Coalition of Alcohol and Drug Educators
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Resiliency Building:

Primary Prevention – and the Indispensable Protective Factor of...

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A Key Missing Element in Prevention Science?

In our now ethics and/or morality ambiguous default culture, caring actors are now tacitly coerced – herded as it were – into spending their energy and effort in only assisting people fix the damage of their unhealthy, unsafe, unwise, or otherwise ***bad*** choices, rather than prioritizing equipping and empowering people to make ***good*** choices when it comes to substance use – particularly in some of the most vulnerable of our citizens, the young.

The former is all too often 'traded' as compassion with kudos given to the *damage manager* – Whereas best-practice and its promotion is almost invariably viewed as interfering, patristic, or worse *judgemental* and consequently scorned, even though it is best-practice on every level. How does this happen?

Simply, because the often-foundational criterion for what is best practice is being culturally denied.

Ethics and/or Morality in Prevention – Where is its place?

An inability to discover or even acknowledge deficits in preventative health, particularly in the alcohol and other drug arena, comes down to a clear omission of a once previously staple in good health and well-being management – an Affective Domain education consideration.

A greater anthropological consideration that simply goes beyond activity engagement or avoidance based on purely teleological outcomes, is required to help facilitate better practices for both individual and society – a greater focus on 'Fence' over mere 'Ambulance' options in public and private health.

Ethical and/or moral prescriptions and proscriptions leveraged off higher psycho-social principles can give better framework for decision making going beyond outcomes and the management thereof.

I. Deficits in Preventative Health:

- When we don't recognize or acknowledge gaps in our efforts to prevent health issues, we lend ourselves to missing best practices.
- For example, not realizing that we are not doing enough in leveraging all measures, including moral and ethical factors, to prevent alcohol and other drug related problems.

II. Anthropological Consideration:

- Looking at best health and well-being practices from a broader cultural and societal perspective.
- Going beyond just individual actions and considering the 'all of community' health and wellbeing context.

III. Affective Domain Education:

- This goes beyond the cognitive domain considerations of, what, when, where, how and/or who, to the more important question of Why. This means considering belief systems, values and feelings issuing from these (or lack of them) when educating people about health.
- It is not just about facts (though vital); it is about what people believe, think, and feel and why. Also is about how these may motivate, compel, coerce, seduce, drive, or otherwise inform their choices.

IV. Ethics/Morality in Prevention:

- Using principles based on ethics and morality to guide decision-making. Behaviour modification motivators or factors that go beyond a potential 'bad outcome' for the individual making the choice. Principle that regards others in their orbit – the 'neighbour'.
- And yes, considering what may be right or wrong when making choices related to health.
- This refers to the ethical and moral aspects related to preventing health and well-being harm causing conducts.
- It involves the primary prevention action of making decisions and taking actions to avoid health problems before they occur.

V. Fence over Ambulance Scenario:

- Instead of waiting for a crisis (then calling an ambulance), we should focus on preventing problems (building a fence).
- Prevention is better than dealing with emergencies – Prevention is always better than cure.

To summarise in part, "morality in prevention" involves making ethical decisions to prevent negative physical, mental, and social health outcomes/issues, not only for the individual but also their community. It is also about considering settings, relationship and psycho-social conditions of the others and looking beyond the myopia of egocentricity to a bigger picture, including the health, safety, wellbeing, and betterment of your neighbour – a more civil and functional, not merely damage managing society.

Again, it is akin to building a fence to minimise health and life risking activities with their ripple effect harms, rather than relying on an ambulance and damage management when things go wrong.

So, how does this all relate to what research has now confirmed about the key protective factor in drug prevention and demand reduction for the youth? Let's look at the science.

Conventions on the Rights of the Child: Article 33

States: Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

What does the Science Say is the Most Important Protective Factor?

Not unsurprisingly, the answer to this question is framed in both a moral/ethical context, along with a health and well-being one.

Protective Factor Number One in Drug Use Prevention Science: *In Denying or Delaying Uptake of Substances the Key Protective Factor for Your Children/Students is the **"Belief that Drugs are Bad".***

Latest research out of University of Illinois, and not before time, has published what has been intuitively known for decades – *That is that the key, and it would appear overarching, protective factor against substance use uptake* is the ***'Belief that drug use is wrong'.*** (Also, parental reinforcement of this belief, along with honest caring and proactive parenting of the child as the other bookend of this primary protective factor).

The researchers found ***individual beliefs that drug use is wrong had twice the magnitude of impact compared to other risk and protective factors examined in the study.*** Thus, influencing adolescents' beliefs about drug use may be an important but relatively underemphasized key to modifying their behaviour.

The researchers analysed information from the 2018 Illinois Youth Survey, which measured risk behaviours among middle and [high school students.](#) The study included more than 128,000 youths in grades 8, 10, and 12 from schools across Illinois. Respondents noted whether and how frequently they had used alcohol, cannabis, or tobacco in the past year. They also answered a range of questions about their attitudes, school, family, and health.

"It is not surprising that drug use beliefs are linked to behaviour; we certainly would expect a correlation between them. What's most noticeable is the magnitude of the effect, particularly in comparison to more established factors included in the analyses," Barton states. In the survey, youth were asked how wrong they think it is for someone their age to consume alcohol or drugs, ranking from "not wrong at all" to "very wrong" on a four-point scale. For each unit increase in response, the likelihood of past-year drug abstinence increased by 39% for 8th graders, 50% for 10th graders, and 53% for 12th graders.

Beliefs not only correlated strongly with past usage, but also with frequency of use. "Even among individuals who used drugs in the past year, individual beliefs that drug use is wrong were associated with less frequent use," Barton says.

The Dalgarno Institute and other primary prevention, demand reduction and community resilience building educators, have been fully aware of this issue for many years and have challenged some of the confusing narratives coming out about drug education priorities which lean toward normalising or even sanitising drug use as, 'part of growing up' in a Western culture.
It is concerning for all communities and their families that pro-drug advocates have been working tirelessly to hijack our very important **National Drug Strategy** and create the very 'cognitive dissonance' we are seeing in many AOD education offerings.

What is even more concerning however, is the outcome (whether intended or not) of sending a strong tacit message to our young people that drug use is somehow 'normal' or at least, *a phase of experimentation that is normal.* Messages that clearly undercut this primary prevention vehicle of *drug use being wrong,* the reason for this undercutting appear varied and concerning.

Consequently, this 'messaging' is priming the emerging generation, (along with a growing and consistent indifference to adolescent drug use) that either ignores best practice of prevention, demand reduction and abstinence or worse; actively mocks these positions as unsophisticated or sub-culturally 'uncool'.

Subsequently this all creates the self-fulfilling predictor that kids are being primed to hear, and that is... *'drug use is normal, a little risky, but manageable', because some of the noisy 'grown ups' are telling me it is!'*

MAKING *PEJORATIVE* REMARKS ABOUT HEALTH AND WELLBEING BEST-PRACTICE: PREVENTION – *ABSTINENCE* AT THE FORE – AND BEST-PRACTICE FOR THOSE EXITING DRUG USE, *DOESN'T LESSEN* THAT BIO-BEHAVIOURAL TRUTH, NOR DOES IT GIVE ANY WEIGHT TO THE ARGUMENT FOR DENYING THIS BEST PRACTICE.

THIS MOCKING DOESN'T CREATE *MINDFULNESS* AND *RESILIENCE* FOR BETTER HEALTH AND LIFE, ONLY *MALICIOUS MANTRAS* FOR CONTINUING PRO-DRUG NORMALISATION AND RESILIENCE *UNDERMINING HARMS.*

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Add to that, the following tactics.

- Socio-behavioural undermining drivers such as couching some psychotropic toxins in a 'medicinal' context – thus feigning a type of legitimacy for 'recreational' engagement. e.g. cannabis and psychedelics.
- The ongoing misuse of legitimate de-stigmatizing vehicles, not to assist those caught in substance use, but more cynically to defend those who willing use substances for 'recreational' purposes.
- The touting of the damage management model of harm reduction (not prevention) as the preferred emphasis in AOD education.
- Not to mention the decriminalisation agendas that all scream at the emerging adult, (all-be-it sub-textually) that 'drug use can't be all that bad!'

It is important for us all to understand these advocacies and the associated conduct in the public square is all an in-kind form of drug 'education', and the pro-drug lobby knows this.
Our Children/Students have as their actual 'Human Right' under Article 33 Convention the Rights of the Child to be protected from all aspects of illicit drug use – all aspects.
Any vehicle or mechanism that undermines or interferes with that authentic human right is at best incredibly concerning, at worst utterly egregious.

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Yesterday was the time that all teaching/learning environments had ***Demand Reduction and Primary Prevention at the centre of all AOD education*** – as we do with Tobacco. With tobacco there is Only one message, one voice and one focus in the public square, and that is Don't Uptake or QUIT. There is no dissenting, contrary or confusing voices in any public sectors of education, medical, government or media policy on Tobacco, so why are we permitting this confusion in the illicit drug space?

It's time we had a *'war for the brains, health and future'* of the emerging generation, and stop pandering to a cultural minority who continue to expend extraordinary amounts of social, intellectual, and financial capital on trying to convince the culture that drug use and the outcome of 'getting high' or 'having fun' is not only manageable, but important.
The usefulness of the lived experience and earned resiliency of the Recovering Alumni – The ex-drug user – in understanding this key protective factor cannot be understated.

Key questions that must be answered...

- What is best practice around AOD (alcohol & other drug) use for the developing brain – Prevention of damage management?
- There is no dissenting, contrary or confusing voices in any public sectors of education, medical, government or media policy on Tobacco, so why are we permitting this confusion in the illicit drug space?
- What 'drug education' are your children and/or students being subject to? Prevention or simply drug use normalising Harm Reduction?
- Why, as educators, would we permit any cognitive dissonance in our teaching and learning environments in the AOD education space?

It's time to #preventdontpromote and work tirelessly in promoting #DemandReduction.

Shane Varcoe - Executive Director, Dalgarno Institute.

References

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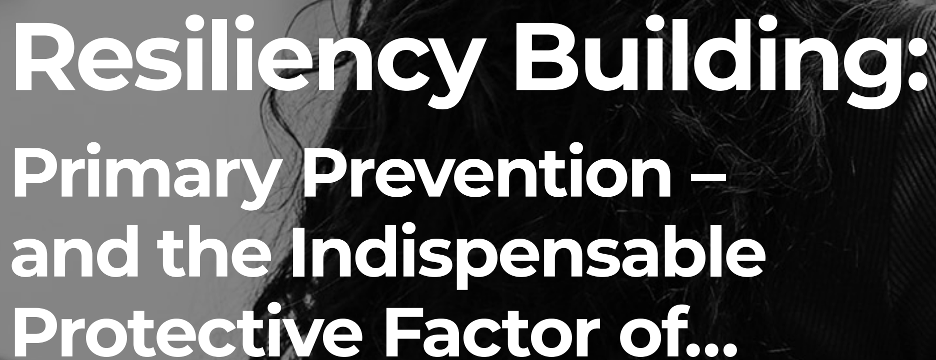

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