

they had their heads screwed on



1 I: So do you think before... you tried it, your views about it were  
2 quite rigid?

3 J: Yeah

4 I: And what do you think changed those views?

*It was sensible, his  
friends were still  
sensible, & it had  
now become part of  
his friendship circle,  
which led him to be  
curious to use*

5 J: I think the main, the main thing that changed those views were  
6 the fact that... people that... I would mix with and erm, were like me,  
7 I would say I was, had my head pretty screwed on and I, you know I  
8 was doing well at school, and erm... those people like that, like me,  
9 were also like that, and the fact that they were doing it and still,  
10 and still... being, like good and stuff and erm, and still attaining,  
11 made me believe that, "oh, maybe it's not so bad. Maybe it's erm...  
12 just give it a try. maybe it's not so bad, maybe it's erm... just erm,  
13 makes you feel like... funny" [Laughs] "or you might enjoy it for a  
14 bit"

*I had my head screwed  
on  
BUT  
Friendship Fabric  
curiosity to use*

15 I: So it was your personal experiences of watching your friends that  
16 changed your mind

17 J: Yeah. Well... yeah, yeah, I would say that. And, but also the fact  
18 that they were doing it, but they were still... it wasn't like they was  
19 deteriorating them in any way in regards to their mental ability to  
20 work and stuff because they were still doing well, at school, and it  
21 changed my mind because I always used to think that people that  
22 did drugs were just going off the rails and in other parts of their life  
23 and stuff, so erm... yeah

*know what we seen*

*his views started to  
change - so you can  
still be a user &  
function*

24 I: Ok, erm, so you started using cannabis at 16-17, do you still use?

25 J: I tried it, I tried it at 16-17 and I didn't like it the first time I did it. It  
26 was... erm... no the first time I did it, I didn't get anything out of it,  
27 but, ooh oh I actually remember the first time now, it was more of a  
28 peer pressure thing to be honest actually, but, I, I did kinda, I just  
29 thought, you know what, lets just try it anyway, coz I, it wasn't a  
30 massive peer pressure thing, it was more of a thing where, it was  
31 like, "Oh just try it, yeah you might like it". I wasn't forced into it but  
32 at the same time I was a bit wary at the same time, so erm... yeah.  
33 But I didn't really enjoy it, and I tried it a couple of times after that  
34 and I, I had a had experience with it, and that made me stop for... a  
35 couple of years

*really knew what it  
felt*

*tempted by friends to  
try but had a bad  
experience - learned  
himself that he didn't  
use it so he stopped*

36 I: And what made you start... using again?

37 J: Well, it was a couple of years after my bad experience, I think,  
38 probably not even a couple of years, probably about a year and  
39 erm... I just thought I'd try it again, just in case i erm... Because I, the

## 2. Publishable Papers

### Experiences of Hospital Admission and Discharge for the homeless population of Islington, London

#### Abstract

[REDACTED]

## Publishable Paper 2

Article in PsyPag

Featured Article/Discussion Paper

Is Talking to Frank doing more harm than good? Why current drug harm reduction campaigns for those who regularly consume are failing.

**PSYPAG**  
Psychology Postgraduate Affairs Group

# Quarterly

Issue 93 December 2014

**Special issue on Health Psychology including:**

**Is Talking to Frank doing more harm than good?**

**Measuring stress in children and adolescents with saliva testing**

**Challenges of health risk communicating health risks to people with psoriasis**

**YP**



# SECTION C: PROFESSIONAL PRACTICE

## Unit 1: Generic Professional Competence

### *Background*

I am currently employed as a Mental Health Advisor for [REDACTED] with my full time hours being divided amongst two teams. These teams include a mental health promotion team called [REDACTED] and an Improving Access to Psychological Therapies (IAPT) team, called [REDACTED]. I have held this role since January 2011. My work involves delivering low-level interventions designed to improve an individual's emotional health and wellbeing, which are often based on Cognitive Behavioural Therapy (CBT). This includes the design, delivery and evaluation of psycho-educational workshops or closed-groups, which can cover a wide range of topics known to affect emotional wellbeing. In addition, I also facilitate 1:1 Guided Self-Help sessions with patients, spanning over a period of 4-5 sessions, a phone line and email service where people can receive advice and information in relation to their mental health, as well as designing written psycho-educational resources for the general public on a range of common issues that can affect mental health and wellbeing. I also regularly design and deliver teaching and training sessions to professionals on subjects such as 'Mental Health Awareness', 'Emotional Resilience in the Workplace', and 'An Introduction to CBT'.

Throughout the duration of my traineeship, I additionally held a Volunteer Telephone Helpline Advisor role within a charity called [REDACTED]. I commenced this voluntary role in April 2010. However, ended my role in August 2015. Within this role I provided advice, information, support, referrals and signposting information to anyone affected by substance use. I was additionally trained to DANOS (Drug and Alcohol National Occupational Standards) for this role.

### ***1.1a. To establish and maintain systems for the security and control of information.***

Within both of my roles, I was required to ensure that I maintained up-to-date systems for the security and control of information. At [REDACTED] all sensitive client information is stored upon Iaptus; a specially designed software programme

which stores confidential patient information, including information such as their name, date of birth, ethnicity, gender and address, as well as their patient records in reference to their assessment and treatment. As this information is sensitive in its nature, it could only be accessed via the [REDACTED] Information Technology (IT) system, and was protected by a unique username and password for each member of my team. All information on this system was required to be as up-to-date as possible, and for this reason, at the first point of contact with the patient, it was ensured that the data on this system was correct, and at every subsequent contact, I ensured that I asked the patient if any of their details had changed. Furthermore, at the beginning of each psycho-educational workshop or training session, I ensured that a group agreement was reached in order to protect an individual's right to confidentiality, highlighting our organisation's policy on myself being required to break confidentiality if there was a highlighted risk to either the individual in question or other members of the population. Within any training that I delivered to healthcare professionals, I ensured that the professionals became knowledgeable on their own organisation's risk and confidentiality policy, as well as the ethical considerations they were required to work within.

Within my role at [REDACTED] I was required to log every call made onto an encrypted online system, and complete separate forms for referral. These logs had to be made within 24 hours of the call, to ensure that patient records were kept up-to-date. I additionally submitted and passed ethical approval for my research into hospital admission and discharge as well as drug education at City University. For my research, I was required for a short time to transport sensitive participant identifiable information to their place of secure storage. Although the names of the participants were not collected within the designed studies, I ensured that I designed the questionnaires so that any participant identifiable information was kept separate to their results. I also ensured that as soon as the data was collected, the results were stored in a locked filing cabinet, or under a password protected file on the City University IT system, to which only I had access to. I ensured that all participant identifiable information was stored separately to the data collected, with data being randomised within the defined time, and thus, participant identifiable information being destroyed at the first opportunity. I also completed Information Governance Training regularly within my role at [REDACTED]

***1.1b. To ensure compliance with legal, ethical and professional practices for self and others.***

I am aware of the British Psychological Society's (BPS) code of conduct and I ensured that I regularly reviewed and reflected upon my practice to safeguard the ethical principles of Competence, Respect, Integrity and Responsibility, within my work, both professionally as outlined above, and academically through my research. For example, within my research, I ensured that all participants understood that their participation was voluntary and they were able to withdraw from the study at any time without fear of retribution. I ensured that I followed the National Institute for Health and Care Excellence (NICE) guidelines and Positive Practice guidelines within my practice, and kept up to date on any amendments or reviews that were made.

***1.1c. To establish, implement and evaluate procedures to ensure competence in psychological practice and research.***

Within my role at [REDACTED] I am regularly asked to provide training to and monitor the work of the Trainee Psychological Wellbeing Practitioners (PWP's) and other new members of staff to improve their psychological competence when delivering interventions, as well as when they are designing written information for a lay-population. To ensure that this is completed within a methodical manner, I ensure that I arrange an agenda for training needs and an evaluation of the training is conducted by the trainee. I additionally provide verbal feedback to the trainee to ensure that they are able to implement the recommended changes and reflect on their delivery or design to improve their practice. Furthermore, within my practice, I did not used to have a formal measure for demonstrating behaviour change within the interventions that I delivered. However, as a result of attending the Interventions workshop at university, I decided to place a measure of perceived held knowledge on the subject area before and after the intervention was delivered. This helped the design of future interventions, as if the knowledge score had not changed, it would have influenced the content of the information within the psycho-educational intervention/teaching and training programme.

I also complete a reflexive diary to improve my own professional practice, and ensured that I maintain accurate records of development in practice in accordance with [REDACTED]

██████ organisational policy. I additionally ensured that I utilised supervision opportunities to raise any gaps in knowledge and to identify my strengths and areas of improvement with my line manager. I have also ensured that I have attended training to improve my training as a practitioner. I have attended many external training courses and workshops, as well as conferences, which I feel have greatly enhanced my learning and knowledge. For example, I completed a course in Behavioural Sleep Medicine through distance learning at the University of Glasgow, which enabled me to design and deliver effective interventions targeting common sleep disorders. In addition, I have completed courses on improving my communication skills with specific client groups, a course on effective digital social marketing, as well as suicide prevention skills, working with those who have learning disabilities, as well as Cognitive Behavioural Therapy.

***1.2a. Establish, evaluate and implement processes to develop oneself as a professional health psychologist and:***

***1.2b. To elicit, monitor and evaluate knowledge and feedback to inform practice.***

In order to establish, evaluate and implement processes to engage in continuing professional development, I attended regular supervision sessions at university as well as within my role at ████████████████████. In order to maintain and monitor my professional practice, and to continue my development as an applied psychologist, I ensured that I partook in regular 1:1 supervision with my supervisor, as well as group supervision with Stage 2 Trainees. I also attended a series of workshops at City University which supplemented the Health Psychology Doctorate programme. These included Motivational Interviewing, Cognitive Behavioural Therapy, Teaching and Training, Consultancy, Quantitative Data Analysis, Qualitative Data Analysis, Designing and Delivering Interventions and Generic and Professional Skills for Health Psychologists. Through attending these workshops, I feel that my skills and competency as a trainee Health Psychologist have improved considerably. In addition, they allowed for me to reflect upon my own practice and make changes in areas which I felt needed improvement. In addition, I also ensured that I attended line management, clinical, and group supervision regularly within my role at ████████████████████ to ensure my ethical conduct remained at the highest level. I also took part in the annual appraisal process on an annual basis. These supervision sessions provided a platform to discuss

any issues that I had concerning my legal, ethical and professional practice, and additionally provided me with a platform to review and reflect on my current work.

***Publications and presentations at conferences and team meetings.***

The area of research in which I hold an interest in has become topical in recent years, especially with information concerning the safe use of recreational drugs. For this reason, I decided to publish an article concerning why current harm reduction campaigns are failing for those who regularly consume. This was published within the Psychology Postgraduate Affairs Group (PsyPAG) Quarterly publication, which produced a special issue on Health Psychology. This was my first academic publication, and I managed to achieve the title of featured article within the publication. This experience was invaluable to me, as I had not previously experienced writing for a journal. I aim to write many more academic papers in the future, including publishing some of my material from my doctorate portfolio.

Furthermore, I have attended a number of conferences including the British Psychological Society Division of Health Psychology 2015 Annual Conference whereby I was invited to deliver an oral presentation on my teaching and training competency regarding training mental health professionals on substance use. My experience in delivering training has largely been for healthcare professionals, and I have designed and delivered 'An introduction to CBT' for this group which I delivered to prison healthcare staff as part of my role at [REDACTED]. Within my current role, I deliver approximately 2 to 4 training sessions every week to professionals working with those experiencing mental ill health. In addition, I also provided psycho-educational interventions regularly to members of the public, specialist groups such as those experiencing physical health conditions such as chronic obstructive pulmonary disease, heart disease or diabetes, as well as specialist groups within society such as carers, the homeless and older adults. I also provided interventions to professionals. The interventions are conducted on topics such as managing anger, depression, anxiety, stress and work stress, self-esteem and communication and assertiveness. Through delivering these sessions, I have learnt the importance of tailoring the detail of information provided, as well as my delivery and approach to meet the needs of the group in question.



### ***1.2c. Organise, clarify and utilise competent consultation and advice.***

I ensured that advice throughout my traineeship was obtained from a variety of different sources. This included my line manager, work colleagues, my supervisor, and other qualified professionals within the discipline as well as my peers on the course. For example, whilst designing my research, I ensured that I discussed my research idea with many experts in the field to help shape my plan, before I presented this to my research supervisor. I believe that this process helped me in shaping my overall research question. I additionally had not conducted a mixed-methods study before, and although I was confident in my qualitative analysis, I was unsure about whether my quantitative analysis was correct. I therefore discussed my analysis with many people, including statistics experts at City University, as well as other health psychologists and work colleagues who were skilled in statistical analysis. In order to write my competencies and research, I ensured that I accessed journal articles, and methodologically made my way through this information so that it could assist with my understanding and the write-up of the area concerned. For example, in order to complete my systematic review, I arranged a meeting with the Psychology Information Specialist at my university's library so that I could access the correct databases and be taught the correct way to sift through the information that my searches produced. I found this meeting invaluable and feel that without it, I would not have been able to complete my systematic review.

### ***1.2d. Develop and enhance oneself as a professional health psychologist and 1.2e. Incorporate best practice into one's own work.***

In order to ensure that my professional competence was developed over time, I sought out relevant training opportunities to enhance my learning as a trainee. Attending conferences such as the BPS Health Psychology Conference in 2015, as well as the Health and Wellbeing Conference in 2012 helped to develop and enhance my skills. In addition, within my line management supervision, I sought to seek out opportunities to develop my skills as a health psychologist within the work setting. For example, sessions were designed to facilitate a behaviour change for patients, where I took the lead of the design and delivery. In order to keep my work as up to date as possible, I ensured that I researched the area of the intervention being provided thoroughly prior

to designing and delivering it, to ensure that I utilised the most up-to-date methods of conducting this. I also took into account the most up to date NICE guidelines, as well as the Positive Practice Guidelines developed for IAPT workers. In addition, through attending conferences and attending high profile meetings, such as the Homelessness Strategy meetings in Islington, I ensured that I tried to capture the essence of the field at the time to learn what had worked previously, what things did not want to be repeated, and what new ideas were emerging within the field.

**1.3a. Assess the opportunities, need and context for giving psychological advice and**  
**1.3b. Provide psychological advice and**  
**1.3c. Evaluate advice given.**

Within both my roles at [REDACTED] as well as my role for [REDACTED] I continually assessed the need to provide psychological advice and information when facilitating services such as the phone line, email service, and within the 1:1 guided self-help sessions that I facilitated. For example, when I facilitate the phone line service, the calls could arrive from any member of the public seeking advice, information or support regarding their current situation. It is my responsibility to ensure that I provide the correct advice and information based on their needs, and provide appropriate psychological interventions if necessary. I have also conducted regular assessments within my role at [REDACTED] to assess the need of the patient and the context in which appropriate psychological advice and information can be provided. The purpose of these assessments is to understand more about the patient's particular situation, so that I can better understand how our service can better meet their needs. Within my role at [REDACTED] [REDACTED] I also facilitate workshops aimed at improving the emotional health. Psychological advice, based on CBT and Acceptance and Commitment Therapy (ACT) techniques were delivered, along with Motivational Interviewing techniques to help facilitate a behaviour change. I ensured that I always evaluated any sessions I delivered, whether this be sessions delivered on a 1:1 basis, or through a workshop, and I use this information to further develop and improve my delivery. I also reflected upon my work to see if I could have improved any areas, and utilise formal and informal methods of evaluation such as supervision and discussion with my colleagues to better my work.

I have additionally produced written psycho-educational material within my role at [REDACTED] including booklets on parenting for children with a mental health condition, substance use and mental health, and sleep and emotional wellbeing. These booklets needed to meet the 'NHS toolkit for producing patient information' guidelines, and therefore needed to be written in a way that was inclusive for all, whilst taking into account reading age. In order to evaluate these, I sent the material off to stakeholders who had a vested interest in the specific topics being discussed so that the information provided could be evaluated. For example, for my substance use booklet, I sent a draft copy of the booklet to the Chairman at [REDACTED] to review.

***1.4a. Evaluate feedback needs of client and***

***1.4b. Prepare and structure feedback and***

***1.4c. Select methods of communicating feedback and***

***1.4d. Present feedback to clients.***

Within all sessions delivered as part of my role at [REDACTED] I ensured that a formal evaluation form was provided to all participants, and an opportunity for verbal feedback was also provided within the break and at the end of each session. I ensured that I utilised the feedback collated from all sessions to improve the design and delivery of future interventions delivered within my practice. Within my role at [REDACTED] I conducted a qualitative analysis on the evaluation of our psycho-educational programmes aimed at the general public called 'Emotion Gyms'. In addition, I have also written evaluation reports on various parts of our service specification delivery to demonstrate how the service elicited, monitored and evaluated feedback obtained from delivering interventions. I disseminated these findings among my team to ensure that this information was utilised to re-design parts of the interventions and to improve future delivery. Feedback to patients was delivered through [REDACTED] strategy "You said, we did", whereby any changes to the design and delivery of the services were advertised on places such as our website, posters, and through other literature we disseminated. Feedback to our commissioners was delivered through the annual reports that my team and I wrote, which discussed an overall evaluation of the service delivered, and highlighted future changes that were to be implemented as a result of these changes.

## ***Reflection***

Within my role, it was a constant battle to advocate the usefulness and applicability of health psychology to my service lead and my role, as my service lead did not appear to see the benefits of health psychology. I was provided with limited support to complete my training within my place of work, as although my line manager was very supportive (as she herself is also in training to be a Health Psychologist), it was difficult to try and negotiate time off to attend university supervision, have study days, or attend external training, workshops or conferences. It was also very difficult to incorporate any relevant models and applications of health psychology within my role, unless it was under the guise of not having a health psychology focus. For this reason, anything that I wanted to do to develop and enhance my learning was conducted through my annual leave allowance. Although meetings were held to try and show the benefits of health psychology and its applicability to my role, my service lead was very clear that the role I was currently employed in did not require a Doctorate in Health Psychology, and she was therefore not prepared to support me in terms of allowing time off to attend conferences, training or workshops. This was difficult to accept at times, as within my team, we additionally have trainee PWP's. Sometimes, as part of their learning, they would disseminate information such as behaviour change models amongst the team, and although these models are strictly health psychology in nature, the service lead would fail to see the applicability of health psychology to my role. This in itself made me even more determined to complete my doctorate.

I feel that as a practitioner I have greatly improved in terms of my competence as an applied psychologist, through the reflexive skills I have developed through my role and through simply going out and putting myself in situations that helped me to grow as a practitioner. I have definitely experienced times where I have been challenged, however I have also experienced moments of real joy. I am proud and excited to work within the field of health psychology, and I know that this is only the beginning of my journey as a Health Psychologist.

## Unit 3: Consultancy

A consultancy service conducted for [REDACTED]

**Setting:** Primary Care.

**Client:** [REDACTED]

**Target Group:** Primary health care professionals who specialise in providing advice, information and interventions to substance misusers living in the community.

**Aims of Consultancy:**

- To provide a consultancy service for [REDACTED] in order to train their health care professionals in providing more holistic and applicable advice, information and support to those who have a substance misuse and mental health condition.

### Introduction

I will describe my experiences of providing a consultancy service to the [REDACTED] [REDACTED] who are an National Health Service (NHS) that provide interventions to those with a mild to moderate substance misuse problem in Surrey. The consultancy was provided for a short period in order to provide their staff with adequate training so that they are able to better support their clients who have a co-morbid substance misuse and mental health condition. This training was provided in order to assist the team with providing a better level of care to their clients, to improve their service delivery, and to additionally raise awareness of mental illness and further sources of support available in the local area. The consultancy was performed under the [REDACTED] as [REDACTED] do not usually provide this type of programme as part of their service specification.

### Background

Upon having various informal consultations with members of the [REDACTED] team, it was identified that there was a clear gap in their knowledge and skills on how to effectively manage and provide treatment to an individual with a suspected dual diagnosis.

Although the team were adequately trained in providing treatment for those misusing substances, the team was made up of individuals who had come from varying disciplines, who had different levels of knowledge of how to provide advice and support to someone with a dual diagnosis. After having an informal meeting with some members of the team, they suggested that the clients who presented themselves with a suspected dual diagnosis appeared to be more chaotic in nature, and had varying needs which the team were unable to meet through the current skills they held. The team additionally seemed unaware of the Improving Access to Psychological Therapies (IAPT) model, and how to effectively prepare a client for the intervention.

### ***Reflection***

I was keen to develop a training package for this organisation as it is a main work objective of mine to ensure that staff working alongside those with suspected mental health problems has the relevant competencies required. The competencies included ensuring that the staff was aware of the different Mental Health Services in Surrey and how to adequately refer or signpost; harm reduction and mental health models; how to identify emotional distress or a mental health problem; how to help someone in emotional distress, and further sources of support. The competencies were discussed with a member of the [REDACTED] team who agreed to discuss the training with their line manager to identify their training needs. Additionally, the interaction and potential relationship present in a suspected dual diagnosis has always been of specific interest to me. I felt that it would be an exciting opportunity for me to enhance the current learning of this particular team from a health psychology perspective, as it initially struck me that this team had no succinct knowledge of health psychology models and the importance they can play in understanding health behaviour. It is important that the team have knowledge in health psychology models so that they are better able to understand the behaviour of their clients, and so are able to better assist them with changing their health behaviour.

### **Assessing Requests for Consultancy**

Within my capacity as a Mental Health Advisor for [REDACTED] I received a telephone call from The Harm Reduction Development Worker at [REDACTED] (the client) to discuss how to further develop the skills required for their existing members of staff. Within this

discussion, it was suggested that staff members came from different backgrounds and therefore had various levels of knowledge around mental health. During this telephone call, I informally presented some of the work that I had done within my role at [REDACTED] [REDACTED] for other organisations in order to increase their staff members existing skills and knowledge on working with those who have an undiagnosed mental health condition or who were experiencing emotional distress. I additionally presented my knowledge on various health belief models and how knowledge of these models could assist the [REDACTED] team to better understand and identify a client's belief and attitudes around their health. I additionally discussed the importance of using client-centred models (such as Rosenstock's (1966) Health Belief Model) and forms of communication (such as Miller and Rollnick's (2012) Motivational Interviewing) to ensure that clients felt empowered through any decisions they made about their own healthcare through placing the emphasis of behaviour change directly on the client, and ensure that the client identifies their own goals which they work towards.

Throughout this process, I ensured that I acted in an appropriate manner to ensure that a smooth relationship was established between myself as the consultant and the existing client. As consultancy is aimed at aiding the client to resolve a specific issue or problem, I utilised the Process Consultation Model (Schein, 1969) to ensure that the client was involved in the diagnosis of the initial issue, and the generating of the solution. At this particular stage, I ensured that I was taking the role of the 'internal' helper, to assist the client to identify the specific organisational concerns so that they were able to make specific decisions about how those concerns could be resolved. The client suggested that it would be more appropriate to arrange a face-to-face meeting to discuss the potential issues that had been raised on the telephone, and to discuss any solutions that could potentially address the team's gap in knowledge.

During this meeting, the issues highlighted above were discussed, and through mutual agreement, it was identified that the most productive way to ensure all staff were working to a similar standard was to deliver a formal training programme, which was to be researched, designed, delivered and evaluated by the consultant. The meeting was utilised to identify the team's requirements, needs and expectations to determine the appropriate level of intervention. I further utilised this opportunity to ascertain the client's expectations from the consultancy process.

The client's expectations were as follows:

- 1) To identify and discuss the training needs of the [REDACTED] team;
- 2) To address how these training needs would be met;
- 3) To ensure that I prepared and delivered a training programme to meet these needs;
- 4) To provide expertise after the delivery of the training if required.

The initial assessment for the consultancy was additionally discussed, whereby the client and I agreed the various aims, objectives, time frames and expected outcomes of the consultancy.

Clients were identified according to Schein's (1988; 1999) model of '*Process Consultation*'.

- 1) Contact Client – Various members of the [REDACTED] team, who approached me initially to discuss providing the consultancy;
- 2) Intermediate Client – Harm Reduction Development Worker, who was involved in the development of the training programme;
- 3) Primary Client – In this case, the primary client is the same as the contact client, as they ultimately own the issue for which they require assistance;
- 4) Ultimate Client – Any individual who accesses [REDACTED] services, whose welfare and interests need to be considered in the planning, development and evaluation of the consultancy.

It is additionally important to identify the *stakeholders* and *sponsor* (Earll and Bath, 2004). *Stakeholders* can come from a wide group of people and organisations who are associated with the client, and whose involvement with the organisation will affect its success in both undertaking and implementing the outcomes of the work. In this case, the Stakeholders would be the Clinical Commissioning Groups that employ [REDACTED] (the umbrella organisation who [REDACTED] and [REDACTED] both work under) to deliver Primary Care services in Surrey. These services may have questions about the information contained within the training package, and the time that may be required for clients to access two separate services if it is highlighted (namely a substance misuse service and an IAPT service if appropriate) when services have national guidelines to work towards. The *sponsor* is the person who will act as the main point of contact for



the consultant and who will lead the necessary project from the organisation who requires the consultancy, in order for the consultancy to develop in a fluid manner. The sponsor in this case is the Harm Reduction Development Worker.

Based on the discussed requirements from the initial meeting, I put together a written proposal that demonstrated how my training would fully meet the needs identified by the client. Within the proposal, I outlined the specific areas that training would be provided on, and detailed what topics would be covered. I additionally prepared training materials in the form of a training outline, the aims and learning outcomes, evidence of delivering similar training, and fees for the consultancy. Please see Appendix 17 for more information. I received confirmation that the proposal was successful and commenced work on the consultancy immediately.

### ***Reflection***

A particular challenge at the start of this consultancy was to re-adjust the existing relationship I had already established with the client. Prior to this consultancy, the client and I had only known each other as colleagues who had not previously conducted any work together. Therefore, a new working relationship needed to be built to ensure the smooth process of the consultancy. A further challenge was the time constraints involved within the design, development and delivery of the consultancy process.

██████ required the training to be delivered by a specific date as their team had been put out to tender by ██████ and they were unsure if their current team would stay working within the same structure. As the primary purpose of this consultancy was to ensure that all members of the ██████ team were trained to a specific level on this topic, it was imperative that the training was delivered within this stringent time frame.

### **Planning Consultancy**

The client and I discussed in further detail the specific areas of what was to be delivered within the training session. The client suggested areas on where there was a gap in knowledge, and I suggested ways in which these gaps could be met. For example, the client suggested that the team had no prior knowledge on what could influence a client's health behaviour, and I suggested that it may be useful to cover Health Behaviour Models to develop this understanding. My written proposal was based on the delivery of a half-day training course aimed at training all members of the ██████ team, to last

for 3 hours in total. A follow-up session would be implemented if required, and only if feedback from the initial session required for it. This was agreed in line with the client, as the client stated that his team would not be granted more than half a day's leave to complete the training. However, I did have some initial concerns when planning the training session, as the amount of material the client had requested to be covered suggested the session would take longer than half a day to deliver. I arranged another meeting with the client to discuss the content of the training session, and at this meeting, I asked the client to suggest what parts of the session they thought would be best to lightly cover, so that there was enough time to deliver the full training within the specified time frame. At this point, I was acting within the Process Consultancy Model as one of the philosophical components of the model specifically states that '*when in doubt, share the problem*' (Schein, 1999). Based on the client's feedback, I spent time revising the plans to the existing training session, and set up a series of meetings with my co-facilitator in order to reduce the material that was to be covered. Following these meetings and the revision of the material, it was agreed that it was feasible to deliver the training within the three hour period, without compromising the overall quality of the training.

After the client had agreed the format and time of the training, the planning of the training was relatively straightforward. The process model of consultancy involves the individual within the consultancy process. The focus of process consultation is to build a relationship with the client (Schein, 1999). Furthermore it demonstrates to the client that they are responsible for the problem that seeks the consultancy (Schein, 1999). Through doing this, the consultant is able to understand the nature of the client's problem and devise the intervention alongside the client (Schein, 1999). The Expert Model of Consultancy suggests that the client is unable to provide the service for which they are seeking consultancy themselves, so they outsource an expert service from a consultant (Lee, 2002). As the intervention in this case was unable to be designed by the client themselves, I moved from the '*Process*' model to the '*Expert*' model of consultancy to research, design and deliver the training session in order to meet the client's requirements.

## ***Reflection***

Although I regularly train organisations on Mental Health Awareness through my role at ██████████ this particular training session was a bespoke design for the client, as the training session needed to cover many areas that are not normally covered within the generic training that ██████████ provide. Furthermore, the addition of new topics required me to carefully adjust the time in which certain material was delivered. This needed to occur without the quality of the training being compromised, which was a challenge.

## **Establish, develop and maintain working relationships with client**

The working relationship that was established between the client and I was conducted via email, telephone, and face-to-face meetings. As stated above, my previous relationship with the client was that of a colleague, who I had no prior working experience with. Therefore it was important for me to establish clear professional boundaries to ensure that the client remained confident in my ability to perform as an external consultant for his organisation. The nature of the consultancy was brief, as it required the delivery of one training session to the ██████████ team, with the possibility of a follow-up session if required by the client. Due to the straight-forward aspect of the process, there were no outward difficulties in conducting the consultancy. However, throughout the design and delivery of the consultancy, it became increasingly apparent that the client felt that his team were particularly negative towards NHS mental health services in the way they provide care for clients with substance misuse conditions. He suggested that the clients who were accessing mental health services had a negative view of IAPT services, and that as a result, his team were often apprehensive to refer someone with a suspected mental health condition to IAPT. The client had advised me to 'prepare for some tricky questions' which may arise concerning the relationship between substance misuse services and IAPT services, and the provisions they make for clients who require access to these services. This honesty allowed me to adequately prepare in advance, and signpost his team to the IAPT Positive Practice Guide for Working with People who use Drugs and Alcohol (2012), so that they were aware of the recommendations that are in place for their client group.

## Conduct Consultancy

The training programme was delivered on the 11<sup>th</sup> October 2013, and despite my initial concerns, the training was delivered on time and successfully. Client expectation needs and requirements were met through the Intermediate Client acting as a bridge between myself and the rest of his team.

## Evaluate the Impact of the Consultancy

I evaluated the impact of the consultancy through employing an evaluation form, which was handed out to participants who attended the training. The evaluation form evaluated the usefulness of the training session that was delivered, along with the effectiveness of the trainers who delivered the session. The evaluation forms measured knowledge of skills held before the training session, and skills held after the training session.

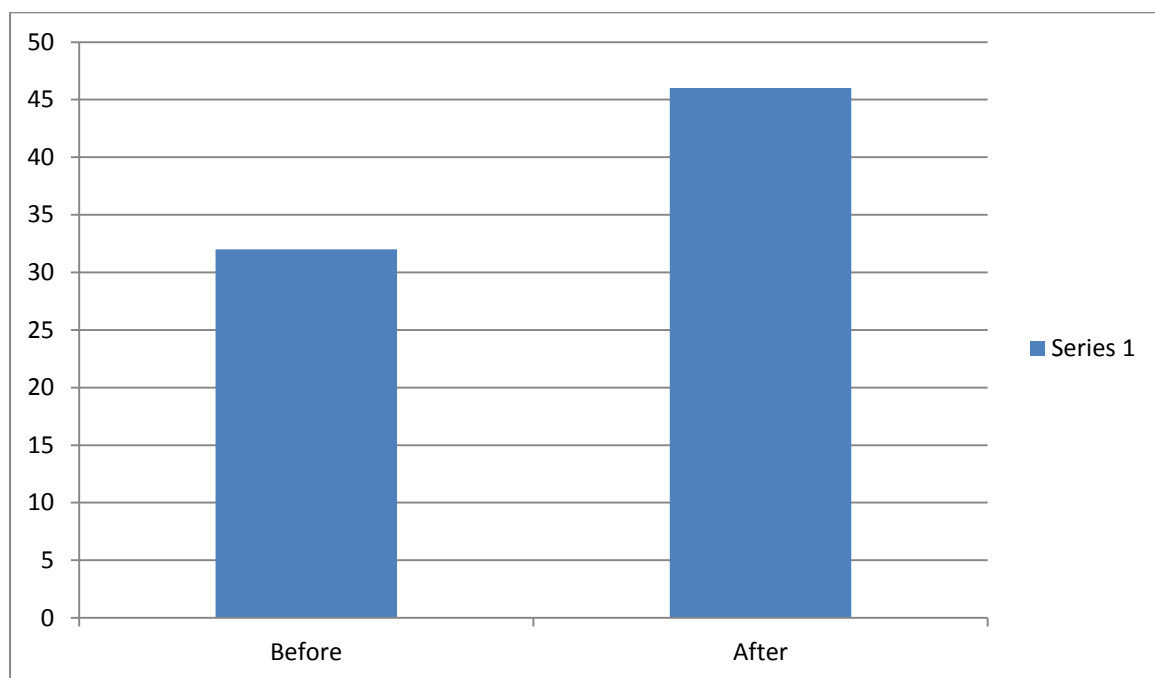


Figure 1.1 Graph showing subjective knowledge ratings before and after the training session

I additionally asked the client for overall feedback 1 week after the delivery of the session, to see how the training was received within the team overall. The training was evaluated positively, and the results indicated an increase in the health professionals' knowledge and skills on the areas that they were trained in.

## ***Reflection***

I feel that the positive evaluations received from the consultancy enabled the client to feel confident with the training that was delivered. It was at the final stages of the consultancy process that I started to feel more comfortable in my role as an external consultant. On a personal note, I feel that my progress can be noted from inception to completion of the consultancy. As this consultancy was a particularly smooth process, it enabled me to gain more confidence as the process went on, and has increased my skills as a Health Psychologist. In terms of my professional development, it has confirmed my assumption that in order to facilitate effective collaborative working, an initial strong foundation must be built for a working relationship to flourish. The client fed back after the training that the training met the needs of his team in full, and that a further follow-up session would not be required due to the thorough planning and implementation of the initial consultancy. It was agreed by between the client and I that I would be available to answer any questions should any arise in the future for his team.

## **Conclusions**

My experience of working as a consultant for this project was a positive one. I believe that I met challenges directly and asked for guidance and clarification from the client when required. All work was carried out to a highly professional standard (e.g., I ensured that meeting minutes were kept, and ensured that I had regular contact with the client throughout the consultancy process to ensure they were up to date on developments), and was completed on time, within cost and without compromising on quality. I feel that the real strength of this particular consultancy was my ability in forging a strong working relationship with the client, which enabled any potential issues to be ironed out without any real difficulty. As a result of the positive outcome of this consultancy, the client has arranged to organise another consultancy to reduce the amount of work-related stress within his team.

## References

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# Appendix 17 – Service Level Agreement

## Training on Mental Health Awareness for those with a substance misuse issue and a suspected Mental Health Condition/Mild to Moderate Mental Health Condition

**1. Who is the client?**

The [REDACTED]

**2. What is the question?**

To provide the [REDACTED] team with information on how to provide advice and support to someone with a suspected dual diagnosis. In addition, this training also aims to provide information on IAPT's guidance for providing treatment to someone with a substance misuse condition.

**3. What is the background and organisational context?**

Improving access to mental health services is a key Government objective, and as no specific services exist for those with a suspected dual diagnosis, collaborative working is encouraged by the Government and IAPT to ensure that the needs of this very specific client group are being met.

**4. Why has the client contacted you?**

[REDACTED] are familiar with the work that I have conducted through my role at [REDACTED] in training other individuals and organisations in Mental Health Awareness. Furthermore, [REDACTED] is additionally aware of my extensive knowledge in health psychology models. Models of effective communication and knowledge of the IAPT service in Surrey.

**5. What is the timeframe for the work?**

The expected timeframe for this work is between August – September 2013.

**6. Is the client realistic in terms of expectations of what you can achieve?**

Yes, the client expects that I will design, deliver and evaluate a training session for members of the [REDACTED] team in order for the team to meet the objectives, as identified above.

**7. What are the client's expected outcomes for this consultancy?**

The client's expected outcomes are as follows:

- a) An understanding of what Mental Health is and its application to their client group
- b) Mental Health Models utilised within IAPT treatment
- c) Models of effective Communication and how these can be applied
- d) How to identify someone in Emotional Distress
- e) How to support someone in Emotional Distress (including effective risk management)
- f) Signposting and further sources of support in Surrey

# Service Level Agreement - Consultancy

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## Service Level Agreement to provide Mental Health Awareness Training for [REDACTED] [REDACTED]

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Between Rhia Gohel

And

[REDACTED]  
(August – September 2013)

### 1. Parties to the Agreement

This agreement is made between:

Rhia Gohel and [REDACTED]  
Surrey.

### 2. Purpose of the Agreement

This agreement is to identify and provide [REDACTED] with the necessary skills required to provide their existing client group with short-term advice and support to someone experiencing emotional distress, or to someone who has a suspected mental health condition. This agreement additionally is to provide [REDACTED] with information on the IAPT process in Surrey, and further sources of signposting.

### 3. Agreement Period

This agreement will commence on 13<sup>th</sup> August 2013, and end on the 11<sup>th</sup> September 2013.

The contract will be terminated, without penalty, if [REDACTED] or the Contractor gives the other party 1 week notice in writing.

### 4. Terms and Fees

No payment is required as both organisations work under the Parent Organisation of [REDACTED].

### 5. Confidentiality/Data Protection

Any information that may be made available to the Contractor shall be held in the strictest confidence and shall not be divulged to any third party without the permission of [REDACTED].



## 6. Unsatisfactory Performance

In the event of the Contractor failing to provide a service to the reasonable satisfaction and expectations of [REDACTED] the problem area(s) will be identified and a corrective course of action will be agreed, within an appropriate timescale.

In the event of continuous failure of the Contractor to provide an acceptable service, [REDACTED] will be at liberty to review the whole agreement and serve Notice of Termination.

### Signed by the Contractor

Signed \_\_\_\_\_

Printed \_\_\_\_\_

Dated \_\_\_\_\_

### Signed for and on behalf of [REDACTED]

Signed \_\_\_\_\_

Printed \_\_\_\_\_

Dated \_\_\_\_\_

## Mental Health Awareness for Suspected Dual Diagnosis

This half-day training course has been developed as a result of the Consultancy project that was undertaken to provide members of the [REDACTED] team with the adequate skills, in order for them to feel sufficiently able to provide appropriate advice and support, and further sources of signposting to those with a suspected dual diagnosis.

### Aims:

- To introduce the key models of mental health therapy, communication, and health behaviour;
- To explore the application of these models to everyday interaction with clients;
- To understand the common signs and symptoms of emotional distress, and how to provide support to someone in emotional distress;
- To have knowledge of the IAPT guidelines for treating someone with a co-existing mental health and substance misuse condition;
- To have knowledge of further sources of signposting/information.

### Learning Outcomes:

- Participants are aware of the basic principles of Cognitive Behavioural Therapy and how this model is applied to treat someone with a mental health condition

- Participants learn the importance of effective communication, and various models of communication that encourage patient empowerment (such as Motivational Interviewing).
- Participants leave with a new set of skills that enhance the work they already carry out.
- Participants have increased confidence in providing advice and support to those with a suspected dual diagnosis, and are aware on how to effectively 'prepare' a client for possible interaction with an IAPT service in the future stages of their recovery.
- Participants are aware of the different agencies they are able to signpost clients to for further sources of support.

### **Training Delivery**

The training session will be delivered through utilising an interactive model, which will include a mixture of presentation-led material, interactive games, role-play, facilitated discussion, and small group work. The training will ensure to be as interactive as possible, and will cater for all learning styles.

### **Detailed Outline of Programme**

1. What is Mental Health in Surrey and how does this apply to your client group?
  - Introduction to Mental Health (quiz)
  - Mental Health in Surrey NHS
  - Statistics on Dual Diagnosis
  - Accessing Mental Health Services – IAPT
  - How to refer into IAPT
  - Measures of Mental Health and Emotional Distress (GAD-7 and PHQ-9; Work and Social Adjustment Scale) and challenges with using these measures
  - Limitations and parameters of Mental Health services.
2. Harm Reduction and Mental Health Models
  - Brief overview to Cognitive Behavioural Therapy
    - What it is, how it works, common techniques used
    - Core Beliefs
    - Challenging anxiety and fears of client (Amygdala and Graded Exposure)
    - Challenges of working within CBT
  - Transtheoretical (Stages of Change) Model
    - To be discussed from a Mental Health perspective – how does utilising this model for mental health cause potential challenges for a drug and alcohol service and vice versa?
    - Identifying the potential challenges that may raise between Substance Misuse services and Mental Health services
  - Models of Communication
    - Communication is a multi-way process
    - Motivational interviewing
    - Health Belief Model
    - Active Listening

- Empathy not Sympathy (where is the focus? Contemplation vs Action)
- Reflection and Paraphrasing (Exercise).

### 3. How to identify Emotional Distress/Mental Health Problem

- Common signs and symptoms of Emotional Distress/Mental Health Condition (Mental Health Awareness Game)
- What is required from you as a professional when working with someone who is experiencing emotional distress/mental health condition?

### 4. Helping Someone in Emotional Distress/Protocol

- Identifying Risk
- Questions used to identify risk
- How to manage disclosure of self-harm/suicide – who to report to
- What happens when I suspect risk?
- Self-Harm
- Protecting yourself – work stress, supervision.

### 5. Further Sources of Support

- Information
- Safeguarding Leads Information
- [REDACTED] Information
- Any Questions?

## The Trainer

**Rhia Gohel** has a clinical background in substance misuse and mental health, and a research background in identifying the meanings associated with substance misuse. She has been working within the Health Promotion field for the last 4 years.

## Qualifications

BSc (Hons.) Psychology

MSc Health Psychology

Trained to DANOS Standard for her role as a Volunteer Substance Misuse Advisor for [REDACTED]

*Currently undertaking her Doctorate in Health Psychology*

## **Unit 4: Teaching and Training**

### **1 hour training programme: pulmonary rehabilitation**

Within my role, I am required to deliver mental health promotion to members of the public concerning their emotional well-being and physical health. In August 2011, our organisation was approached by the pulmonary nurse specialist within Surrey Primary Care Trust (PCT) to deliver a session regarding the interaction of emotional well-being and physical health to patients suffering with breathlessness. On further discussion, it was found that an existing Pulmonary Rehabilitation programme was running within the East Surrey area. Considering the nature of acquired pulmonary conditions and my knowledge of the field of smoking and its related diseases, it was decided by my line manager that I would co-produce and co-facilitate the sessions alongside her. After delivering a pilot session and receiving positive evaluations from both the patients and pulmonary nurse specialist it was decided by the pulmonary rehabilitation team and our organisation to co-facilitate one pulmonary rehabilitation session in each rolling group which discussed the particular emotional difficulties that somebody with a pulmonary condition may face. I will describe how I contributed towards the planning, delivering and implementation of the one-hour rolling group session, and my experience of doing so.

### **Plan and design training programmes**

#### **Assessment of participants' needs**

Each rolling group had a total of 8-12 patients who had varying respiratory conditions, which resulted in them suffering from breathlessness. The pulmonary rehabilitation sessions initially focussed on managing symptoms of the breathlessness through using specific physical exercises. However, a need was identified by the lead nurse of the service for an introduction of an emotional well-being session which primarily focussed on using self-help CBT techniques to manage existing anxiety and low mood, and using these techniques to improve overall well-being. Further research was carried out by my line manager and me to ascertain the specific emotional needs that this group may have. Bandura's (1986) social-cognitive theory predicts that improvements in self-efficacy

will play a central role in the regulation of emotional well-being (e.g. affect, emotion, and mood) and other cognitions (e.g. judgements of life quality). To support this, Atkins, Kaplan, Timms, Reinsch and Lofback (1984) and Toshima, Blumberg, Ries and Kaplan (1992) found significant correlations between well-being and self-efficacy amongst patients with chronic obstructive pulmonary disease. Furthermore, Coventry (2009) found that a comprehensive pulmonary rehabilitation programme does effectively manage psychological morbidity in COPD. In order to combat mild to moderate levels of emotional distress and mental health conditions amongst this population, our session plan and design of the teaching group were based on focussing on role loss and role change, encouraging participants to strengthen '*protective factors*' (such as spending time regularly with family and friends, doing activities they enjoy, SMARTER goal setting) and using some self-help CBT exercises such as keeping thought/action diaries and using relaxation techniques to improve self-efficacy, which should have an overall improvement in emotional well-being. In addition, emotional well-being is often a subject which was not previously discussed within the pulmonary rehabilitation programme, so the session was designed to encourage participants to interact with one another to share stories of coping and tips and strategies to improve emotional function (Lox & Freehill, 1999).

### **Programme Structure and Content**

The session consisted of three main sections, namely a group discussion on why emotional well-being may be relevant to talk about in the context of pulmonary rehabilitation which encouraged participants to explore their perceptions of emotional well-being, common symptoms of stress, low mood and anxiety and the Cognitive 5-areas model (Garland, Fox and Williams, 2002; Williams & Garland, 2002a; Williams & Garland 2002b) and evidence-based techniques for reducing symptoms of stress, anxiety and low mood. The first three sessions were co-facilitated by my line manager and me. Every subsequent session was then alternated between my line manager and me. Please see Appendix 18 for a session plan.

### **Training approaches and methods**

The style in which I delivered the sessions in was that of a democratic facilitator (Exley & Dennick, 2004), which enabled me to intervene only to guide participants to keep

them focussed on discussing the subject matter, and allowed me to work in partnership with the participants to set objectives and activities which would be beneficial for improving their emotional well-being.

The first part of the session consisted of a 10 minute discussion around how a person's emotional well-being can be affected by their physical health, and vice versa. This discussion was mostly participant-led, but I intervened as the facilitator to guide the conversation around emotional well-being and distress and the impact that this can have on their physical health. I used a combination of both didactic and interactive teaching methods to encourage debate and discussion amongst the participants so that they were able to share their existing knowledge and were able to express any issues or difficulties they have faced when trying to manage their emotional well-being.

The training was delivered within a range of theoretical frameworks which included:

**Transtheoretical Model** (Prochaska & DiClemente, 1986): Assessing participants' stage of change with regards to initiating behaviour change

**Motivational Interviewing** (Miller & Rollnick, 2012): Exploring readiness to change behaviours concerning improving emotional well-being, exploring ambivalence about change and any obstacles or barriers the participant may face, and using motivational interviewing to deliver the session through a client-centred approach

**The Health Belief Model** (Rosenstock, 1966): In delivering the presentation – perceived susceptibility/severity of emotional distress associated with a reduction of 'protective factors' which encourage emotional well-being, and perceived benefits of increasing '*protective factors*' to reduce stress, anxiety and low mood.

**Self-Efficacy Theory** (Bandura, 1984): Assisting in building self-efficacy beliefs of participants that role change does not surmount to role loss, and previous activities that were once enjoyed can still be done, but with necessary adaptations.

## **Materials Used**

Flipchart paper

Flipchart Pens

Handout/Participant Sheet (Appendix 19)

██████████ emotional advice and information leaflets.

## **Delivery of the sessions**

### **General**

Since the inception of ██████████ involvement of the pulmonary rehabilitation programme, I have delivered over 10 workshops. These workshops have varied in terms of participant receptiveness, willing to change their behaviours, and group involvement.

### **What Worked Well**

The session was run as part of an existing Pulmonary Rehabilitation programme and we were invited to attend for a one hour session on the 7<sup>th</sup> week of an 8 week rolling-group. This meant that participants' had time to get to know one another personally, and therefore were more comfortable with discussing their personal emotional difficulties or challenges than if we had been invited on the first week. It is unfortunate that there is much stigma and discrimination that surrounds mental ill-health, and thus I felt that providing this session on one of the latter weeks for participants went in my favour as it enabled for discussions to be had which would have been otherwise difficult if participants' had not had the chance to get to know one another.

Facilitating the session with a democratic facilitator style also worked very well as it allowed participants to talk about real subject matters which affected them, and it was found that other participants within the group often shared their experiences, tips and techniques with overcoming difficulties that other participants expressed. For example, one participant stated that she often felt anxious when the telephone rang as it took her a long time to get to the telephone and she felt like she had to rush to answer it. This resulted in her becoming breathless, which had a real impact on her condition. Another participant expressed that to avoid that situation, they simply carry the telephone around with them in the house wherever they go. By standing back as the facilitator and

allowing for debate and discussion, the shared strategies that were brought up by other participants encouraged feelings of self-efficacy within the group.

### **Training Challenges**

An initial challenge of the session was time-keeping within the one-hour time slot that was provided. As the session was essentially *'piggy-backing'* on to another already developed session as part of the Rehabilitation programme, sometimes I was given less time to deliver my part of the session as the previous part had over-run. This meant that during some sessions I found that I had to rush through the content so that it would all be covered, which understandably was reflected in the feedback. As the session was created from scratch, I was unsure as to how long the session would take to deliver. In addition, and on delivering the session more frequently, I found that some sessions ran quicker than other sessions. This is primarily because the session format and style of delivery was decided to be delivered in a democratic facilitator led style, and thus depended on the *'chatty-ness'* of the audience concerned. At times, I did find that I needed to speed up the delivery of parts of the session in order to finish on time.

### **Assessing Learning Outcomes**

Learning outcomes were assessed by an evaluation form which was handed out to participants at the end of the session. A specific question measuring learning outcomes was asked, namely *'Have you learnt anything new from today's session?'* Out of 36 attendees for the sessions I co-facilitated/facilitated, it has been found that 2 person rated 1 (nothing), 1 participants have rated 2 (somewhat), 20 participants have rated 3 (a little), 9 participants have rated 4 (a fair amount) and 4 participants have rated 5 (Lots).

Participants have fed back the following comments:

- Speaker very friendly, the book and handout given were very detailed;
- I have learnt how to manage stress differently;
- The session makes you think about stress;
- I liked most of the talk;
- Not to put so much pressure on myself to do things;
- Speaker needs to speak clearer and louder, difficult to follow at times!
- Needs more time to allow group to feel involved.



## **Planning and Implementation of Assessment Procedures**

As this workshop was evaluated based on the evaluation feedback, sessions were modified and altered by myself and my line manager as the sessions went on. This occurred on a monthly basis. On the first session, we received many comments about running over time, this was taken into consideration when planning for the next session, and we reduced the amount of material that was delivered. I also received feedback from a session to '*cut writing out on the board*' as they were given a paper copy of the session anyway. I suggested to my line manager that instead of cutting out the writing on the board, perhaps the handout should be given after the end of the session, to compliment as many learning styles as we can.

## **Evaluate Such Training Programmes**

The delivered training was evaluated through a formal evaluation form which asked participants to rate whether they would recommend the session to a friend, whether they felt they had learnt anything new from the session, and how they found the style and format of the session. Participants were also encouraged to express their favourite part of the session and whether they think any improvements could be made to the session. Finally, participants were asked if they would do anything differently as a result of their session. It was found that participants had enjoyed the session overall, and would increase efforts to change their current behaviour to improve their emotional well-being. Please see Appendix 20 and 21 for the questions asked on the evaluation and the results.

## **Conclusion**

To summarise, I found the delivery of the pulmonary rehabilitation session challenging as this was the first time I had worked with a group of clients who had a debilitating physical health condition to facilitate emotional health-behaviour change. Nevertheless, I found this session personally rewarding as I felt a real sense of achievement in facilitating the participants to '*think out of the box*' to encourage their learning. I believe that the aims and objectives were met and that the sessions were well received by the participants.

Having reflected upon the delivery of the workshop, I would make the following amendments to improve the sessions in the future:

- Ask the facilitator of the Pulmonary Rehabilitation Programme for more time within the rolling programme to develop a more comprehensive session which would look at utilising thought and activity diaries to improve emotional well-being;
- Conduct a focus group prior to the implementation of the sessions to find out what Pulmonary Rehabilitation patients would like to see discussed and taught in an emotional well-being session.

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## **Case Study 2: Drug and Alcohol Awareness**

My current role involves delivering mental health promotion/development training to a wide range of professionals including those working within healthcare, mental health, and social care programmes. In April and May 2010 I attended a 7 day training session which trained me to DANOS (Drugs and Alcohol National Occupational Standards) standards. This training was facilitated through [REDACTED] a Surrey charity that provides telephone support, advice, information, guidance, telephone counselling and referrals into the relevant drug and alcohol services within a person's local area, should they so require it. I have been volunteering for this charity and have been working as a telephone advisor since May 2010. The aims of this case study are to describe how I planned, designed and delivered a half-day training course, and my experience of doing so.

### **Context**

The Drugs and Alcohol awareness training was designed by myself to provide the opportunity for staff working within the [REDACTED] team (who all work within advisory and information-giving roles) to increase their knowledge base on drugs and alcohol, and to enhance their communication skills and learn new skills for working with this specific clientele and facilitating behaviour change. The training took place at Woking Community Hospital, Surrey in May 2012.

### **Plan and Design Training Programmes**

#### ***Assess Training Needs***

A formal training request was raised by the Team Lead of [REDACTED] who had identified a gap in knowledge concerning drug and alcohol effects and use; initiating behaviour change and appropriate signposting information for this clientele.

In addition, a formal needs assessment was carried out by asking all staff members who had signed up to attend the training to fill out a needs assessment form, so that the training could be designed appropriately with the staff members' specific needs in mind. From this needs assessment it was found that staff members had little or no knowledge on harm minimisation techniques, and also had little or no information on how to communicate effectively with this clientele. Both the needs of the Team Lead as well as

the results of the needs assessment were amalgamated and incorporated into the design of the training.

Six participants attended the training programme: 2 Team Lead's, 1 Specialist Mental Health Advisor, 2 Mental Health Advisors and 1 Assistant Mental Health Advisor. All of the participants worked for ██████████ which is a mental health promotion service tiered at levels 0-1 of the National IAPT (Improving Access to Psychological Therapies) programme. Participants' were asked if they had received any formal training in Drugs and Alcohol prior to the course starting; one member of staff said they had, but that this training was delivered over 10 years ago. Within the needs assessment carried out prior to the training, participants were asked to fill out a series of questions on how important they felt a specific area of training was in relation to their work responsibilities and how confident they felt in carrying out or delivering the activity mentioned. This enabled me to identify what training gaps there were within the team, so that these areas could be focussed upon within the training. The information provided within the learning needs analysis also provided me with useful information to plan the format of the training. The full breakdown of the questions asked and the format of the learning needs analysis is available within Appendix 22.

I provided participants with information about my background and why I was qualified to deliver the training session they were about to receive. To gain an insight into the knowledge base of the participants, I designed the opening exercise to encourage participants to share their already held knowledge about drugs and alcohol use/misuse. This consisted of asking all participants to choose a laminated card from a set at random, which all had a different picture of a recreational drug on them. Participants were asked to identify the drug and how the drug is consumed, state how it makes a user feel, two psychological effects of consuming the drug, two physiological effects of consuming the drug, and two risk factors which may present themselves whilst consuming the drug. This exercise was also designed to re-confirm what the participants had initially stated within their learning needs analysis, and to serve as a self-assessment for their own learning needs. Following this exercise, the training objectives which were listed by participants on the learning needs analysis were written up on the wall so that participants could see if their needs were met by the

training provided. This activity was conducted so that participants felt proactive within the training approach and could form their own learning contract.

### **Programme Structure and Content**

As this was the first time I had delivered the training, I had planned with some flexibility of time, as I was unsure when questions would be asked, or when a specific part of the training would provoke questioning. In my planning I was mindful of the exercises and tasks I had given the participants, for example their complexity, timing, and concentration requirements. Within the training I also utilised various forms of media to ensure that I was not delivering a passive training session, but a proactive one where participants were encouraged to ask questions as and when they felt necessary to ensure that their aims and objectives were met. The main components of the training included what is a drug, why individuals choose to use, initiating behaviour change, communicating with those under the influence, harm minimisation, and signposting information for local organisations.

### **Training Approaches and Methods**

The training was delivered in an informal style, to make the participants feel relaxed and at ease to ask questions if needed. I aimed to deliver the training within a learner centred model (Exley & Dennick, 2004). This model emphasises the importance of valuing the experiences that the participants bring to the training and working alongside them to enhance their collaborative learning. In accordance with this model, I ensured that I did no more than 50% of the talking and ensured that the participant had an active role in the training process. Participants were encouraged to be directly involved within their learning and were given opportunities to apply their learning through case studies and role plays. Participants also received immediate feedback on their application opportunities. In addition, participants' experiences were valued and used as examples to make the training relevant towards their role.

The training was delivered using a variety of methods, both interactive and didactic, to cater for the difference in learning styles identified within the learning styles questionnaire handed out for participants to fill in prior to the training. This included delivering information through small group exercises, facilitator-led role play demonstrations, brief video and audio clips describing personal experiences of

recreational and addicted users, and *'what if'* scenarios which facilitated group discussion. The training was structured and designed to ensure that it was interactive, and also delivered in a relaxed informal style so that participants felt that they were able to ask questions as they went along. In addition, I ensured that a break was given in the middle of the training, and ensured that the training was *'broken-up'* by placing the above learning activities amongst delivering information on the slides. Time was provided at the end to ensure that participants were able to de-brief after the training was delivered.

### **Materials Used**

- Laptop and projector
- Flipchart paper
- Flipchart pens
- Handouts
- Pens
- Video and audio footage
- *'Drug Game'* cards
- Leaflets of local drug and alcohol services (which were scattered in the middle of the table)
- Health promotion leaflets about drugs and alcohol (which were scattered in the middle of the table)
- Evaluation forms.

### **Delivery of training programme**

#### **General**

This training session was specifically designed for the [REDACTED] team to increase their knowledge and understanding of drugs and alcohol, and their communication with this specific population. As a result, this was a one-off training session. I was fairly confident about delivering the training session, however had some initial concerns regarding timekeeping (in particular, whether the training session would suffice for 2 and a half hours or whether I would go under or over the time allocated) and the size of the group (specifically concerning group dynamics). Typically, my training groups consist of

approximately 15-30 participants. Nevertheless, having a small training group held its advantages, and participants were given more time to discuss parts of the training in more depth, and were also provided with more time to provide examples of their own experience working within the subject matter.

### **Training challenges**

A personal major challenge was that I was training a team who I work closely alongside with on a daily basis. I am unfamiliar in training colleagues who I have a close working relationship with, and this did make me feel more nervous than usual when delivering my training. I combated this nervousness by using relaxation techniques such as focussing on my breathing to ensure that my nerves passed. I also ensured that I was very well prepared, and practiced my presentation beforehand to ensure that I was familiar with the content.

Another challenge was that a member of staff who had worked within the drugs and alcohol field over 10 years ago attended the training. Within the needs assessment carried out prior to the training session, I did note that this particular participant had much greater knowledge than the other participants. However, I was instructed by my manager to develop a training session that would bring the team up to an '*equal standard*', which resulted in me having to include some information which this participant would have held prior knowledge over. Nevertheless, I felt that this was ok to do as this participant had specifically stated within their learning needs assessment that they were attending the training as a refresher session. At times, I did feel as if this particular participant was receiving the training in a negative fashion. I felt that the participant would often question my knowledge about what I was delivering, and that the questioning was conducted in a manner which felt like I was being interrogated. Other members of the training also noted this, and raised these issues with me after the end of the training session. During the break, I heard from another participant that this particular participant was talking about how my training was not suitable to deliver for the team, and this resulted in me feeling even more nervous and apprehensive about delivering the rest of my training session. However, I changed the focus of my training session from that point onwards to explicitly point out how what was being delivered was relevant for the team. I also provided this participant with a platform to raise any



issues with the training with myself so that I could address them, (Heron, 1999). Furthermore, evaluation and feedback forms were handed out at the end of the training session to ensure that participants were able to provide a critique of the delivered session. To ensure that this does not occur again, I will discuss with my manager the specific training needs of every member of the team, and if some team members are already adequately trained in the area, I will recommend that those participants do not attend the training session.

### **Assessing Learning Outcomes**

I felt that it was particularly valuable to test participant's prior and obtained knowledge from the training session alongside the training being delivered. I did not feel that it would be productive to put together a formal assessment of learning as I felt that this may have resulted in participant's feeling like they were required and forced to listen. Therefore, at the end of every exercise, an informal environment was created whereby participants were asked to reflect what they had learnt from conducting the exercise and what they will adopt within their roles. In addition, within the evaluation forms, participants were asked to reflect on how useful the specific methods used to deliver the training were on a scale of 1 to 5.

### **Managing questions**

As the group that the training was being delivered to was relatively small, questions were answered as and when they arose. Participants were actively encouraged to ask questions as and when they felt the need to. If questions were asked that would be answered later on in the course, they were noted down on a piece of flipchart paper which was positioned on the wall, and were referred to when the appropriate time arose. This ensured that the questions were not being forgotten, and also ensured that the questions would be returned to at a later stage. When the group discussion role-play was conducted, the facilitator asked questions to the participants creating '*what if*' scenarios. This encouraged participants to think outside of the box, so that they were able to put their training into use. Positive reinforcement and alternative suggestions were offered to the participants to demonstrate that there may be many different pathways to tackling a problem, and to improve participants acquired skills. Positive

reinforcements were given alongside suggestions to ensure that participants' learning was facilitated in a supported learning atmosphere.

### **Planning and implementation of assessment procedure**

The training was evaluated informally using an evaluation questionnaire for which a 15 minute time slot was allocated. A further 5 minute slot after this was also allocated if participants had a specific question that they wanted to ask myself privately.

Participants were asked 10 simple questions to rate the efficacy of the training objectives, the style and format of the session, the usefulness of the training objectives, the usefulness of the various media used to learn and test knowledge, the pace and content of the training, and the training style of the presenter. In addition, participants were asked what their main reasons were for attending the training. Participants were asked to write their names on the evaluation sheet if they wanted to, but they were not required to.

### **Evaluation of training programme**

The training was evaluated using the training evaluation forms that I developed, which resulted in a small-scale evaluation report. Feedback was also obtained from my workplace supervisor of how the training programme went. In addition, self-reflection was also utilised as an evaluation tool.

### **Conclusion**

Having reflected upon my practice, I will make some changes to improve further training:

- Add a confidence self-rating scale to be conducted prior to, and directly after the training to note a more accurate measure of learned skills;
- Add a section to record the rationale behind why participants gave themselves the following ratings;
- Ensure appropriate discussions were conducted with the necessary parties to exclude those with a high level of knowledge from the training sessions if appropriate.

I thoroughly enjoyed delivering this training session and would like to improve my skills on delivering training to those who work within the area of health behaviour change. Overall, I was pleased with the training session, format and style, and felt that the content and structure were appropriate and well received. I also received positive feedback on the evaluation report and from my workplace supervisor.

## References

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# Appendix 18: Session plan – Pulmonary rehabilitation

## Pulmonary Rehabilitation Session Plan

**Introduction** – Introduction to [REDACTED]

**Group discussion:** Why do you think it's relevant to talk about emotional well-being in the context of pulmonary rehabilitation?

E.g. stress, anxiety and breathlessness, role loss, feeling vulnerable, feeling like life is not fair, feeling disempowered.

*(Facilitator to provide information to the patients that we are aware of how long term health conditions can have an impact on physical health).*

- Emotional well-being and mental health concerns are major health issues in their own right. But they can also greatly affect physical health. On the other hand, your physical health condition can also have a great impact on your emotional wellbeing and overall mental health (e.g. anxiety and depression).
- **Example:** breathlessness can be linked to frustration, panic and stress, which increases sensations of breathlessness – it can become a vicious circle.

### Symptoms of Stress and Anxiety

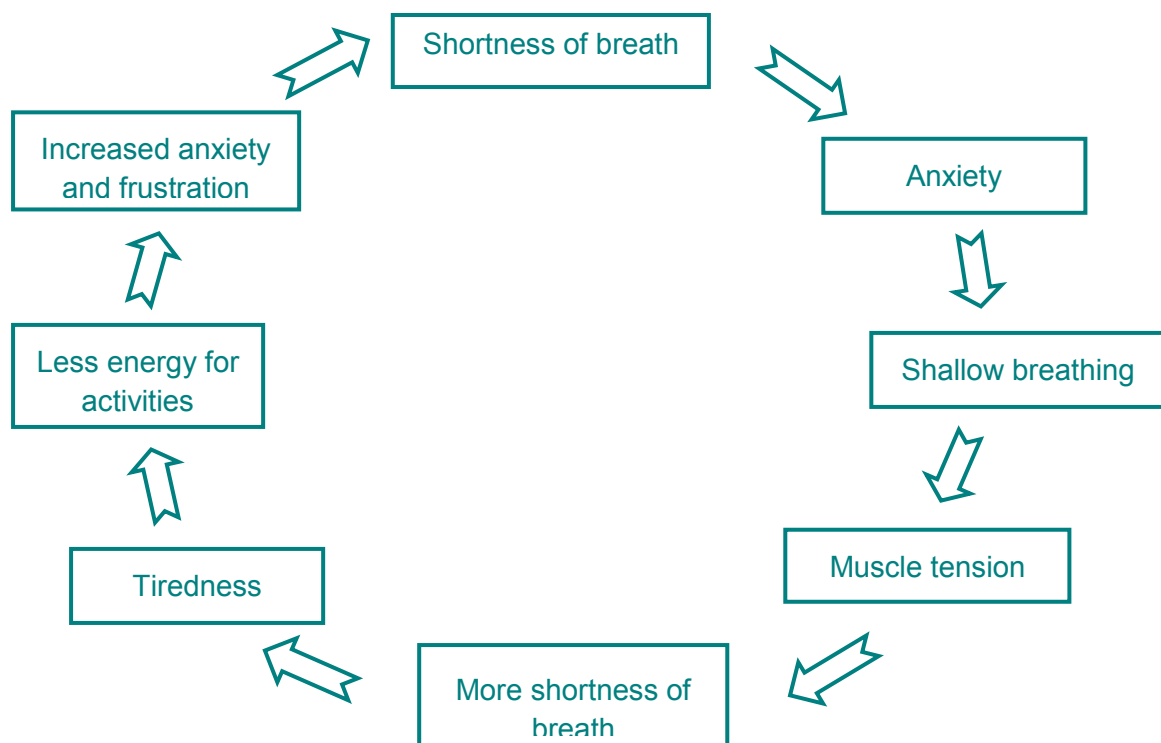
How would you recognise your symptoms of stress and anxiety?

- What physical symptoms do you experience?
- How does your thinking affect you?
- What sort of behaviours do you notice?

Stress and anxiety can impact on our lives, and can result in:

- difficulty concentrating / muddled thinking
- increased forgetfulness
- short temper
- feeling overwhelmed
- getting frustrated and picking fights with others
- seeing only the negative
- constant worry
- headaches
- breathlessness
- not being able to do the things that you used to do

People who have breathing problems often find themselves in a cycle where the symptoms of lung disease interact with the symptoms of anxiety and stress:

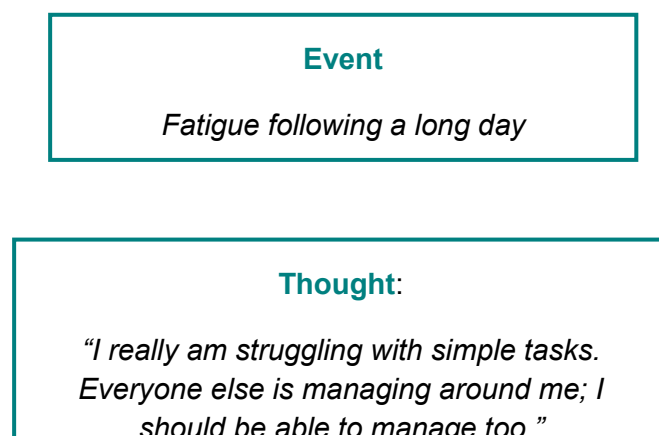


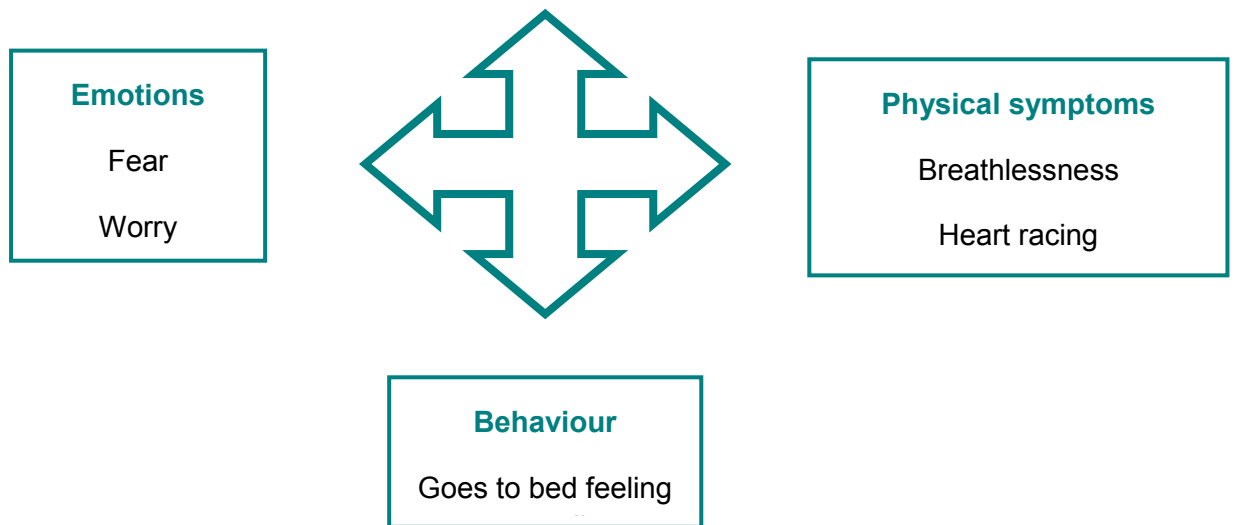
BUT there is something we can do about this. Finding/developing new roles, as well as adapting, is an important part of making the most of your life.

**Stress Jug** – draw the analogy of the stress jug and explain how we all have a capacity for a certain amount of stress in our lives, and that it is important to reduce the amount of stress so that we are able to keep emotionally well.

### Your thoughts, your emotions, your body and your behaviours

How can we go about identifying where our stress, anxiety and low mood comes from?





**How is this going to impact the person?**

**Where could we break this cycle and increase the chance of a more positive outcome?**

### **Secrets of Everyday Emotional Well-being**

Just as achieving physical fitness takes time, practice and commitment, so too does achieving mental fitness. There are 3 basic principles in obtaining emotional wellbeing: the first is to **maximise the things that make you feel good, and minimise the things that make you feel bad**; second is **valuing yourself**; and third is to **recognise that you can change**.

Some feel good factors include:

- making time for relaxation
- being able to express your feelings
- having achievable goals to aim for
- making time for the things you enjoy
- maintaining a healthy diet
- work you find rewarding (if you are still working)
- time to yourself, to do the things that interest you
- time for friends and family.

Some things to minimise:

- unnecessary stress
- feelings of rage or frustration
- expecting too much of yourself and negative thoughts and feelings

## Self-Management Skills

- Take care of health problems
- Carry on doing normal activities
- Manage emotional changes.

## Roles

Throughout life, we are required to carry out many different roles. For example, you may be required to be a mother or a father, a brother or a sister, a specific role at work. Perhaps you have a role within your local community; perhaps you are a part of a sports team or another club. However, when you develop a chronic illness such as lung disease, you may find that you are unable to do the things that you once were able to do within your roles – *does anyone have any experience of this?*

Because of your condition, you may notice that the roles you once had have been changed. However, it might be about adapting these roles to suit your current situation.

**Example:** we know of a woman who was a keen gardener, but as a result of her COPD found it difficult to maintain her garden in the way that she wished. She was able to arrange for a neighbour to mow her lawn and instead of planting flowers in the garden, she designed many window boxes and plant pots. This added colour to her garden and allowed her to carry on enjoying her hobby.

Has anyone got an example of their own that they would be happy to share?

## Action Plans

Some people find it useful to set themselves an action plan, e.g.

- Something you want to do
- Is it achievable?
- Make it action specific (how will you do what you do?).

Make sure any goal setting that you do is:

**S**pecific  
**M**eaningful  
**A**chievable  
**R**ealistic  
**T**imely

And make sure to:

**E**valuate  
**R**edo



## Appendix 19: Handout/participant sheet – Pulmonary Rehabilitation

### How your Physical Health can Impact on your Emotional Well-being

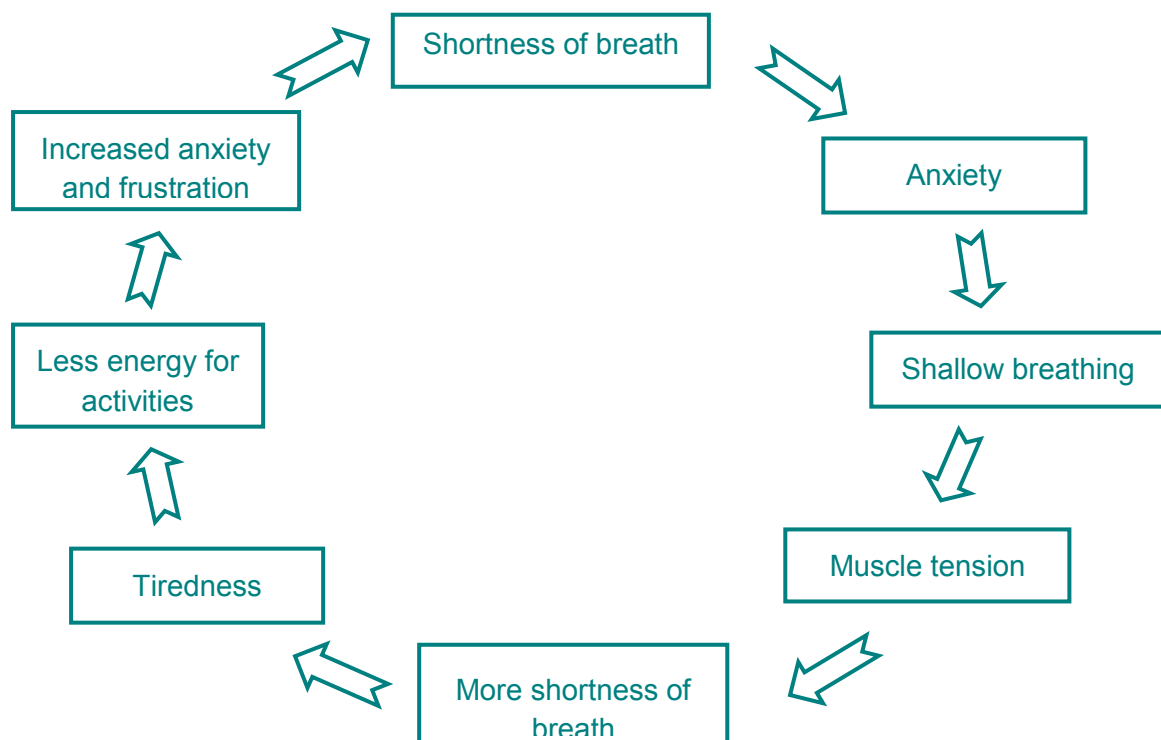
Emotional well-being and mental health concerns are major health issues in their own right. But they can also greatly affect physical health. On the other hand, your physical health condition can also have a great impact on your emotional wellbeing and overall mental health.

### Symptoms of Stress and Anxiety

Stress and anxiety can impact on our lives, and can result in:

- difficulty concentrating / muddled thinking
- increased forgetfulness
- short temper
- feeling overwhelmed
- getting frustrated and picking fights with others
- seeing only the negative
- constant worry
- headaches
- breathlessness
- not being able to do the things that you used to do.

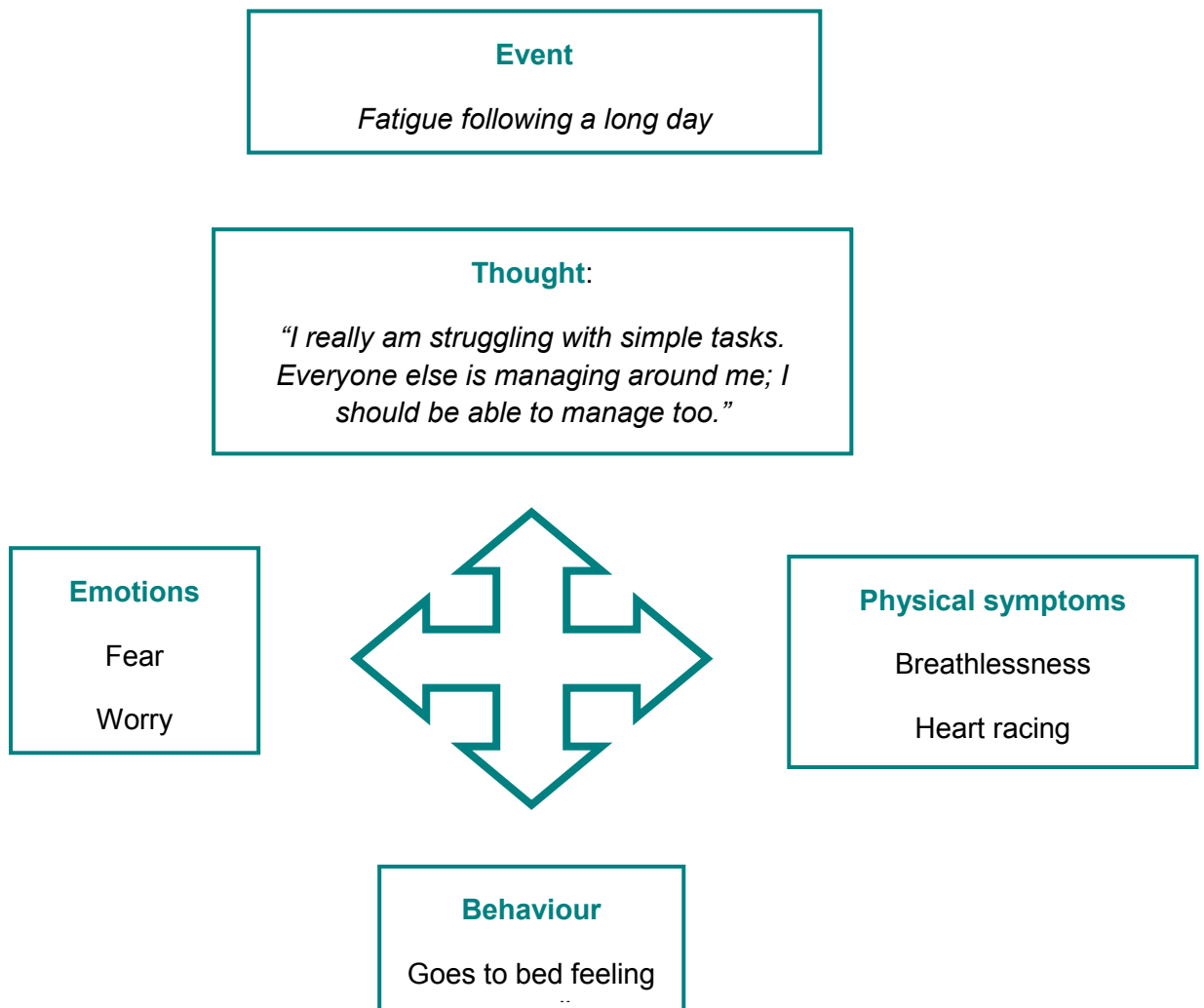
People who have breathing problems often find themselves in a cycle where the symptoms of lung disease interact with the symptoms of anxiety and stress:



BUT there is something we can do about this. Finding/developing new roles, as well as adapting, is an important part of making the most of your life.

### Your thoughts, your emotions, your body and your behaviours

How can we go about identifying where our stress, anxiety and low mood comes from?



How is this going to impact the person?

Where could we break this cycle and increase the chance of a more positive outcome?

## Secrets of Everyday Emotional Well-being

Just as achieving physical fitness takes time, practice and commitment, so too does achieving mental fitness. There are 3 basic principles in obtaining emotional wellbeing: the first is to **maximise the things that make you feel good, and minimise the things that make you feel bad**; second is **valuing yourself**; and third is to **recognise that you can change**.

Some feel good factors include:

- making time for relaxation
- being able to express your feelings
- having achievable goals to aim for
- making time for the things you enjoy
- maintaining a healthy diet
- work you find rewarding (if you are still working)
- time to yourself, to do the things that interest you
- time for friends and family.

Some things to minimise:

- unnecessary stress
- feelings of rage or frustration
- expecting too much of yourself and negative thoughts and feelings.

### Self-Management Skills

- Take care of health problems
- Carry on doing normal activities
- Manage emotional changes.

## Roles

Throughout life, we are required to carry out many different roles. For example, you may be required to be a mother or a father, a brother or a sister, a specific role at work. Perhaps you have a role within your local community; perhaps you are a part of a sports team or another club. However, when you develop a chronic illness such as lung disease, you may find that you are unable to do the things that you once were able to do within your roles – *does anyone have any experience of this?*

Because of your condition, you may notice that the roles you once had have been changed. However, it might be about adapting these roles to suit your current situation.

**Example:** we know of a woman who was a keen gardener, but as a result of her COPD found it difficult to maintain her garden in the way that she wished. She was able to arrange for a neighbour to mow her lawn and instead of planting flowers in the garden, she designed many window boxes and plant pots. This added colour to her garden and allowed her to carry on enjoying her hobby.

## Action Plans

Some people find it useful to set themselves an action plan, e.g.

- Something you want to do
- Is it achievable?
- Make it action specific (how will you do what you do?).

Make sure any goal setting that you do is:

Specific  
Meaningful  
Achievable  
Realistic  
Timely

And make sure to:

Evaluate  
Redo

**This Information has been provided by [REDACTED]. If you would like to contact us regarding additional support, please call [REDACTED] on Tuesdays and Wednesdays 12pm - 4pm, and Thursdays 2pm - 6pm. Alternatively, please email us on [REDACTED]**

## Appendix 20: Evaluation



# Pulmonary Rehabilitation

Date ...../...../.....

We would greatly appreciate your comments to help improve future sessions. Please feel free to make comments in the spaces provided below.

*Would you recommend this session to a friend?*

Not at all		Somewhat		Very
1	2	3	4	5
2		15	11	7

*Have you learnt anything new from this session?*

Nothing		A Little		Lots
1	2	3	4	5
2	1	20	9	4

*How did you find the style and format of today's session?*

Didn't like it		Neutral		Liked it a lot
1	2	3	4	5
2		14	16	4

*What was your favourite part of this session?*

- Just listening to advice
- Don't know
- Stress
- Strategies to manage anxiety/stress
- Joint discussion
- Very well explained
- Being able to ask questions face to face with someone
- Realising that help is at hand if needed

Knowing about it  
Stress

**Asked for input**

Talking about stress etc

Most of the talk  
Makes you think about stress  
Emotional well-being

speaker very friendly, the book and handout given was very  
detailed  
dealing with anxiety  
anxiety  
Story examples

***Are there any improvements you think we can make to this session?***

Table for the board  
needs to speak a bit clearer and louder, difficult to follow at times  
needs more time to allow group to feel involved  
not really  
Cut out writing on board - we have a copy anyway!

***As a result of today's session, is there anything you may do differently in future?***

## Appendix 21: Evaluation Report

### 1. Main reasons for taking part in training

It is part of CPD

To refresh knowledge and skills

To improve how I work with clients

I was asked to take part by my manager

To learn new knowledge and skills

### 2. How do you feel the following training objectives were met? (1= Not Met, 5 = Fully Met)

	1	2	3	4	5
Developing an understanding of what different drugs and alcohol are, their effects, and the risks of taking them				2	4
Understanding the various reasons why people use		1		1	4
Understanding the difference between recreational use and addiction			1	1	4
Developing an understanding of the models of behaviour associated with drug/alcohol use			2	2	2
Initiating behaviour change ' <i>planting the seed</i> '				3	3
Communicating with those under the influence			3	1	2
Understanding the concept of harm minimisation and basic harm minimisation techniques					6
Having further information of other organisations to signpost those who need more information/support Surreywide				1	5

### 3. How did you find the style and format of today's session? (1= very bad, 5=very good)

4 participants responded with a 5

2 participants responded with a 4

**4. How useful were the following training objectives to you? (1= not useful at all, 5= extremely useful)**

	1	2	3	4	5
Developing an understanding of what different drugs and alcohol are, their effects, and the risks of taking them		1		2	3
Understanding the various reasons why people use			1		5
Understanding the difference between recreational use and addiction			2	2	2
Developing an understanding of the models of behaviour associated with drug/alcohol use			1	2	3
Initiating behaviour change ' <i>planting the seed</i> '			2		4
Communicating with those under the influence			3	1	2
Understanding the concept of harm minimisation and basic harm minimisation techniques		1		2	3
Having further information of other organisations to signpost those who need more information/support Surreywide					6

**5. How useful did you find the following to help you learn and test your knowledge? (1= not at all useful, 5= very useful)**

	1	2	3	4	5
PowerPoint slides				2	4
Videos				4	2
Real life scenarios			2	2	2
Game			2	1	3
Handouts				2	4

**6. How did you find the pace of the training? (1= very poor, 5= very good)**

3 participants rated this as a 4

3 participants rated this as a 5

**7. How did you find the content of the training? (E.g. amount and difficulty) (1= very poor, 5= very good)**

1 participant rated this as a 3

2 participants rated this as a 4

3 participants rated this as a 5



**8. Please rate your trainer in the following areas: (1= very poor, 5 = very good)**

	1	2	3	4	5
Knowledge of the subject					
Creating interest in the subject					
Relating the training to your job role					
Understanding your needs					
Responding to questions					

**9. Would you recommend this training to other colleagues?**

All participants stated yes.

**10. Any further comments?**

Excellent training. Feel a greater understanding of the subject. Feel more confident in knowledge of area and delivery to others.

Very interesting and informative but would have been good to link more to our service and our roles.

Rhia presented very well, clear and professionally.

Very informative, covering all topics thoroughly. The presenter had excellent skills, and answered all questions really well. Thank you!

Useful refresher and good to understand more about Surrey-specific services.

## Appendix 22: Learning Needs Analysis

### Learning Needs Analysis – Drugs and Alcohol Training

Consider each item in the list below and then tick the appropriate columns to indicate:

- The importance of each activity within your work responsibilities (i.e. is this a significant part of your role?)
- How confident you feel in carrying out the activities: (is this an area in which you would benefit from further developing your knowledge, skills and understanding?)

	How important is this in your role?			How would you rate your confidence in this area?		
	Very Important	Fairly Important	Not Important	Very Confident	Fairly Confident	Not Confident
An understanding of the different types of drugs and alcohol that are used		4	1	1	4	
An understanding of the effects that different drugs and alcohol can have on a person	1	4			5	
The reasons why people use and misuse substances	3	2		2	3	
A look how drugs and alcohol use impacts the wider society	2	2	1	1	4	
Drug/alcohol use, different age groups and their specific needs	1	4			4	1
Mental Health and substance use/misuse	4	1		1	4	
Helping address problems and needs of users	3	2		1	3	1
Working within appropriate legal frameworks	1	4			4	1

#### What are your main learning objectives from this training?

To be able to have discussions in an appropriate way without sounding authoritarian.

Good understanding of the subject, and ways to help address needs of user.

To gain a better understanding of the above areas and to feel confident in giving advice and signposting clients within current job role.

A refresher.

Refresh Prior Knowledge.

**Is there anything in particular that you would like to see covered within this training? If so, what?**

Success stories – why certain things have worked well.

Self-help support and support groups available and what they do.

Nothing more than the above

# Unit 5.1 Implementing Interventions to Change Health-Related Behaviour

## Theoretical Background

Sleep disturbance is perhaps one of the most prevalent complaints of patients with chronically painful conditions (Latham & Davis). Dysfunctional sleep and chronic pain are two major, yet unmet, public health challenges with an enormous societal cost (Daley, Morin, LeBlanc, Gregoire & Savard, 2009; Latham & Davis, 1994). Sleep disturbances are shown to be prevalent in 50-89 per cent (Marty, Rozenberg, Duplan, Thomas, Duquesnoy et al., 2008; McCracken & Iverson, 2002; Tang, Wright & Salkovskis, 2007) or more (Rohrbeck, Jordan & Croft, 2007; Theadom, Cropley & Humphrey, 2007) patients with chronic pain. The relationship between clinical pain and insomnia has been shown to be reciprocal and that using Cognitive Behavioural Therapy (CBT) to manage pain and secondary insomnia is effective as an intervention to reduce pain and improve sleep quality (Smith & Haythornthwaite, 2004).

Some medications used to treat insomnia and/or pain may cause further sleep disturbances or pain problems. For example, some over the counter medications aimed for inducing sleep can cause side effects which cause discomfort and pain for the user (such as diphenhydramine which has a side-effect of causing restless legs in users). Those who experience persistent pain are sometimes left feeling frustrated with their pharmacological medication not fully meeting their needs, and thus are unable to sleep due to the pain they are in. Those with chronic pain are also sometimes limited in the type of medication and the amount of medication that they are able to take as many medication side effects can result in drowsiness or other unwanted side-effects that affect day-to-day functioning. These issues result in patients having an overall reduced quality in life as they are unable to get to sleep, maintain sleep, or awaken earlier than desired.

An intervention to address the emotional and mental health needs of those with chronic pain had been set up by the IAPT Tier 2-3 service for Surrey PCT. I was invited by the course lead for the pain management programme to design and deliver a two hour session on managing insomnia through using self-help behavioural interventions which

were based on the CBT Five Areas model that would become part of the pain management programme. The course lead approached me to deliver the sessions as many clients were displaying issues with their sleep. She informed me that this had a significant impact on her client's well-being and perception of pain. The facilitator approached me as I have completed a course in Behavioural Sleep Medicine with the University of Glasgow and have an interest in understanding the effect of pharmacological interventions in managing pain and their related side effects including impact on quality of life.

The aim of the intervention is to:

- Provide patients with a platform to find out about insomnia and pain and how the two can influence each other;
- Reduce anxiety about insomnia by providing tools which will help to improve self-efficacy and a sense of control;
- Improve health-related quality of life by providing tools to make lifestyle changes to improve sleep hygiene;
- Give patients the opportunity to learn new self-help behavioural techniques to manage their insomnia.

### **The Group Intervention**

The intervention is delivered over a 2 hour period as part of the existing Pain Management programme. Patients are recruited for this programme through being referred by their General Practitioner (GP). The Pain Management programme as a whole is delivered over 9 weeks, and the sleep and insomnia intervention was delivered on the 9<sup>th</sup> week. It was decided by the main facilitator and myself to deliver the Insomnia intervention on this week to allow for the group to bond so that they are comfortable to share experiences as a large part of the designed intervention requires group participation. All patients were offered the chance to talk about their specific condition if required at the end of the session. On arrival, clients' are asked to answer two questions:

1. How easy do you find it to sleep at the moment?
2. Do you use any behavioural sleep techniques to help you to sleep at the moment?

These questions were answered using a Likert scale and were asked so that any changes in behaviour as a result of the intervention could be noted by the client and myself.

A variety of techniques were used within the intervention, as listed in the below table.

**Table 1 – Techniques used in psycho-education session in Pain Management group.**

<b>Technique</b>	<b>How it applies to the session</b>
<b>Normalising and encouraging help seeking</b>	If clients struggle with managing pain in relation to their insomnia, it was actively encouraged for them to go and see their GP or other healthcare professional.
<b>Normalising emotions</b>	Acknowledging the change that patients are experiencing and how this may have an impact on other areas in their life.
<b>Understanding how the 5 Areas Model applies to insomnia</b>	Discussing the unwanted and intrusive thoughts that may appear before bed-time and how this impacts on their physical reactions, their behaviour and their mood. Clients already had prior knowledge of the 5 Areas Model through previous Pain Management sessions.
<b>Practical tools and advice on lifestyle changes – maintaining good sleep hygiene</b>	Introducing tools to help make changes: e.g. keeping a regular sleep-wake routine, introducing a relaxation technique 30 minutes before bed-time, ensuring that intrusive thoughts are

	interrupted through using relaxation and distraction exercises as perception of pain has been found to be significantly higher before bed-time. In addition, keeping a thought record before bed-time interrupts intrusive thoughts. The importance of diet and exercise were also highlighted.
<b>Importance of maintaining social relationships</b>	Outlining the importance of spending time with friends and family – that we forget that we ‘work to live’ but the shift often happens where we ‘live to work’. Remembering the importance of seeing loved ones.
<b>Encouraging patients to utilise the techniques/advice discussed</b>	Finding out if any of these clients have previously used any of the tools discussed and asking them to share their experiences with the group if they have. Finding out what specific techniques each user plans on using.
<b>Encouraging sharing of information amongst the group</b>	This provides a forum where clients can discuss ideas and techniques that have worked for them. It is to encourage empowerment amongst the group.

The session lasted for 2 hours and took place on Session 9 of the Pain Management group (the last session). All clients were offered the opportunity to discuss their individual circumstances with me after the intervention had taken place. Clients were also provided with a handout which covered what was discussed within the session in more detail, and a [REDACTED] booklet, which has the telephone helpline number, email address and web address should they want to access more information or support.

### **5.1a. Assess suitability of clients for health-related behaviour intervention**

Insomnia is common within patients who have chronic pain (Jansson-Fröjmark & Boersma, 2012). Pharmacotherapy remains the most widely used treatment for sleep disturbances secondary to painful medical problems (Aronoff, Wagner & Spangler, 1986; Mellinger, Balter & Uhlenhuth, 1985) despite the fact that long term efficacy has not been established (King & Strain, 1990). Furthermore, the prolonged use of sleep medication may carry health risks and may have undesired side-effects such as poor sleep quality and impaired daytime functioning. There is a growing body of evidence supporting the efficacy of using non-pharmacological treatments to manage secondary insomnia in patients who have chronic pain, and in specific Cognitive Behavioural Therapy as an alternative to medication, to avoid the unwanted side effects described above (Currie, Wilson, Pontefact & deLaplante, 2000; Jungquist, O'Brien, Matteson, Smith, Pigeon et al., 2010; Mayer, Jennum, Riemann & Dauvilliers, 2011).

It has also been suggested that the association between pain and sleep disturbance may be viewed as a reciprocal vicious cycle, with pain contributing towards disturbed sleep, which, in turn may enhance pain sensitivity (Modolfsky & Scarisbrick, 1976). Insomnia symptoms have also shown to be associated with a wide range of pain variables including pain threshold and chronic pain conditions (Chiu, Silman, Macfarlane, Ray, Gupta, et al., 2005; Giron, Forsell, Bernsten, Thorslund, Winblad et al., 2002; Ohayon, 2005). In addition, experimental studies have shown that pain results in lighter sleep and less restorative effects of slow-wave sleep (Smith and Haythornthwaite, 2004). It is also found that this sleep disturbance, particularly interruption in slow-wave sleep, can increase pain sensitivity (Smith & Haythornthwaite, 2004).

Discussions with low and high intensity cognitive behavioural therapists have revealed that there was no general psychological support in place to help clients who attended the Pain Management intervention for their insomnia. While some patients required more support than others, common problems included:

- Early morning awakening
- Difficulty getting to sleep
- Difficulty maintaining sleep
- Lack of '*restful*' sleep



- Daytime napping
- Side effects of medications including irritability, restless legs, drowsiness
- Loss of motivation
- Feeling lethargic/lack of energy.

Speaking to the therapists gave me insight into the multiple problems faced by chronic pain patients and allowed me to design an intervention with a focus on providing the patients with self-help tools and CBT techniques to improve their sleep, thus having an effect on their overall ability to manage and tolerate their pain.

For the purpose of this intervention, all patients who attended the Pain Management intervention were identified as suitable as they generally all had identified an issue with having a regular and restful sleep schedule. As the group was already established, it was decided by the main facilitator of the intervention and myself to deliver the intervention in the existing group format. In addition, as this session was to become part of an already existing intervention, there were constraints on time and thus I only had a one two-hour session to deliver the intervention. I provided all attendees with a take-away handout that I developed especially for the session (See Appendix 23) so that they were able to re-visit the materials discussed in their own time. At the back of the handout I also provided references for extra reading and the contact details of [REDACTED] in case the attendees required additional support.

### **5.1b. Identify and negotiate the behaviour change goals of the clients**

At the beginning of the session, clients were asked to fill out a '*rating score*' chart (based on a Likert scale of 0-10) which subjectively measured how easy they find it to sleep at the moment and whether they use any techniques to sleep at the moment (please see Appendix 24). This clients within the Pain Management programme are explained the 5 Areas Model and discuss this model in relation to the impact it has on their physical well-being and their perception of pain. They are advised to start challenging their thoughts, behaviours and physical reactions. In line with this, patients are also advised to make a series of lifestyle changes which will improve their self-efficacy. These changes included (but are not limited to) their diet, the amount they exercise and the type of social support they received. One of the goals of the programme is to improve

patients' well-being and perception of pain. Another goal is to also reduce feelings of anxiety and/or depression to improve social functioning.

As every client had slightly different issues with their sleep, each client was advised to prioritise their own key goals. However, within this specific session, the main goal for clients was to learn new ways of improving their sleep hygiene behaviour. Sleep hygiene recommendations are almost uniformly included as part of cognitive behavioural treatments for insomnia (Edinger, Wohlgemuth, Radtke, Marsh & Quilian, 2001; Morin, 1993). As the rest of the sessions within the Pain Management intervention focus on the 5 Areas Model, this specific session will focus more on identifying how an individual's thoughts, behaviours, physical reactions and mood can be influenced when sleep hygiene is improved. The sleep hygiene measures used are derived from Hauri (1977; 1992; 1993), Schocket, Bertelson and Lacks, (1988), Friedman et al, (2000) and Guilleminault, Clerk, Black, Labanowski, Pelayo, et al, (1995).

### **5.1c. Assess the cognitive, behavioural and situational determinants of, and influence on, current behaviour**

At the beginning of the session, patients were asked to identify any issues they experienced with their sleep. They were asked to talk about why they think they had these issues. Patients were then given some background information on the link between insomnia and chronic pain and the reasons why some behaviour may be maintaining their issues with sleep. The Long-Term Health Conditions Cycle model is used to explain how pain interacts with behaviour, physical feelings and mood. This cycle is then broken down using the CBT 5 Areas model. Disturbances in sleep are shown to be within the behaviour and physical reactions components of the model. Patients were asked to contribute towards filling in the rest of the model. Once this had been completed, patients were then encouraged to share their beliefs and understanding about their current patterns of thinking, behaviour, and physical reactions and mood that may prevent them from keeping 'good' sleep hygiene. For example, one patient discussed that she found it very difficult to fall asleep before 1am, and on probing it was found that she drank a lot of high energy and high caffeine drinks (sometimes in excess of 8 cans or cups of coffee in a day). She believed that she would suffer terribly from 'caffeine withdrawal' if she stopped consuming and was also

worried that she would be unable to complete the tasks she normally does in a day if she did not consume these drinks. I explained to the client that she did not have to give up drinking caffeine completely, but that she may want to start slowly reducing how much she drinks in a day to improve her sleep. By cutting down slowly, she would reduce the chance of developing caffeine withdrawal symptoms, thus reducing her physical reactions. In addition, I also advised the client to limit how much caffeine she had from 6 hours before her bedtime as the half-life of caffeine is 3-4 hours. I also explained to her the impact that her thoughts would have on her ability to sleep. We discussed the possibility of '*breaking the cycle*' at the thoughts, behaviours and physical reactions stage to promote better sleep. Although the group discussion was useful, I would have liked to include a task where all clients noted down an area of concern for them and a group discussion on how each client could resolve that concern. However, this was not practical due to the time constraints of the session.

#### **5.1d. Develop a behaviour change plan based on cognitive-behavioural principles and**

##### **5.1e. Ensure monitoring and support for behaviour change plan**

The intervention was based on four models: specifically the Stages of Change Model, the Biopsychosocial Model, the Theory of Planned Behaviour and Reasoned Action and the Self-Efficacy theory. I also used Motivational Interviewing to deliver the session, to explore participant's readiness and ambivalence to change and to explore any obstacles that participants may envisage. Motivational interviewing was also used to encourage the session to be person-centred. These theories were integrated into the Cognitive Behavioural Model to deliver a session which took the participants needs and wishes into account.

In the group, patients were asked to identify specific issues that they had with sleep. They identified 3 key areas: difficulty getting to sleep, difficulty maintaining sleep and difficulty with waking up in the morning. Patients were asked if they were happy with their current sleep behaviour. One client in specific vehemently believed that his caffeine intake was not a reason why he found it difficult to sleep, so I '*rolled with the resistance*' and re-focussed his attention to think of other reasons why he may find it

difficult to sleep. He indicated that other areas could be improved (i.e. his bed-time routine) which we discussed as a group.

Clients were then explained about different CBT techniques they could use to reduce unwanted thoughts. Unhelpful patterns of thinking were described to the client group and clients were asked if they recognised themselves carrying out any of these. I taught clients about using thought diaries to recognise these patterns and challenge unhelpful ways of thinking. A client specifically mentioned that he has unwanted thoughts when he is lying in bed which can stop him from falling asleep. We talked about '*putting the thought to bed*', whereby the client writes down the thought on a pad and puts the pad in a drawer, so that it is ready and waiting for him to deal with the next day. We also discussed using relaxation techniques to help the body relax before bed-time.

Techniques such as deep breathing, progressive muscle relaxation and visualisation were described. I signposted clients towards the [REDACTED] website (the service that I work for), as I have created downloadable audio relaxation techniques for clients to download for free.

Regarding the behaviour component of the model, clients were delivered each piece of sleep hygiene information and were asked whether they thought it would improve their sleep. If so, they were also asked about how they think they would incorporate this new information within their lifestyle. Clients were primarily directed to focus on the following psychological strategies:

- *Response Substitution*: For clients that napped in the day I encouraged them to think of behaviours they could easily introduce which would essentially prevent them from doing so. For example, by going out of the house and doing errands or by inviting a friend over for lunch.
- *Positive changes*: I encouraged clients to start introducing activities which would help them to relax, such as reading a book or taking a bath before bed-time.
- *Stimulus Control*: I also encouraged clients to keep the bedroom for sleeping and sex only. I explained that by doing so, they will learn to associate their bedrooms as a place of relaxation. Clients were encouraged to work or relax in other areas of their home. I also encouraged clients to not watch TV in their bedrooms as this may prevent them from falling asleep.

- *Social Support:* I advised clients to inform their friends and family about the changes that they planned to make and to ask them for support if they required it. This was so that they could receive extra support from their loved ones which would encourage them to carry out their behaviour change. Additionally, it would inform friends and family in case the behaviour change initially affected the client in an adverse way (such as increased moodiness as a result of a lack of sleep).

Best outcomes of behaviour change occur when the behaviour change is planned, initiated, and maintained with the potential for relapse recognised and planned for (Sniehotta, Scholz & Schwarzer, 2005). Therefore, I highly encouraged clients to use SMARTER goals to encourage good sleep hygiene. Clients were then given an activity within the session to create their own SMARTER goal so that their learning was person-centred. Self-efficacy was also increased, as this action-planning was designed and set by them and was also individual to them. Whilst clients were conducting the activity, I advised them to *'start small'* and to only set one goal at a time. This was to encourage clients to find a smooth and easier transition into implementing their behaviour change, and to also set goals that they think they should be able to keep. Some clients did need additional help to set a goal that was achievable. For example, one client wrote *'I want to sleep at the same time every day'* as their goal. I suggested that this goal was probably too big to start on, and asked the client how they thought they would be able to *'break down'* the goal into more manageable steps. They suggested they should really try to at least get in bed and wake up at the same time every day, so I suggested that this be their SMARTER goal instead.

After this activity was completed, I asked clients to think about what they would do if they were unable to meet their goal. I encouraged clients to think of a plan of action if this did arise and to write this down. I also stated to clients that if they were unable to achieve their goals to not give up, and to instead use what they learnt to evaluate and redo the goal with their learned experiences in mind. Active listening (including reflection, acceptance, summarising, and positive affirmations) was a key factor in aiding clients to formulate SMARTER goals which applied to them. Some barriers to initiating behaviour change included:

- *Cognitive*: Racing thoughts and negative thinking patterns (e.g. 'clock watching');
- *Behavioural*: 'Life' getting in the way and preventing them to stick to their pattern;
- *Physical Reactions*: Feeling tired in the morning after disturbed sleep at night.

Many clients had conflicting emotions when deciding to implement a specific behaviour into their routine. The question was opened out to the rest of the group to see if anyone else had any ideas to resolve the conflict. For example, one client stated that they were not sure when they would find the time to carry out a relaxation exercise, and worried that they would not be able to keep this within their routine. It was suggested that perhaps they could practise it before they went to bed.

Clients were also encouraged to reward themselves if they had managed to achieve their goal. At the bottom of the sheet, clients were asked to write down what the reward would be so that they could focus on something positive whilst trying to achieve their goal. Additionally, other long term suggestions from the group included having more energy in the morning to do tasks, feeling more alert, having a regular routine, and feeling healthier. Other reasons included '*having one less thing to worry about*', and '*feeling more normal again*'.

We additionally discussed expectation management when deciding on behaviour change. For example, one of the physical reactions a client mentioned above was that she would be very tired if she was waking up at the same time every morning. I said that this would occur, but that if she was able to resist from taking a nap in the day, that she should be able to sleep better on the following night.

## **5.1f. Evaluate Outcome**

### ***1. Assess the extent to which the goals have been achieved***

At the end of the intervention, I asked clients if any of the strategies discussed today would be helpful for them. This information was collated using a form by a Likert Scale (please see Appendix 24). Clients were then asked to relay any questions or queries they have. I informed clients that I would be available to talk to any clients at the end of the session if they would like to discuss anything in private. I also informed clients that I

would be calling them in a few weeks to see how they were getting on. Clients were also provided with the information to contact [REDACTED] if they needed more advice or support in the future. Two weeks after the intervention was delivered, I telephoned the clients to ask them on their experiences of introducing the taught techniques and their current sleep behaviour. The results show that seven out of nine clients had seen improvements in their sleep and energy. Seven out of nine clients had said that they noted an improvement in their pain levels.

### ***2. Identify the effective components of the behaviour change process***

Within the telephone questionnaire, clients were asked what they found worked particularly well for them. The collated comments are in Appendix 25. Clients specifically noted the usefulness of SMARTER goals, advice on reducing caffeinated beverages and thought diaries as effective components of the behaviour change process. Clients also specifically stated that regularising their sleep routine had an impact on their tiredness.

### ***3. Identify reasons for lack of goal attainment where this occurs***

Some clients had not managed to improve their sleep behaviour. When queried, one client noted that they were unable to do so as it became '*one more thing*' that they had to do on top of everything else they were trying to juggle. Another client felt that they were unable to maintain a regular sleep pattern as they worked shifts and so it was impractical. However, this client did state that they had introduced relaxation techniques into their schedule to help aid restful sleep.

### ***4. Identify unintended consequences of behaviour change, negative or positive***

One specific client noted that her husband had recognised a change in her mood as a result of the intervention, and that she was '*more pleasant to be around*'.

### ***5.1g. Completion, follow-up, or referral as appropriate***

As part of the Pain Management programme, relapse prevention groups are held once every 2 months which all clients who have completed the programme are invited to attend. In addition, [REDACTED] run a programme using CBT approaches to improve sleep ([REDACTED]) which clients were encouraged to refer themselves

on if they felt they would benefit from the programme. This programme is a much more in-depth intervention which takes place over 5 weeks and uses techniques such as sleep restriction to manage a client's insomnia.

## **Conclusion**

In summary, I found this client group a pleasure to work with. They seemed genuinely interested in learning more to help themselves and seemed motivated to introduce behaviour changes to improve their well-being. I feel from this case study that I managed to establish and form relationships with clients in a short amount of time. This is a particularly difficult client group to engage with as they were attending a behavioural clinic to manage a very physical condition. Many clients who attend this clinic have tried all pharmacological interventions that are available and are thus attending the CBT group as a more permanent way of managing their condition. For this reason, and from talking to clients, I had the understanding that they placed much importance on learning the techniques described as there were 'no other options left' to manage their condition. Designing and delivering this intervention has provided me with a useful learning experience. I have managed to design an intervention which was packed full of information, but also delivered it in a short time constraint. I have also learned about delivering information to client groups who are (sometimes) difficult to engage with. I used a variety of resources, including handouts, group discussion, drawing diagrams on the board and recorded exercises such as the visualisation and relaxation recordings to ensure that clients had access to a variety of different resources. I believe that by including this within the design of my intervention, it strengthened the delivery and increased the understanding of the clients. If I were to undertake this project again, I would definitely try to negotiate more time to deliver the session, as there was a lot of information to get through. Furthermore, I would also have liked to have conducted a focus group with the client group before the design of the intervention to ensure that they had more of an input.



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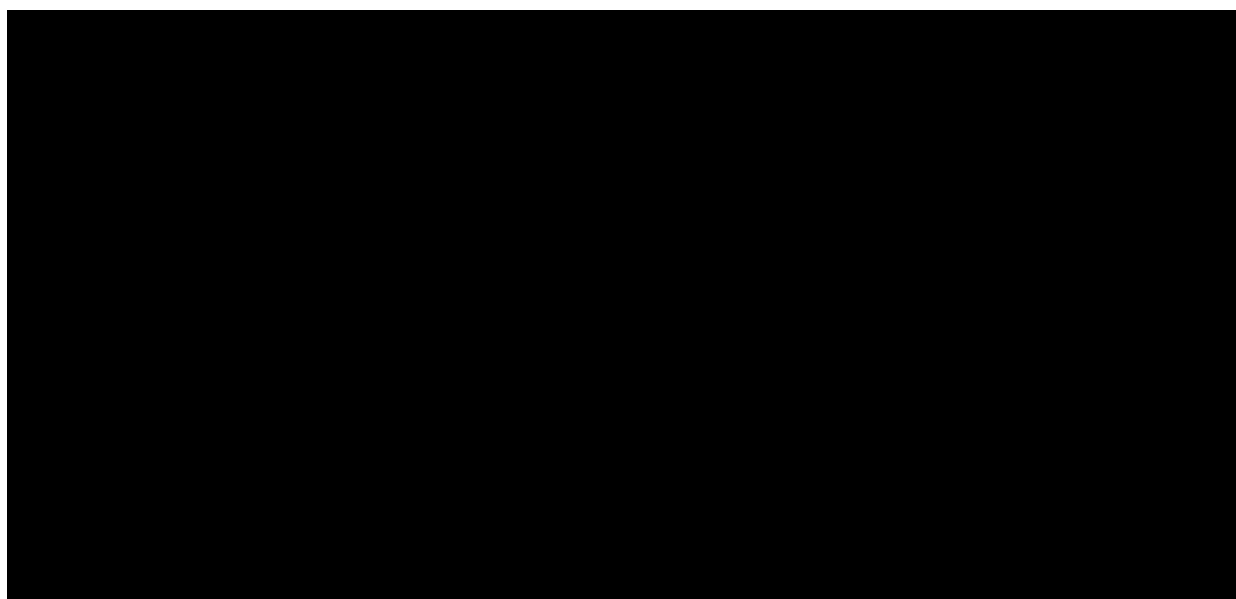
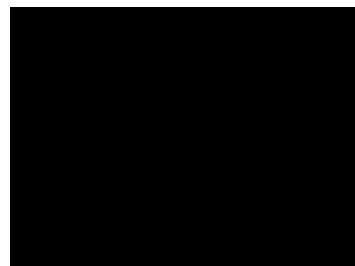
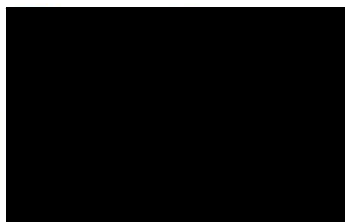
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## Appendix 23: Sleep Handout





## Appendix 25: Table of Collated Results

Has this had a positive or negative impact on your Management of pain? Why?	Have you noticed anything else that might have changed as a result of what was taught?	Have you used any of the exercises taught in the Intervention? If so, what?
slightly positive - as feel more rested in morning	n/a	SMARTER goals, reduced caffeinated drinks
positive - able to use relaxation techs to block out pain before sleep	n/a	reduced caffeine, relaxation exercises and unwinding time before bed
Positive - being more rested means that I'm not tired as well as in pain!	Generally happier more positive person!	relaxation and distraction exercises
slightly positive - more capacity to deal with pain as not tired as well	n/a	putting thought to bed', thought diaries
n/a	n/a	relaxation techniques, 'unwinding' before bed, not working in the bedroom
positive - able to cope with more pain than before	n/a	relaxation exercises, thought diaries
Positive - you feel worse after a bad night's sleep and I've realised that!	a	regularising sleep routine, relaxation exercises, SMARTER goals
	n/a	relaxation exercise, regularising sleep routine
positive - more rested in morning	Husband noticed change in mood 'more pleasant to be around!'	relaxation exercise, regularising sleep routine, not working in bedroom

## **SECTION D: SYSTEMATIC REVIEW OF LITERATURE**

### **A systematic review on the effectiveness of television based mass media campaigns on reducing cannabis use in adolescents**

#### **Introduction**

Illicit and recreational drug use continues to be a public health concern globally among the adolescent population; specifically marijuana use (Bouchard, 2010; Orwin, 2004; Xiao, 2008). For example, a national survey taken within the United States of America (USA) indicates that nearly half of all students would have tried marijuana at least once before the end of high school (Johnson, O'Malley, Bachman & Schulenberg, 2010), with results reporting similar effects in the United Kingdom (UK) (European Monitoring Centre for Drugs and Drug Addiction, 2015). Marijuana dependency has been reported to develop in approximately 14–17% of all adolescents who ever use marijuana (Anthony, 2006; Hall & Degenhardt, 2007). These findings pose an issue for Health Psychologists as marijuana use has been associated with a range of harmful consequences including increased risk of other illegal drug use (Skenderian, Siegel, Crano, Alvaro & Lac, 2008); depressive and psychotic symptoms (Hall & Degenhardt, 2007); delinquency (Block & Ghoneim, 2008); and poorer academic achievement and higher school dropout (Lynskey & Hall, 2000). Furthermore, although not necessarily a gateway drug, those who use marijuana may be more likely than others to use cocaine or other hard drugs (Merrill, Kleber, Shwartz, Liu, & Lewis, 1999). Considering the potential detrimental health effects that can occur from marijuana use, it is important to consider all scientific evidence that may prevent or reduce the harm from using marijuana within these vulnerable populations.

A popular method of targeting adolescents who misuse marijuana has been through the use of social marketing campaigns via mass media outlets, including the television, through the form of public service announcements (PSA's). PSA's are a type of advertisement that is used to disseminate advice or information about a particular health-related concern, or a concern that has the potential of affecting the community as a whole. These types of campaigns are a frequent component of large-scale health campaigns as they are able to reach a large amount of the targeted audience in a cost-

effective manner (Farrelly, Hussin & Bauer, 2007). Previous research has indicated that anti-drug PSAs have been successful in reaching target audiences (Reiss, Duggan, Adger, & DeAngelis, 1994), changing attitudes to be more anti-drug (Davis, 1997), and getting their attention (Black, 1991). PSAs have also been found to be effective in targeting other health-related concerns such as tobacco use in targeted populations (Siegel, 1998).

In the period of 1998-2006, the USA spent over \$1.6 billion in drug prevention campaigns (United States Government Accountability Office, 2006). Furthermore, there is evidence to suggest that social marketing tools such as PSAs are gaining popularity within the UK (Department of Health, 2004). Initiatives such as the National Social Marketing Strategy (NSMS) for Health (led by the National Consumer Council and the Department of Health) have been created to reflect the way that social marketing tools can be used to change the health behaviours of the general public (National Consumer Council and Department of Health, 2005).

Anti-substance misuse PSAs are largely based upon the Health Belief Model (HBM) (Becker, 1974; Becker, Drachman & Kirscht, 1974; Becker & Maiman, 1983; Maiman & Becker, 1974; Rosenstock, 1974). The HBM posits that an individual's behaviour is determined by a number of beliefs about threats to their well-being and their perceived susceptibility to this threat. It suggests that one will determine their health choices based on this information. According to this model, two conditions must be met for an individual to try marijuana: availability and openness to trying. The latter implies that the individual has called into question the social norms that condemn marijuana as a harmful product. Therefore, the aim of most PSAs is to increase an individual's susceptibility to problems associated with smoking marijuana by utilising messages that suggest using illegal substances will have a detrimental impact on an individual's physical and psychological health and wellbeing, and will also negatively affect relationships with others and their ability to function as a productive member of society. This therefore will prevent them from trying and/or using marijuana. It is clear that attitudes around smoking have changed amongst adolescent populations, with attitudes amongst existing being predominantly negative about smoking tobacco (Grandpre, Alvaro, Burgoon, Miller & Hall, 2003). However, it is not clear if the same applies for marijuana. This suggests that there may be a growing perception amongst

society that suggests tobacco is a clear health threat, with the perceived health risks of marijuana being less profound.

By utilising this type of campaign, it could be that hundreds, if not thousands would benefit (Noar, 2006a, Noar, 2006b). However, critics have argued that media-interventions targeted at reducing substance misuse or changing public perceptions may not produce desired results (DeJong & Wallack, 1999). For example, a meta-analysis conducted on anti-substance abuse mass media based interventions from across the globe revealed mostly inconclusive results (Derzon & Lipsey, 2002). A previous systematic review was also conducted by Gordon, McDermott, Stead and Angus (2006) on the effectiveness of social marketing interventions for health improvement. Part of this review focussed on how social marketing interventions are implicated for the use of illicit drugs, alcohol and tobacco use. This review concluded that social marketing interventions targeting alcohol and substance misuse overall had a positive effect, with 8 out of the 13 studies reviewed being shown to have a positive affect overall, four having mixed or moderate effects and one having no effect. A further systematic review and meta-analysis was conducted on the effectiveness of anti-illicit drug PSAs by Werb, Mills, DeBeck, Kerr, Montaner et al. 2011. This review concluded that the dissemination of anti-illicit drug PSAs may have a limited impact on the intention to use illicit drugs or the patterns of illicit drug use among target populations, with 16 PSAs being more effective than the control at reducing intention to use illicit drugs among study participants, eight having no significant effects in comparison to the control, and six were significantly less effective than the control in reducing intention to use illicit drugs.

### ***Objectives***

A systematic review on the available literature was conducted in order to see if anti-marijuana PSAs are effective at reducing marijuana use, or reducing the intent to use marijuana among the adolescent population. According to the Theory of Planned Behaviour (Ajzen 1985, 1991; Ajzen & Madden, 1986) and the Theory of Reasoned Action (Fishbein & Ajzen, 1975) intention to act is the best predictor of any given behaviour, and demonstrates the willingness to engage with the behaviour in question. Therefore, an intention is able to provide a somewhat indicator of how hard someone is



willing to try to engage with the given behaviour. It is for this reason that intent to use was also included within the systematic review.

## **Methods**

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were referred to in order to conduct the review (Moher, Liberati, Tetzlaff & Altman, 2009).

### ***Eligibility Criteria***

Literature searches were conducted to examine the effectiveness of television based anti-marijuana Public Service Announcements (PSA) on the effectiveness to use Marijuana. Although previous reviews on the effectiveness of drug PSA's exist, there are few in number and are not solely focussing on television-based anti-marijuana PSAs. The primary focus of this systematic review was to review the effectiveness of television based anti-marijuana PSAs in changing the intentions to use marijuana or actual use of marijuana. Both observational studies and randomised controlled trials were considered for this review. In addition, studies were considered from peer-reviewed journals, international conferences and governmental reports. Studies that included multi-component interventions (such as interventions which had a two-pronged approach, taking place in two settings) were excluded for this study. Any studies that evaluated PSAs which targeted all illicit drug use were excluded. However, those that had a specific measure for marijuana use were included.

### ***Information Sources***

The following 13 electronic databases were searched on 10<sup>th</sup> March 2015 DARE, PsycINFO, Academic Search Complete, CINAHL Plus with Full Text, Cochrane, Communication Source, Health Policy Reference Center, HEED: Health Economic Evaluations Database, MEDLINE Complete, PsycARTICLES, SocINDEX with Full Text, PROQUEST and OpenDoor.

### ***Search***

A search was conducted for all English articles and abstracts between January 2004 – December 2014. Search items included 'Marijuana', 'Cannabis', 'Cannabinoids', 'Cann\*

Misuse', 'Mari\* Misuse', 'Substance Misuse', 'Substance Abuse', 'Television advert\*', 'Public Service Announcement\*', 'Public Service Advertisement\*', and 'TV'. References from relevant articles were also examined.

***Study Selection***

A predefined protocol was established by the researcher. Subsequently, all abstracts that appeared in the relevant search were scanned. The full texts of all articles and reports that evaluated a measure of intent to use marijuana or actual use of marijuana were obtained. After all potentially relevant full-text articles and abstracts were identified; the articles were re-reviewed to achieve homogeneity regarding eligibility.

**Table 1: Study Selection Criteria**

<b>Participants</b>	Adolescents aged between 11-19 who had received some exposure to the below intervention
<b>Intervention</b>	A television-based anti-marijuana intervention/interventions targeted at reducing marijuana use.
<b>Outcomes</b>	A reduction in marijuana use intentions or actual marijuana use
<b>Study Design</b>	Randomised controlled trials or observational studies

***Search Terms***

The following search terms were utilised to locate articles in the above mentioned databases:

**Table 2: Search terms**

<b>AND</b>	<b>OR</b>
Marijuana <b>and</b>	Television advert* <b>and</b>
Cannabis <b>and</b>	Public service announcements <b>and</b>
Cannabinoids <b>and</b>	Public service advertisements <b>and</b>
Cann* Misuse <b>and</b>	TV

Mari* misuse <b>and</b>	
Substance misuse <b>and</b>	
Substance abuse <b>and</b>	

### ***Data Collection Process***

Once suitable papers had been found, a data collection form was designed prior to data collection, and data was collected subsequently independently by the researcher.

Information that was extracted included the study design and binding, inclusion and exclusion criteria, recruitment procedures, the outcome definition measure that was utilised, and the results. The data was then reviewed again to ensure that no mistakes had been made by the researcher. After this, a quality assessment checklist was designed to assess the quality of each of the papers. A score of 0-9 was given for each paper. One point was given for each of the following criteria.

The following assessment scoring system was used:

- 1) Is the aim/objective of the study clearly identified? (Yes = 1; No = 0)
- 2) Are the main outcomes to be measured clearly described and appropriate? (Yes = 1; No = 0)
- 3) Is pre-intervention data available for the participants? (Yes = 1; No = 0)
- 4) Were the eligibility criteria specified? (Yes = 1; No = 0)
- 5) Are the characteristics of the participants clearly described? (Yes = 1; No = 0)
- 6) Is the intervention clearly described? (Yes = 1; No = 0)
- 7) Are the main findings of the study clearly identified and described? (Yes = 1; No = 0)
- 8) Was the sample size adequate (Over 100)? (Yes = 1; No = 0)
- 9) Are the key limitations described? (Yes = 1; No = 0)
- 10) Were the statistical tests used to describe the main outcomes appropriate? (Yes = 1; No = 0)

The quality assessments were carried out independently by two researchers. Papers with a score of 7 and above were considered to be of 'Good' quality, with papers with a score of less than 5 were considered to be of 'Poor' quality. The purpose of the quality

assessment was to see if any papers were considered to be of 'Poor' quality. If any papers were found to be of 'Poor' quality through this assessment, they would have been excluded from the review.

## Results

In total, 18 papers were found to be initially suitable for further review. Out of these, 11 were excluded from the overall study. They were excluded for the following reasons:

- **Leonora and Comello (2013a)** - They were comparison studies measuring the effectiveness between one anti-marijuana advert to another anti-marijuana advert, with no control.
- **Sajahan, Khir, Johari and Jaafar (2012)** - They were measuring multiple illicit drugs through one measure.
- **Quick (2013)** - This paper was concerned with measuring the sensationalist aspect of an advert and how that impacts on psychological reactance.
- **Leonora and Comello (2013b)** - They were concerned on a participant's self-attributed label regarding their substance use and how this impacted overall scores.
- **Czyzewska and Ginsburg (2007)** - This paper was measuring an individual's attitudes about the drug rather than actual and/or intended use.
- **Wang, Solloway, Tchernev and Barker (2012) and Weber, Huskey, Mangus, Westcott-Baker and Turner (2014)** - These papers were excluded as they were focussing on how the anti-drug adverts may be cognitively processed and how this may predict intent to use or actual use.
- **Zhao, Sayeed, Cappella, Hornik, Fishbein et al. (2006)** - This paper was not directly measuring intent to use/actual use of marijuana but was attempting to find predictors that would indicate intent to use.
- **Kang, Kappella and Fishbein (2009)** - This paper was excluded as it was concerned on marijuana scenes within an advert on adolescents' perceptions of advert effectiveness.
- **Alvaro et al. (2013)** - This paper was excluded as it was concerning how participants attitudes towards the adverts predicted intentions and actual use of marijuana.

- Slater, Kelly, Edwards, Thurman, Plested et al., (2005) and Slater, Kelly, Lawrence, Stanley, Leonora et al. (2011) – These papers were excluded as they were measuring the effects of an in-school campaign in conjunction with an external media community campaign on adolescent drug use.

The following studies were found to be suitable for the review.

**Table 3: Quality Assessments for Studies Conducted on the Effectiveness of Television Based Mass Media Campaigns on Reducing Cannabis Use**

<b>Study</b>	<b>Rating</b>
<b>1. Carpenter, C. S. and Pechman, C. (2011). Exposure to the above the influence antidrug advertisements and adolescent marijuana use in the United States, 2006 – 2008. <i>American Journal of Public Health, 101, 5, 948-954.</i></b>	<b>9</b>
<b>2. Hornik, R., Jacobson, L., Orwin, R., Piesse, A. and Kalton, G. (2008). Effects of the national youth anti-drug media campaign on youths. <i>American Journal of Public Health, 98, 12, 2229-2236.</i></b>	<b>8</b>
<b>3. Orwin, R., Cadell, D., Chu, A., Kalton, G., Maklan, G., Morin, C., Piesse, A., Sridharan, S., Steele, D., Taylor, K. and Tracy, E. (2006). Evaluation of the national youth anti-drug media campaign: 2004 report of findings. Retrieved from <a href="http://archives.drugabuse.gov/initiatives/westat/NSPY2004Report/Vol1/Report.pdf">http://archives.drugabuse.gov/initiatives/westat/NSPY2004Report/Vol1/Report.pdf</a></b>	<b>8</b>
<b>4. Palmgreen, P., Lorch, E.P., Stephenson, M.T., Hoyle, R.H. and Donohew, L. (2007). Effects of the office of national drug control policy's marijuana initiative campaign on high sensation seeking adolescents. <i>American Journal of Public Health, 97, 9, 1644-1649.</i></b>	<b>8</b>
<b>5. Scheier, L.M. and Grenard, J.L. (2010). Influence of a nationwide social marketing campaign on adolescent drug use. <i>Journal of Health Communication, 15, 240-271.</i></b>	<b>9</b>
<b>6. Scheier, L.M., Grenard, J.L. and Holtz, K.D. (2011). An empirical assessment of the above the influence advertising campaign. <i>Journal of Drug Education, 41, 4, 431-46.</i></b>	<b>9</b>

Two reviewers independently assessed each study.

### ***Overview of the Studies***

Carpenter and Pechman (2011) examined the relationship between the *Above the Influence* antidrug media campaign in the USA and adolescent marijuana and alcohol use from 2006 to 2008. Hornik, et al. (2008) examined the cognitive and behavioural effects of the National Youth antidrug media campaign on youths, which included past 30-day marijuana use. Orwin, et al. (2006) conducted a report on the evaluation of the National Youth Anti-Drug Media Campaign's report of findings from 1999-2004. This included information on trends of marijuana use that occurred whilst the campaign was aired, along with intentions about marijuana trial use among non-users. It also provides information on the associations between advertising exposure and intent to use marijuana. Palmgeen, Lorch, Stephenson, Hoyle, and Donohew (2007) evaluated the effects of the marijuana initiative portion of the National Youth Anti-Drug Media Campaign on high sensation-seeking and Scheier and Grenard (2010) examined whether awareness of an anti-marijuana advert benefitted the youth by reducing their drug use. Scheier, Grenard and Holtz (2011) evaluated the efficacy of the *Above the Influence* campaign which was aimed at reducing marijuana use in adolescents.

There were a total of 183,418 participants across the 6 studies consisting of adolescents aged 9 to 18 years. The studies within the review were conducted only in the USA. All the studies were also observational in nature – this meant that no studies had data to compare effects of pre-intervention and post-intervention. Data was collated through a variety of methods; data used in some of the studies was collated through already existing studies and some data was collected via independent recruitment.

All studies were aiming to identify the behavioural effects of the anti-drug PSA's on marijuana use or intent to use. In addition, some of the studies also were measuring for additional components. This included measures for alcohol (Scheier & Grenard, 2010; Palmgreen, et al., 2007; Carpenter & Pechmann, 2011), other illicit substances (Palmgreen, et al., 2007), and cigarette use (Scheier & Grenard, 2010; Palmgreen, et al., 2007).

All the intervention PSAs studied were part of the Office of National Drug Control Policy's (ONDCP) National Youth Anti-Drug Media Campaign, which is considered to be

one of the largest public health advertising campaigns in history (ONDCP, 2009; Palmgreen, et al., 2007). Although messages were disseminated largely through the use of advertisement space on television utilising both local, cable and network channels, the campaign also used a variety of other media sources such as the radio, newspapers and magazines, the internet, cinemas, billboards and other forms of outdoor advertising (such as on public transport).

**Table 4: The Method and Outcome of the six included studies**

<b>Author, Year</b>	<b>Study Population and Intervention</b>	<b>Data Collection Procedure</b>	<b>Outcomes</b>
Carpenter and Pechmann (2011)	Adolescents in Grade 8, 10 and 12 being exposed to the Influence Advertising Campaign in the USA from 2006 – 2008 (n= 130245).	Monthly advertising exposure was examined from the Office of National Drug Control Policy and drug use data from the Monitoring the Future Study.	For Eighth-grade adolescent girls, greater exposure to anti-drug advertisements was associated with lower rates of past marijuana use and lower rates of lifetime marijuana use. Associations were not significant for adolescent boys or for students in grades 10 or 12.
Hornik et al. (2008)	3 nationally representative cohorts of youths aged 12.5-18 years exposed to the National Youth Anti-Drug Media Campaign in the	The National Survey of Parents and Youth (NSPY) was used as a data source for this study. The NSPY collated data on recalled exposure to	Most analyses showed no effects from the campaign – however one round more advert exposure predicted less intention to avoid marijuana use

	USA (Round 1 n=8117; Round 2 n=6516; Round 3 n=5854; Round 4 n=5126).	antidrug messages aired by the campaign and other sources, cognitions and behaviour related to marijuana, and individual and household characteristics. Data was collected in 9 waves within 4 rounds.	and weaker anti-drug social norms at the subsequent round. Also, it was found that exposure to the adverts at round 3 predicted marijuana initiation at round 4.
Orwin et al. (2006)	Youths aged between 9-18 and their parents exposed to the National Youth Anti-Drug Media Campaign in the USA (n=3142).	The NSPY was used as a data source for this study. The NSPY collected data on recalled exposure to the campaign and other information such as marijuana use and intent to use, along with individual and household characteristics from 9 waves of data collection within 4 rounds.	There were no favourable effects found on the youth population. The report found that there were indications of an increase in marijuana use between 2000 and 2002 followed by a decrease in both past month and lifetime use of marijuana between 2002 and 2004. Among non-using youth there were favourable changes over time in anti-



			<p>drug attitudes and beliefs, and the proportion of youth saying they would definitely not try marijuana. However the overall data showed largely unfavourable trends between marijuana rates of initiation and campaign exposure.</p>
<p>Palmgreen et al. (2007).</p>	<p>Youth samples from two counties in the USA (Fayette, n=4795; Knox, n=4803) were collated with 100 public school students from the same age cohort in each month in each county.</p>	<p>An interrupted time-series design was used to collate data. This is considered to be one of the strongest quasi-experimental designs for inferring causal effects of an intervention. Personal interviews were conducted with independent random samples of 100 public school students from the same age cohort in each month in each county. Interviews assessed the</p>	<p>The Marijuana Initiative reduced 30-day marijuana use among high sensation-seeking adolescents and significantly reduced positive marijuana beliefs and attitudes in this at-risk population. The intervention had no significant effects on low sensation-seeking adolescents. The study's analysis suggests that the reasons for the effects on high</p>

		<p>television viewing and exposure to the Office of National Drug Control Drug Policy’s Marijuana Initiative Campaign’s television and radio adverts, responses to the advertisements, attitudes towards use of marijuana and use of other drugs, and other various risk and protective factors, particularly sensation seeking.</p>	<p>sensation-seeking adolescents are due to the dramatic depiction of the negative consequences of marijuana use within the PSAs.</p>
<p>Scheier and Grenard (2010).</p>	<p>Youths aged between 12 and 14 was compared to data with youths aged between 15 and 18. Participants were contacted for participation through the National Survey of Parents and Youth in the USA (n=2515).</p>	<p>A growth modelling strategy was used to examine whether change in recall or campaign brand awareness was related to declining patterns of drug use. Data on the use of marijuana was specifically collated. Two separate growth trajectories were modelled to</p>	<p>The growth trajectories showed a steady and positive increase in alcohol, cigarette and marijuana consumption over time. In the early part of adolescence, youth remembered more of the video clips depicting marijuana usage, and reported more</p>

		account for growth amongst younger (12 to 14 year olds) vs older (15 to 18 year olds) youth.	radio listening and less television watching. When they were older, these same youth reported declines in the same awareness categories except for specifically recalling campaign adverts and radio listening. Although this study found significant effects for both alcohol and cigarette use, it did not find any significant effects for marijuana use – however the data trended in the direction of increased awareness associated with declining drug use.
Scheier, Grenard and Holtz (2011).	Youth aged between 14 and 16 who were recruited through a shopping mall intercept from 25 malls across the USA (n=12305).	Data was collected by an external research company who have experience conducting mall intercepts. Data was	Findings suggest that awareness of the <i>Above the Influence</i> campaign is associated with greater anti-drug beliefs, fewer drug

		collected on media campaign on the following measures: media campaign awareness and exposure, beliefs around marijuana use, marijuana intentions and marijuana use.	use intentions and less marijuana use.
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### ***Exposure to PSAs***

Exposure to the specific PSA's were collated in different ways by each of the studies. As Hornik, et al. (2008) used the NSPY as its data source, a measure which asked for self-reported measures of how often they had seen or heard anti-drug advertisements in the media in the recent months, as well as asking respondents to recall specific advertisements, where participants were played an advert and were asked if they had ever seen the advert, how often they had seen the advert, and their assessment of the advert. This was the same for Scheier and Grenard, (2010) and Orwin et al. (2006). In addition to this, Orwin et al. (2006) used Gross Rating Points (GRPs) which are the customary unit for measuring advertising exposure within the advertising industry. Scheier, Grenard and Holtz (2011) asked adolescents if they remembered seeing any anti-drug advertising that specifically mentions key phrases, in addition to asking them to view pictures from a recent media campaign television adverts on a screen and recall the ones they have seen. The data was collated in this way in order for it to be allowed to be directly compared with the data from the NSPY. Carpenter and Pechmann (2011) used monthly Targeted Rating Points (TRPs), a scoring system which measures the delivery of a media campaign to a specific target audience and therefore measure their likely or estimated exposure to the campaign. Palmgreen et al. (2007) used self-reported single-item frequency scales to measure exposure to television and radio anti-marijuana adverts.

### ***Intentions to use marijuana***

Intentions to use marijuana were not collated by all of the studies within the review. The NSPY did collect data on marijuana usage intentions, and for this reason, Orwin et al. (2006) and Hornik et al. (2008) reported data on usage intentions, which was collated by asking a single item question. Hornik et al. (2008) argues that the intention to use marijuana is useful to capture as it is a reliable predictor of future behaviour, in line with the Theory of Reasoned Action (Fishbein & Ajzen, 1975). Scheier, Grenard and Holtz (2011) also reported intention to use marijuana estimates. They gathered this data through the use of 4 items, of which the scores from each item were added up and the final score averaged to form a composite score to reflect an intention to use score.

### ***Use of marijuana***

Marijuana intent to use/actual use was additionally collated using different formats. Marijuana use data was also collected through the NSPY, and as a result, Hornik et al. (2008) and Scheier and Grenard (2010) collated usage data on lifetime, past-year and past-30 day marijuana usage. However, Scheier and Grenard (2010) did not report this data within their study. Orwin et al. (2006) reported marijuana use in terms of the estimates gathered by the NSPY pre-2004, in addition to comparing marijuana use trends with other data sources (Monitoring the Future (MTF), the Youth Risk Behaviour Surveillance System (YRBSS), and the National Survey on Drug Use and Health (NSDUH)). Palmgreen et al. (2007) asked participants to self-report on current (30-day) marijuana use. Carpenter and Pechmann (2011) used data from the Monitoring the Future study which asked if an adolescent had ever reported using marijuana, or had reported using marijuana in the past 30 days. Scheier, Grenard and Holtz (2011) used a single item within their design to ask a participant's marijuana usage over the last 30 days only.

### ***Findings***

Orwin et al. (2006) found that there was no significant change in marijuana usage in the NSPY data between the data collated in Waves 1 and 2, and Wave 9, or between Waves 3 and 4 and Wave 9 in lifetime, past year, past month, or regular use of marijuana overall for adolescents aged 12.5–18 years old. The report also shows that there was a decrease in past month use in the first half of 2004 compared to 2002 for 16 to 18 year olds, for

female 14 to 18 year olds and for white 14 to 18 year olds. However, the NSPY analysis showed a significant increase in past month marijuana use between 2000 and 2002 for 12.5–18 year olds, and shows that in general, there were increases for older youth aged 14 to 18 across all measures of marijuana use, although many of these figures were non-significant. However, analyses of the changes from the 2002 data to the 2003/2004 data combined found statistically significant decreases overall in both lifetime and past-month marijuana use, which were mostly concentrated in the 16-18 year old age group. The data from the NSPY was compared with data collated from the MTF and YRBSS to see if the data found in the NSPY was found through chance. This comparison found that there were general decreases in the MTF for 8<sup>th</sup> and 10<sup>th</sup> graders and no trend for 12<sup>th</sup> graders on all marijuana measures between 2000 and 2002, with statistically significant decreases for 20<sup>th</sup> graders in past year and past month use between 2001 and 2002. The YRBSS shows general declines in all marijuana measures, with statistically significant declines in lifetime and past-month marijuana use for 14 to 18 year olds. However, the NSDUH showed increases between 2000 and 2001 across all age groups and measures, many of which were statistically significant. The report argues that due to methodological changes in the NSDUH for 2001 – 2002, comparisons are unable to be made. This suggests that there is some ambivalence present about marijuana use trends at this time. Nevertheless, the evidence for a decrease between 2002 and 2003/2004 is more consistent across all of the surveys used, as each of the surveys used shows a decline in marijuana use across all measures and across all age groups for this period, although the only statistically significant decreases are for past year use in 2002 and 2003 for MTF 8<sup>th</sup> graders and for lifetime use between 2002 and 2003 for 12 – 17 year olds in the NSDUH. Regarding intentions to use, there was no statistically significant change for the full 12.5 to 18 year old sample, among prior non-users. Nevertheless, there is a statistically significant favourable change for the full 12.5 to 18 year old sample, among prior non-users between 2002 (which is the period of the campaign prior to the Marijuana Initiative) and 2004, following the Marijuana Initiative and Early Intervention Initiative.

Hornik, et al. (2008) found that 94% of youths reported exposure to antidrug advertising. The study also found that there was no change in the prevalence of marijuana use among those aged 12.5 to 18 years between 2000 and 2004. The study

also found that there were some significant changes between years; specifically a change in intention to use from 2002 to 2004. The study also found that there is no significant evidence to suggest an association between exposure to anti-drug advertising and any of the outcomes, and states that non-users who reported more exposure to anti-drug messages were no more likely to express antidrug cognitions than youths who were less exposed. The study also found that there was no evidence of anti-marijuana effects among those who had been exposed to advertising in an earlier round of data collection, however conversely indicate that viewing the advertisements may indicate pro-marijuana effects, with 2 out of the 10 associations being statistically significant, both in a pro-marijuana direction, and results for 6 of the remaining 8 being not significant, but nevertheless in an unfavourable direction. The paper therefore argues that there is “*an overriding pattern of unfavourable lagged exposure effects*” (Hornik et al., 2008: 2232).

Scheier and Grenard (2010) found that growth in campaign awareness is positive for those aged 12-14, except for television viewing behaviour. However, as these youth become older, 14-18, their awareness declined for every media output except for specific recall of advertisements shown on a screen and radio listening behaviour. The paper also found that those youth with initial high levels of campaign awareness grew faster in marijuana use (with three effects being significant for marijuana). The paper also found that increased awareness and recall of campaign messages was associated with declining levels of drug use, and specifically with the exception of radio listening, all marijuana models supported positive anti-drug campaign effects. However, none of these were significant.

Carpenter and Pechmann (2011) found that drug use rates differed in terms of reporting by gender and grade, with more marijuana use being reported by adolescent boys and by adolescents in higher grades. They also found that greater exposure to anti-drug advertisements was significantly related to having ever used marijuana, but in eighth grade girls only. The study also found a statistically significant result for eighth grade girls in past-month marijuana use. However, this study found no statistically significant relationship between advertisement exposure and lifetime marijuana use among eighth grade boys, or for both genders in grades 10 or 12. The study also found

no statistically significant relationship in past-month marijuana use for the same populations.

Palmgreen et al. (2007) divided their population sample into high-sensation seekers and low sensation-seekers. The study found that the intervention provided a sharp downturn in use at the intervention's onset, which continued over the gathering of the data over the 6 month period. The intervention had no effect on low sensation seekers, however it was noted within the study that a large majority of low sensation seekers were non-users of marijuana, even at the end of data collection. In addition, this paper also found that there was a significant correlation between advert exposure and a reduction in marijuana use. The paper suggests that as a result, it is unclear to see whether the reductions in marijuana use by high sensation-seekers was as a result of greater exposure to the advertising campaign rather than the content and style of the advertisements.

Scheier, Grenard and Holtz (2011) found that campaign exposure and advertisement recall were moderately associated with greater anti-drug beliefs, fewer use intentions and less marijuana use. The study also found that recall of a specific advert was also associated with the above. The study states that awareness was associated with more anti-drug beliefs, and anti-drug beliefs was significantly associated with fewer intentions to use marijuana, and less recent marijuana use. The study also found that intentions were negatively and significantly associated with marijuana use, with less intentions to use associated with less marijuana use.

## **Discussion**

This systematic review demonstrates limited evidence to suggest that anti-marijuana PSAs are effective in reducing marijuana use or intent to use among adolescents. Out of the six studies reviewed, only two studies reported significant effects in the PSA interventions reducing marijuana use and usage intentions (Palmgreen et al., 2007; Scheier, Grenard & Holtz, 2011), with one study only showing a reduction in intent to use and actual use among one population sample (Carpenter & Pechmann, 2011). Two studies were provided results that were inconclusive (Hornik et al., 2008; Orwin et al., 2006), with the final study showing trends in declining marijuana use, but with no significant effects (Scheier & Grenard, 2010). Although some studies showed significant



effects in reducing marijuana use in the short-term, no long-term effects were reported in any of the studies reviewed. These findings are very important considering the amount of expenditure anti-marijuana PSAs can account for, in addition to the high levels of reported marijuana use in adolescents across the globe (World Health Organisation, 2015).

Furthermore, the secondary effects of anti-drug media campaigns need to be explored. For example, it has been found that anti-drug PSAs may inadvertently create support for a hard-line approach to drug use, which results in marginalising those who already use and with drug rehabilitation centres only receiving weak levels of support as a result, creates hostility between the using and non-using population (Blendon & Young, 1998).

In addition, the models which anti-marijuana PSAs are based on may not fully take into account additional variables that may influence behaviour. The HBM (Becker, 1974; Becker, Drachman and Kirscht, 1974; Becker & Maiman, 1983; Maiman & Becker, 1974; Rosenstock, 1974) argues that one will make decisions about their health behaviours based on their perceived risk, however this model does not take into account behaviours that may be conducted for reasons that are not to do with health. For example, a study conducted by Parker, Williams and Aldridge (2002) suggests that drug use is normalised within mainstream society and as a result, users may continue to use as it is socially accommodated. In addition, the Theory of Planned Behaviour and Reasoned Action (Ajzen 1985, 1991; Ajzen & Madden, 1986; Fishbein & Ajzen, 1975) posits that an intention to act is a direct predictor to actual behaviour. However these models additionally fail to take into account other external variables that may play a part in an individual making a decision, such as socio-demographic and environmental variances which may alter an individual's ability to act in accordance to their intentions (Brown & Stayman, 1992).

Furthermore, the above studies do not provide any insight into why specific PSAs were effective and others were not. A qualitative analysis needs to be conducted to further understand the meanings derived from the PSAs, and what other variables may have influenced an individual's decision to reduce their marijuana use. Without this, the above studies add no further information in whether use of PSAs is beneficial in reducing marijuana use.

### ***Limitations of the review***

Findings of this review may not be able to be generalizable as all the studies took place within the USA. This has possible cultural implications as findings may not be to other populations who have a different demographic makeup and alternative cultural norms. In addition, although the population sample size for the studies was large, the sample size of six studies is small. Further research needs to be conducted in the area in of the effectiveness of anti-marijuana PSAs before findings can be applied at a population level. Furthermore, as no long-term data is available on marijuana use, the findings in this study are limited to providing information at a short-term level.

### **Conclusions**

It is difficult to establish from this review whether using anti-marijuana PSAs are effective at reducing intent to use marijuana or reducing actual use of marijuana. The challenge for future research in the area would be to measure the impact of the PSA intervention on marijuana use, whilst taking into account other mediating or moderating variables that may affect the decision-making process.

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