Coalition of Alcohol and Drug Educators

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Social Determinants and Substance Use.

A perspective beyond the policy 'silo' pragmatics.

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"These authors have written a deeply insightful and carefully researched and referenced paper summarizing the key elements of policy development and social responsibility underlying the many twists and turns involved in drug policy and regulation.

Quoting and reviewing many of the leaders in addiction and social policy analysis worldwide the authors have produced a profound deeply insightful and very useful policy summary relating to addiction which is useful to policy makers globally.

It should be widely read, carefully considered and thoughtfully implemented everywhere societies struggle with the difficulties the seductions and the tsunamis posed by the plethora of addiction epidemics worldwide. I thoroughly commend their work to your thoughtful consideration and the wider viewing of the thinking policy making body politic."

Professor, Dr Stuart Reece

SOCIAL DETERMINANTS AND SUBSTANCE USE

FOREWORD

Integrating system, behavioural and moral theories to improve substance abuse prevention policies.

I am pleased to contribute a foreword to the paper by Shane Varcoe and Derek Steenholdt. Their paper takes aim at aspects of harm minimisation policies that advocate throwing out illicit drug prohibitions as a means of reducing drug problems. The authors argue that some aspects of these policies run the risk of causing increased problems by failing to address the underlying determinants that cause substance abuse and by increasing "pro-drug use" attitudes.

My research team have previously documented how some aspects of Australian harm minimisation policies through the 1990s caused large populations of Australian adolescents and young adults to experience increasing substance abuse problems. Australian advocates of harm minimisation policies argued in the 1980s that USA abstinence policies were misguided because adolescents had an "inherent predisposition" to take risks such that adolescents could never abstain from using substances. My research team ran a large cross-national comparison study from 2002 (www.iyds.org). This study found that youth attitudes and behaviours aligned with the differing policies operating in Australia and the USA. Youth in the USA were more likely than their Australian peers to see substance use as unacceptable within their families, communities and peer groups and, unsurprisingly in hind-sight, this was associated with lower substance use in the USA (Hemphill et al, 2011: www.ncbi.nlm.nih.gov/pubmed/21856525). Parents in Australia believing that moderate adolescent alcohol use was acceptable, were more likely to supply and supervise adolescent alcohol use. Unbeknown to the Australian parents at the time, this was leading to heavier alcohol use as their children grew up (McMorris et al, 2011: http://dx.doi.org/10.15288/jsad.2011.72.418).

In my view the way forward for substance abuse policy is to integrate knowledge from a variety of fields including child development and international human development. Child development theories provide clear directions as to what needs to be done to prevent substance abuse while also encouraging healthy moral development (Toumbourou, 2016: http://dx.doi.org/10.1037/gpr0000081). In the area of human development the United Nations Sustainable Development Goals support clear and evidence-based restrictive market regulation policies such as the framework convention on tobacco. Similarly market regulation restrictions are recommended to address problems related to alcohol use. It is timely to debate substance abuse policies and to raise the question as to whether legalising illicit drugs may do more harm than good?

Prof John W Toumbourou PhD, Chair in Health Psychology
(Professor – Deakin University, Australia).

A CULTURAL SHIFT AWAY FROM PERSONAL RESPONSIBILITY

In the early 20th century, the push for responsibility for behaviour in our 'first world' societies, moved from the personal into the collective arena, but at first only in the political space. This facilitated the need for the political arena to take responsibility and act against socio-behavioural problems – usually around and within a legislative framework building on a well-established (and for the most part, collectively held) moral values-based system of social management.

However, in the second half of the 20th century this 'collective responsibility ownership' paradigm transitioned. A commencement step for this transition was by decommissioning recognised collective values and then, with the emergence of the 'post-modernity' (officially labelled in the early 1970.s) saw the fostering of amoral eclecticism, inadvertently aided and abetted by an ever-growing pluralism, which all but completed the transition into a relativistic social and subsequent state sponsored welfare focused space.

Consequently, we have shifted culturally into the relativistic social and welfare space for the purpose of collectively supporting the, now *unaccountable* individual, who in this new cultural environment can now be perceived and/or labelled as 'disadvantaged'. One of the consequences of this continuing shift to collective and non-personal responsibility was the recalibrating (if not abandoning) of any 'objective' (or at least agreed upon) evaluation processes.

Prominent Sociologist, Professor Amitai Etzioni, was a little more 'pointed' about this phenomenon in his robust work The New Golden Rule – *Community & Morality In a Democratic Society* when referring to the advent of collective responsibility.

> *"Still another ideology that grew in influence.. was the notion of system rather than personal victimology. This ideology blames the social system for whatever antisocial conduct in which a person engages. Drug abuse, alcoholism, and violence are said to occur because people are poor or unemployed, have only "dead-end" jobs.. or have not been empowered. While social systems factors are always important, and sometimes dominate the situation, when they are used to imply that the victims have no choice in the matter, which exempts the actors from moral responsibility for their acts, the notion becomes highly damaging to the moral voice."*
>
> ***(Etzioni, A The New Golden Rule – Community & Morality In a Democratic Society BasicBooks, 387 Park Ave South, New York, NY 1996, Page 137)***

AN ETHICAL SHIFT TOWARDS AN AMORAL APPROACH

This new supposed amoral matrix for 'assessing' (not evaluating – values laden process) of responsibilities for behavioural outcomes has ensured that accountability mechanisms be moved away from investigating actual 'origins' as influencers of behaviour, toward almost solely focusing on the collective responsibility for them. Without an agreed upon socio-behavioural standard it has meant the default mode of the 'collective' is to manage outcomes of behavioural issues without ever referring to (let alone addressing) some of the core morality/ethics in and for behaviours and conduct. Consequently, there has emerged (either by design or simply unintended by-product)

the avoiding, if not abandoning altogether the origins of such maladies. One clear outcome of this new 'collective responsibility' paradigm is that it ensures all tax-payers become responsible for self-harming behaviours of an often much smaller sub-demographic without any recourse to the requirement for change of the individual's behaviours that facilitate the self-harming outcomes.

Now do we have a 'chicken or egg' scenario? Whilst certain environments can clearly be defined as social determinants, there is a greater and greater 'blurring of the line' about whether environment creates behaviour or behaviour creates environment.

To use a clear example let us take North Korea. The information and evidence that is consistently emerging from this dictator State sees enormous inequality and poverty with high malnutrition rates, labour abuse, social oppression and even torture common. From all reports the health of the overwhelming numbers of marginalised poor is ever deteriorating. However, evidence emerging doesn't appear to indicate that behavioural issues of the citizens of this oppressive State are adding to the burden of 'disease', (I.e. alcohol and other drug use) even though they are victims of such appalling social determinants.

On the other hand you take a first world country like the USA which has, arguably, the world's largest economy, and whilst it may be operating on a meritocracy platform, as a first world nation it still has world leading health-conducive environs – sustainable population, lower pollution, adequate shelter, enough food and consistent utilities and shelter. What is interesting though is that this same nation is the largest consumer of both pharmaceutical and illicit drugs, and a leading consumer of legal drugs like alcohol and tobacco. Use of both licit and illicit substances in this nation, for the most part, is no longer driven by 'traditional' motivators (and in most western nations still clung to drivers) of poverty and social disadvantage.

An interesting juxtapose to this has emerged in a very recent study conducted by Columbia University's Mailman School of Public Health.

> *"Latest research from a national sample of almost 10,000 U.S. adolescents found psychological trauma, especially abuse and domestic violence before age 11, can increase the likelihood of experimentation with drugs in adolescence, independent of a history of mental illness. "Abuse and domestic violence were particularly harmful to children, increasing the chances of all types of drug use in the adolescent years", says Dr. Carliner."*
>
> *Carlliner et al (2015) Reported in a Medical press news article in: http://medicalxpress.com/news/2016-06-trauma-childhood-linked-drug-adolescence.html*

What we also glean from this data and from the following evidence is that the 'trauma' in this first world nation that can lead to drug use, is at the hand of (by any base moral standard) the dysfunctional family. In the vast majority of the cases alcohol or other drugs are touted as an integral part of these familial contexts. When validated by growing emergence of evidence-based data, we will see that choices to engage in the use and misuse of both licit and illicit drugs can in fact initiate decline into dysfunctional familial structures and settings. Furthermore, this decline will almost inevitably promulgate a model that the children of these settings then replicate – the socialisation dynamic in this space from infancy all but guarantees such – without early and thorough intervention.

However, this 'origin' of dysfunction and the part the recreational use of substances play in this is either ignored or downplayed, particularly by pro-drug advocates who want no poor press for their libertine agendas. If such stakeholders are engaged in the data collection, compiling and reporting space, then research quality control is most definitely compromised.

Data on this generational trend can be very difficult to procure and even this older data from Australia you can see the cyclical impact. (These percentages have been well exceeded, but reports are no longer forthcoming) * (see footnote below)

In 2008, research compiled by the Australian Institute of Family Studies found that..

33 % of parents experienced significant problems with substance abuse and 31 % with alcohol abuse.

Disturbingly, it is estimated that 30 % of abused or neglected children go on to maltreat children in some way when they are adults.. The saddest reality of all is that there is a correlation between child abuse and drug abuse – with a multiplier effect, which is now intergenerational.

So, much of the pre-pubescent trauma is from drug use/misuse in what should be the safest and most protective environment of all, the family. One then has to look at the psycho-social, as well as ethical and moral drivers of these family settings and the subsequent behaviours; not just poverty or lack of education to understand drug use and uptake.

However, for the large and growing part illicit drug use in the nations of greatest consumption – first world west – is now 'recreational' use and that aligned with entitlements to 'happiness', experimentation and unabashed hedonic drivers that are significant (but not sole) factors producing the increase in substance use and misuse. The following data out of the U.S. is not at all unsurprising.

> *"The U.S. has 4% of the world's population and consumes 63% of the world's illegal drugs."*
>
> ***'America's Worst Drug Epidemic' 2013 Seminar Robert M. Stutman (Former DEA Supervisory Agent)***

> *"USA with 5% of population consumes 80% of opioids and 95% of Vicodin in the world."*
>
> ***(Institute of Addiction Medicine)***

If we also consider further disturbing statistics coming out of Australia on drivers for uptake you will see very similar motivations from the 'lucky country' on illicit drug use initiation and engagement. Not only is it about 'excitement' and 'curiosity', it is also the result of trusting friends and trading off their 'good word and experience'. It is only a small minority of users who actually engage with illicit substances on the basis of what are commonly referred to as the key drivers for substance use – that is poverty, trauma and/or powerlessness.

Table 5.27: Factors influencing first illicit use of a drug, lifetime users aged 14 years or older, by age, 2013 (per cent)

Factor	14–19	20-29	30-39	40+	14+	18+	Recent user[a]	Ex-user
Friends or family member were using it/offered by friend or family member	44.4	51.3	52.5	51.6	51.4	51.7	51.2	51.5
Thought it would improve mood/to stop feeling unhappy	19.2	8.7	6.7	5.1	7.1	11.9	11.9	4.1
To do something exciting	32.4	23.2	21.4	14.3	19.2	26.8	26.8	14.6
To see what it was like/ curiosity	72.2	69.1	69.2	62.2	66.2	67.0	67.0	65.8
To enhance an experience	16.3	16.8	14.9	10.0	13.3	212.1	22.1	7.8
Other	*4.4	4.2	2.8	3.0	3.3	5.3	5.3	2.0

* Estimate has a relative standard error of 25% to 50% and should be used with caution.
(a) Used in the previous 12 months.

Notes:
1. Base is those who have illicitly used at least 1 of 17 drugs in their lifetime.
2. Respondents could select more than one response. (*Source: National Drug Strategy Household Survey 2013 detailed report)

*(*Source: National Drug Strategy Household Survey 2013 detailed report)*

It is this clearly held recreational entitlement that is now adding to *the burden of non-communicable disease* in these nations. Again, let us be unambiguously clear, for the most part this demand and consumption is not driven by abject poverty, social oppression, malnutrition, lack of education, starvation or physical environment toxicity; it is ostensibly driven by pure self-indulgent hedonism and its 'feeder' issues of neo-nihilism, materialism, individualism and relativism.

If it is not abundantly evident by now, at the very least any semblance of subtlety in the agenda being foisted on society is gone. The progressive erosion or marginalisation of cultural underpinnings, such as sustainable and objective morality/values, sustainable meta-narratives, religion, and family security, stability and well-being, has seen this relentless push to redefine conditions, states and behaviours via a 'values neutral' labelling, avoiding anything even suggesting *'bad/poor/wrong'* choice or behaviour (unless you are a pro-drug policy advocate and one challenging policies that do not permit drug use – more on that later). Drug use in this emerging and aggressively posited matrix has now moved from a behavioural issue with negative health/social outcomes, to a purely health issue with some behavioural side effects.

However, serious clinicians and practitioners were onto this ruse in very early days of what has become known as 'harm reduction only' drug policy frameworks. One such psychiatrist who writes under the pseudonym 'Theodore Dalrymple' penned his many concerns in his poignant and insightful work *Junk Medicine*. The author exposes some of the lies, (and damned lies) used to justify, not only drug uptake and the beginning of addiction, but also the utter absurdity of the self-justifying narratives around addiction victimology from both users and the majority of the professionals charged with trying to help these 'victims' deal with the illicit drug use;

> *A man is somehow or other exposed to heroin. But how is a man exposed to heroin? The use of the passive voice is here very instructive. The heroin comes to the man, the man does not go to the heroin. It is as if the heroin has a will of its own, unlike the man. The heroin is active, the man is passive. A fine, and not untypical, example of this kind of thinking came my way recently in the statement of a young criminal, charged with robbery, on whom I prepared a medical report at the request of his lawyer:*
>
> *When we moved to D_____, I just fell into taking drugs by the usual route. I met two blokes who were somewhat older than me and it all started off with a few drinks and one day one of them had a cannabis joint, I smoked that, things progressed, then on another day somebody brought in some crack cocaine, that was smoked and one thing led to another and then I find myself a heroin addict.*
>
> *On this highly selective account, almost no human agency, at least on the part of the addict, is admitted. "It" starts off, "things" lead to one another, and a person finds himself in a position as if he had been kidnapped and taken blindfold by main force to a completely unknown destination*
>
> *Clearly such an account is self-serving, in the sense that it implies no control, and therefore no blame. What, perhaps, is more surprising is that large numbers of well-trained, or at least indoctrinated, people – doctors, therapists, social workers, and the like – swallow such clearly self-serving accounts more or less whole. ...*
>
> *Many addicts say that they did not know what they were getting themselves into when first they took heroin, but this is simply not credible; they could not have failed to know.*
>
> *When I ask heroin addicts why they started taking heroin, the great majority of them reply with one of two answers. These are: "I fell in with the wrong crowd" and "Heroin's everywhere."*

Dalrymple, T. (2007) Junk Medicine pp 12-13

This victimology narrative was not lost on proactive and prevention focused drug policy architects either. Robert L. DuPont, MD, President of the Institute for Behavior and Health, Inc. and first Director of the US National Institute on Drug Abuse (1973-1978) distilled the debate on the issue down into the following two camps;

> *The clash of drug policies today is at root simple: "harm-reduction" vs "drug-free" All harm reduction rationalizes and sustains drug use -- waiting always patiently for some change of heart in the drug user leading to an unforced decision to not use drugs meanwhile softening to the extent possible the inevitable negative consequences, up to death, of the drug-using behavior. The decision to use drugs is personal but any problems are explained by seeing the drug user as a victim and not as the responsible agent of his or her own fate. Harm reduction denies personal responsibility for outcomes and glorifies personal responsibility for decisions. It is accountability free for the drug user.*
>
> *In contrast all drug-free policies insist on the goal of no use of drugs for the health of the individual as well as for the health of the family and the entire community. Creating and maintaining this drug-free standard starts with individual responsibility but it extends to community and even to international responsibility. The decision to use drugs, in this view, is the responsibility of the individual AND of the family and the community. Drug-free is a shared value that is to be respected and appreciated together. It is rooted in mutual interest and natural law because it works while alternative, drug use, does not work in the public interest.*

FLOW ON EFFECT TO LANGUAGE ABOUT DRUG USE

However, that very succinct and clear perspective is not viewed favourably by those wishing to legitimize, if not sanitize, the ongoing use of illicit substances, so new perspectives must be couched in language that ensures a 'credibility' that either endorses, or at the very least, overlooks *bad behaviour and poor personal choices* when it comes to illicit drug use.

This new sociological *language* is at best disempowering; it has created a 'victim' posture in people that supposes they are without choice. Whether deliberate of inadvertent, this new space ensured that education, accountability and responsibility, were devalued whilst simultaneously elevating/promoting mechanisms that enabled/permitted ongoing drug use, but with a strong (and for the most part) sole emphasis on, not health protection, but a token attempt to minimise severe trauma or death, whilst enabling, empowering and even equipping the drug user to continue to engage in harmful and health diminishing practices with impunity.

So disempowering and so complete the new narrative, that the very notion of saying 'NO' to drugs (which is actually not only a best health practice, but also best community benefiting one) is now not only not an option, but ridiculed (by pro-drug activists) as *utterly ridiculous* and mocked accordingly! This carefully crafted tirade seeks to ensure all evidence supporting the empowerment of best practice of abstinence is culled or, as stated, mocked. Any caring, civic minded citizen, let alone clinician, would have to ask; *'why, in our harm reduction only focus on drug policy, are we seeking to actively disempower the ability to choose not to use drugs? Who said this will be the best way to move forward?'*

The following excerpt, is just a snapshot of the little known impact of what many considered a naïve and out-of-touch conservative notion, that actually worked – especially when all of government, media and community ***chose*** to empower the 'NO' message.

When the Reagans moved into the White House on Jan. 20, 1981, drug use, particularly among teenagers, was hovering near the highest rates ever measured. Of that year's graduating class, 65 percent had used drugs in their lifetimes and a remarkable 37 percent were regular drug users.

After the upheaval of the 1970s, Americans had chosen in Reagan a strong, optimistic leader to guide them to a more hopeful future. But there could be little real hope while one of the '70s more damaging legacies—astronomic drug use—was consuming the rising generation.

Fortunately for that generation of young people, Ronald and Nancy Reagan were stronger than the threat.

Eight years later, when the Reagans left Washington, only 19.7 percent of 1989's graduating class were regular drug users, a 47 percent reduction. And the trend that began under their leadership persisted until it reached an all-time low of 14.4 percent in 1992, 61 percent lower than 1981.

While it is too simplistic to credit Nancy Reagan alone with this downturn, it is impossible to ignore her leadership and the massive shift she led against the drug culture. Her off-the-cuff response to a young Oakland girl who asked her what to do if confronted with drugs became a clarion call: "Just say no."

(http://dailysignal.com/2016/03/11/nancy-reagans-just-say-no-campaign-helped-halve-number-of-teens-on-drugs/ (cited 16/3/16))

In 2015 a forum was conducted in the second most populated State in Australia, Victoria, The (at the time) principal policy manager of the Department of Health and Human Services (Prevention & Population Health), Monica Kelly presented a workshop to government and non-government agencies titled *'Prevention the New Frontier'* (a title that informs even the most disengaged clinician,

"This carefully crafted tirade seeks to ensure all evidence supporting the empowerment of best practice of abstinence is culled or, as stated, mocked."

that this vital health driver, *Prevention*, has long being missing, if not subdued in the policy space, specifically when it comes to AOD policy) Of course the address was to look at all community health issues from diet, exercise, through to alcohol and other substance use and their impact on community health and wellbeing. In her presentation she quoted the State Public Health and Wellbeing Act 2008, specifically its two core values

1) Improve health and wellbeing
2) Protect health and wellbeing

She went on to point out that it was not just simply about 'evidence based' data being the only consideration. By that she wasn't saying 'evidence free', rather referring to the many successful community based enterprises that are marking very good head way in the public health behaviour changing space. The lack of time, money and research needed to confirm what is clearly anecdotally manifest should not preclude these effective enterprises from the policy implementation space.

> *From our experience, whether deliberately crafted or not, it is often the incumbent clinicians who may be harm reduction only, who have access to the research budget who conduct evidence based research pitched to a particular framework, that can easily, if not inadvertently, preclude prevention and/or demand reduction protocols and programs. Thus the 'evidence' base continues to reinforce the already policy dominating paradigm.*

As we have just alluded to, behind much (but definitely not all) of this there has clearly emerged a meta-narrative, if you like, around drug policy and it appears from all evidence presenting in the marketplace, it has been labelled the 'progressive' policy agenda which appears to sponsor a mode that obstructs the prevention/demand reduction agenda.

However, in essence, it can only do that easily if the fundamental tenet of this progressive social agenda is the deconstruction/removal of most, if not all, moral/ethical foundations for behaviour, replacing them with 'health' language/definitions for evaluation/assessment purposes.

The following quote gives us a little, if not confusing, insight into both of the previously mentioned examples. The excerpt goes on to outline (using very moral language, I might add) what the World Health Organisation posits may contribute to social determinants and/or outcomes. Note terms in the following extract like *'toxic, poor, unfair'* and even just *'bad'*, are used without qualification.

> *Social determinants of health are the economic and social conditions – and their distribution among the population – that influence individual and group differences in health status. They are risk factors found in one's living and working conditions (such as the distribution of income, wealth, influence, and power), rather than individual factors (such as behavioural risk factors or genetics) that influence the risk for a disease, or vulnerability to disease or injury. According to some viewpoints, these distributions of social determinants are shaped by public policies that reflect the influence of prevailing political ideologies of those governing a jurisdiction.*

Mikkonen, Juha; Raphael, Dennis (2010) "Social Determinants of Health: The Canadian Facts" (http://www.thecanadianfacts.org/The_Canadian_Facts.pdf cited 26 Feb 2016).

The World Health Organization says that:

> *This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies, unfair economic arrangements [where the already well-off and healthy become even richer and the poor who are already more likely to be ill become even poorer], and bad politics."*

World Health Organization, Commission on Social Determinants of Health (2008).

Now whilst these elements are separate from other risk factors such as genetics or behavioural factors, they can and do influence and add to these risk factors, but can also spread and/or enhance them. As we looked at in the previous juxtapose of North Korea and the USA, 'bad – toxic – poor' political, policies and ideologies that create inequality, poverty, powerlessness and deprivation can most certainly lead to mental and physical disease and shorter life expectancies; these do not necessarily lead to drugs use. Yet it would appear if we applied the same adjectives of 'bad – toxic – poor', to the social engineering policies of the USA, one can see how they add to and enhance the engagement with both licit and illicit drugs.

66TH WORLD HEALTH ASSEMBLY ADDRESSES SOCIAL DETERMINANTS OF HEALTH

Given the growing recognition of its importance, action on social determinants of health was again discussed at the *66th World Health Assembly (WHA66)* held in May 2013 in Geneva, Switzerland. The WHO Director-General, Dr Margaret Chan, reminded Member States that:

> ***"Factors that contribute to good health at low cost include [1] a commitment to equity, [2] effective governance systems, and [3] context-specific programmes that address the wider social and environmental determinants of health."***
>
> *66th World Health Assembly (WHA) May 20-28, 2013 , Summary of Opening Address by Dr M Chan (emphasis added)*

Let's unpack these three recommendations:

[1] A commitment to equity:

That's a very good commitment to have. However, the first action required is to establish a credible and workable definition of the term equity in this socio-political space. Equity is a 'standard laden' word and refers to qualities such as 'fairness, justice, impartiality' and even 'objectivity'. Of course in a criminal/legal context it refers to the application of the dictates of conscience or the principles of natural justice to the settlement of controversies.

It becomes very evident that in public policy development all these key elements must clearly be part of constructing this foundational premise for building on. What is important, even inescapable to note, is that elements such as justice, objectivity, fairness and dictates of conscience, must have an agreed upon benchmark from which to be measured and this benchmark, regardless of the arbiters of it, will invariably have to determine that some actions/activities/behaviours are 'non-compliant' with what is determined equitable. It is these breaches that have to be managed and it is policy that must ensure those non-compliant positions are bought into compliance – how that is done is now the purview of implementation practitioners. *What is concerning for the purveyors of this compliance creating process, is that antagonists and non-compliant people will rail against any measure to produce compliance that breaches their personal sense of comfort as 'coercive' and as such a 'breach' of their perceived human rights* - More on this later.

For example, if we refer to the Constitution of the United States of America, 'all humans beings are created equal', we must also note that this statement goes on to discuss the context for that 'equality' in terms which our current post-modern relativist Western Culture cannot work with. This values/moral laden supposition refers to a 'Higher Power' that created humanity in 'Its' image, but secular-humanist authorities do not subscribe to that, and rightly so if this is (a) incorrect or (b) untrue. So then, it remains incumbent upon policy

makers to determine what makes people of worth and weight and it must be geared to some standard and/or measurement – So, what makes us distinctly unique as humans and what, if anything, determines inequality? Furthermore, what would contribute to or detract from that equality? These are questions that must be answered, and answered more than adequately, for this platform for justice to have substance.

[2] Effective governance systems:

If we haven't established a sustainable and well 'anchored' platform for the criterion of equality, it is difficult to build a policy framework on that. Governance systems are only as good as the presuppositions and clear foundations they can work from. If definitions keep changing at the whim of capricious 'power brokers/policy makers' or even an ever morphing manufactured consensus, then what is 'equity'? What benchmark or 'plumbline' does one employ as the standard to which a policy or program is measured?

[3] Context-specific programmes that address the wider social and environmental determinants of health.

Where do you begin with this statement of purpose? Context-specific no doubt refers to the anthropology, culture, environment and the behaviours they produce in a particular region or people group. Or does it refer only to the cultural perceptions/values of the policy contriver? Are supra-cultural, philosophical and/or religious factors considered in program development and deployment, or such world-view considerations, marked inferior by the ones interpreting policy? (It is very important to note that Post-modern politically correct theory insists that *no culture is inferior in the global market-place*. Again, this is another perspective that flies in the face of 'evidence'.)

Does an anthropological elitism of the First World secularist declare on one hand 'all cultures and peoples to be equal', yet then undermine that grand declaration with the denial and often forced cessation of long held cultural beliefs that a people group may determine as 'best practice' for them?

Now, it is not difficult to determine that say *widow burning* in Hinduism, or *cannibalism* in Melanesian culture, or *foot binding* in Chinese culture, are worthy of cessation for a number of health and well-being issues. However, what of other practices in the West that diminish health and wellbeing, such as promiscuous sexual practices and drug use? Are they to be addressed or just relabelled as personal choice and 'managed' despite their non-compliance with best health practices?

This begs the following questions:

- Who then, in this subjective space, gets to determine what best practice is socially and morally in regard to positive health and social outcomes?
- Does it all distil down to 'health outcomes' as the final arbiter of what is best practice? If that is so, then what evaluation matrix is placed on a policy that increases/ enables drug use rather than decreasing or preventing it?
- Does one have to also consider moral and/ or ethical values and practices that are efficacious in formulating a drug policy that reduces demand and fosters prevention? Or do only proscriptions or prohibitions apply to cultural practices that are arbitrarily deemed inferior by those formulating the policy?

NON-COMMUNICABLE DISEASES (NCDS) AND COST EFFECTIVE INTERVENTIONS

The W.H.O. report of WHA66 went on to posit the following:

> *'An investment of US$ 11 billion spent on cost-effective interventions against non-communicable diseases can prevent over US$ 47 trillion-worth of future damage to the world's economies by 2030. If unaddressed, the NCD burden will in turn explode government budgets in the coming years, and will have a 'huge impact on sustainable development'.*

Doherty, W.J. (1995)

This Author in bewilderment asks: *"Is no one paying attention to the detail of these assertions/ proclamations, or do they simply allow inappropriate spin to interpret these according to situational ethics?"*

We need to question

- What does that $11 Billion dollar intervention look like?
- Will the intervention address both NCD (Non-communicable Disease) and 'Socio-behavioural' Illness? If so, then how? (if 'socio-behavioural illness' is the predicate for NCD then addressing NCD's without addressing behavioural issues is pointless!)
- Will the intervention classify or categorise behaviours and if they are to be ignored, modified or stopped? If the latter, then what criterion do they use to determine the cessation of certain behaviours and how will they implement them? *(No matter how the recommendation is contrived, proscriptions and prohibition components will invariably be part of the equation!)*
- What is the responsibility of government in this process?
- What is the responsibility of the individual in this process; is it collaborative with government, or do 'autonomy' and 'privacy' claims prohibit such cooperation for change? How do governments a) determine that and, b) elicit compliance? Do they apply education and/or Legislation? What definitions will be used and expectations set? *(Again, no matter the recommendation contrived, proscription and prohibition components with invariably be part of the equation!)*
- By using the classification of 'socio-behavioural Illness'; does the conduct of individuals simply fall under the 'health' banner and if so does their conduct and the subsequent outcome then become the responsibility of government only?
- If the government takes responsibility for further legislation, what measures do they implement to a) remove susceptibility and/or exposure to the detriment of health/wellbeing and productivity or b) resource 'irresponsible' individuals (if such a 'label' is allowed to be applied) to continue not only to maintain their existing lifestyle with a non-communicable disease, but increase its impact on their health and its spread to other individuals?

DEFINING 'HEALTH'

> *The WHO Constitution states that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, and that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. Further, it recognizes that the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States, and states that the Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures!*
>
> *However, there is now evidence that the poorest in developing countries face a triple burden of communicable disease, non-communicable disease and s**ocio-behavioural illness.***
>
> *WHO (May 2013) [emphasis added]*

It is vital to note here the latter category of *socio-behavioural illness* and the careful wording of this title. In the First World culture's emerged relativist framework there is the perpetual endeavour to avoid traditional labels and particularly the avoidance of moral language, as they may be construed as pejorative. Yet attempting to deny or deconstruct traditional morality does not mean 'immorality' vanishes from the socio-cultural arena – it cannot because we will always continue to suffer the 'illness' that immoral behaviour produces. Thus, it would appear, the necessary invent of this new category - *'socio-behavioural illness'.*

WHO REPORT ON SOCIAL DETERMINANTS OF HEALTH AND THE AUSTRALIAN CONTEXT

A significant milestone in efforts to have Australia take contemporary action on social determinants of health was achieved in March of 2013. With the Australian Government having ignored the 2008 release of the World Health Organisation (WHO) report ***Closing the gap in a generation: Health equity through action on the social determinants of health***, the Labor Party, the Liberal Party, and the Greens, through a Parliamentary Inquiry, agreed in March 2013 that the WHO Commission on Social Determinants of Health report should be ratified by the Australian Government as part of ameliorating the social causes of ill health.

A joint research publication of the Social Determinants of Health Alliance, the Australian University and Monash University (Carey, G and Crammond, B 2014) makes the observation that, despite the best efforts of those involved, little to no action had occurred since the Parliamentary Inquiry agreement in March 2013 to give effect to the decision of the two main political parties who at all times since Federation have either served as our elected Government or primary Opposition.

The research found that participants were uniformly aware of the social determinants of health evidence and were favourable in their assessment of its accuracy. Despite this familiarity, participants believed that policies to equalise the distribution of the social determinants of health were out of step with both the structural and discursive aspects of the political process. Structural limitations, such as departmental silos, work against large-scale social

change and create system-norms which favour the presentation of problems and policies in a way that fits within departmental boundaries.

In summing up their research into this matter, Carey and Crammond (2014) found that advocates and researchers should not shy away from adopting 'normative positions' or engaging in more of an ideological debate. While objective 'evidence-based' approaches have been favoured in recent years, ***participants argued that moral and ethical arguments sit at the core of public policy.*** [emphasis added] To disengage with these is to disengage with the issues around which political and policy arguments are fought and won.

So labelled 'policy pragmatists' who inadvertently contribute to much of the 'silo' culture in public policy implementation, essentially have adopted a relativist posture and thus ethos and rationale in addressing social determinant understandings.

This of course becomes its own ideological framework and colours both the understanding and implementation of issues. So policy makers believe they can, if not ignore, then negate moral and ethical evidences/issues. In essence they look only to 'outcomes' and as such may glance at operations to that end, but rarely if ever venture into the space of investigating 'origins' of socio-behavioural issues.

These so called pragmatists want to 'build' change but only want to focus on the 'structure' of operation and potential outcome without first focusing on building a solid foundation. The relativist approach is like trying to build on thin air or at best, quick sand. When the foundation is non-existent or the reference/anchor point is indefinable, you have little chance of building holistic change – again this becomes another motivator to revert to silo responses so people can feel 'ok' about doing 'something' to possibly affect change.

Who or what is driving the socio-political agenda – Who is at the wheel? (Cultural language and the regressive removal of moral judgments and mores)

Anyone who works in or deals with the alcohol and other drug sector is often 'assaulted' by the behavioural outcomes of the use and misuse of substances. The source of this continuing and growing behavioural dysfunction is not the drug use itself (that's now labelled (ironically) non-communicable disease). No, the underlying assumptions, beliefs and motivators that precipitate that dysfunction are what need to be addressed. These 'origins' are now no longer categorized 'wrong' or immoral or even unethical. As we have read previously they are now labelled as a socio-behavioural illness. Time will not permit us to unpack the continual attempt to avoid addressing the 'elephant in the room' when it comes to identifying key contributing factors to social determinants as risk factors, but even a cursory glance will scream for action on this issue.

WHO OR WHAT IS DRIVING THE SOCIO-POLITICAL AGENDA – WHO IS AT THE WHEEL?

(Cultural language and the regressive removal of moral judgments and mores)

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behavioural illness. Time will not permit us to unpack the continual attempt to avoid addressing the 'elephant in the room' when it comes to identifying key contributing factors to social determinants as risk factors, but even a cursory glance will scream for action on this issue.

Pulitzer Prize recipient, Ellen Goodman was lamenting this wanton departure from reason decades ago when she wrote (see azquotes.com);

> *I rarely side with people who want to put good and evil stickers on every piece of human behaviour.. But there are times.. when I wonder where our adoption of 'Shrink-ese' as a second language, the move from religious phrases of judgement to secular words of acceptance, hasn't also produced a moral lobotomy. In the reluctance, the aversion to being judgmental, are we disabled from making any judgements at all?"*

This closing question appears to be clearly answered with a firm; "No, we are not!"

Psychologist William Doherty (1995) recalls his thoughts in his article "Bridging Psychotherapy and Moral Responsibility":

> *Like many others, I was trained to avoid "should"-ing my clients, to never inflict the language of "ought" on them. I had been socialised into a therapy profession that by the 1970's had developed the firm conviction that "should" entraps people into living life for someone else. According to this school of thought, the only authentic life is one based on heeding the dictates of "I want."*

Professor Orval Hobart Mowrer earned his doctorate degree from Johns Hopkins, and had four years tenure as instructor at Yale; taught for eight years at the also prestigious Harvard and in 1954 became president of the American Psychological Association. He also weighed in on this emerging (now seemingly entrenched) paradigm, and to his detriment. When he submitted the paper, *"Sin, the Lesser of Two Evils,"* to the American Psychologist in 1960, he received scathing responses from many of his peers. However, Mowrer stood resolute on this issue. The following is an excerpt from that submission.

(What is also worth noting is that Professor Mowrer considered himself an atheist and to observers he was seen as *'no friend of religion.'* What is also noteworthy and tragic is that Mowrer committed suicide at age 75.)

> *For several decades we psychologists have looked upon the whole matter of sin and moral accountability as a great incubus and we have acclaimed our freedom from it as epic making. But at length we have discovered to be free in this sense to have the excuse of being sick rather than being sinful is to also court the danger of becoming lost. In becoming amoral, ethically neutral and free we have cut the very roots of our being, lost our deepest sense of selfhood and identity. And with neurotics themselves, asking, "Who am I? What is my deepest destiny? And what does living really mean? (He went on in the article to quote the lyrics from the psychiatric folk-song by Anna Russell) 'At three I had a feeling of ambivalence toward my brothers and so it followed naturally I poisoned all my lovers – But now I'm happy I have learned the lesson this has taught – that everything I do that's wrong, is someone else's fault!'"*

Orwellian commentary even weighed into the emerging cultural dilemma around morality, sin, behaviour and the human psyche;

> *For two hundred years we had sawed and sawed and sawed at the branch we were sitting on. And in the end, much more suddenly than anyone had foreseen, our efforts were rewarded, and down we came. But unfortunately there had been a little mistake: The thing at the bottom was not a bed of roses after all; it was a cesspool full of barbed wire.. It appears that amputation of the soul isn't just a simple surgical job, like having your appendix out. The wound has a tendency to go septic."*
>
> *(Orwell, G 1940)*

In referring again to the W.H.O. report (WHA 66: 2013), it goes on to inventory its definitions/ acknowledgements of 'inequalities' and has listed the following...

> *Investment in social determinants and reduction of health inequities – to realize the right of all people to have equal opportunities for health and to pursue lives that they value – is a* ***moral imperative*** *that coincides with the commitments all countries have made to health and human rights through international human rights treaties."*

So this policy directing document now unabashedly declares that it promotes, *"...the right of all people to have equal opportunities for health and to pursue lives that they value – is a moral imperative..."* The cognitive dissonance emerges with the emphatic usage here of the context of 'human rights'. This premise is now in direct conflict with the ethos of the 'judgement/morality-neutral' tenor needed in crafting what is a seemingly ideologically driven social determinants health agenda.

It would be helpful for us to unpack the previous statement some more. Note the careful wording about what is classified (at least in this setting) as ***moral imperative:***

- equal opportunity for health and
- pursue lives they value.

There seems to be no problem in using prescriptive moral language in the ideological arena, 'moral imperative' and 'human right', but when it comes to the implementation of risk reducing public health policy, the prescriptive language is avoided. This of course makes sense if the 'rights' of the individual are geared to the *'mood, urge, taste, flavour, preference or symptom'* of the individual and not to objective and holistic societal and health benefiting activities, choices and options.

However, in the attempt to avoid 'prescriptive language' about the application and implementation of policy on 'risk management' or 'health benefiting' or 'societal safety and productivity', we are confronted by an impasse. Right here we have conflict; and questions have to be asked to help put boundaries, or at least discernible clarifications, on this *moral imperative* and *human right*:

- Who gets to determine the 'risk factor' boundary? and,
- What 'human right' and 'moral imperative' will be invoked to justify that boundary?

> *Errors do not cease to be errors simply because they're ratified into law."*
>
> E.A. BUCCHIANERI, 'BRUSHSTROKES OF A GADFLY'

INFLUENCE OF THE PRO-DRUG AND ALCOHOL LOBBY GROUPS ON LEGAL AND 'RIGHTS' DIALOGUE AND THE MANIPULATION OF LAW.

Of course, the pro-drug lobby have invoked the 'rights' of 1) Privacy, 2) Autonomy and 3) Health care (with impunity I might add) in their push for ongoing and unabated drug use; but what of the 'rights' of other human beings who will be potential socio-financial victims of clearly health and productivity damaging behaviours?

The questions continue:

- What part does the government and individual then play in contributing to 'equal opportunity for health'?
- What level of responsibility falls on the individual?

But to answer that, we must 'unpack' the second moral imperative in this statement.

- What constitutes a life that *they* value? Who are they, the individual?
- Is the fact that *they* value a certain way of living sufficient grounds for it to be permitted/sanctioned/endorsed by government?
- Does that then mean every personal taste, flavour, urge, sensation, goal, attitude or preference, be protected by this category of ***moral imperative***?
- If those upholding 'pursuit of personal value' fail to collaborate with government in setting terms of reference for risk to social determinants of health, who then is responsible?
- Lastly; once *responsibility* has been determined, who then is even able to recommend or prescribe change if accountability processes are viewed as 'coercive'? (Pro-drug activists work tirelessly to remove any coercive prescriptions in their pursuit of ***their*** moral imperative.)

Yet any 'rights' claims without a foundation in virtue, adrift from a sustainable others focused morality, are nothing more than autocratic dictates as reflected in the remarks from the following significant social commentators and academics:

> *"Even the most 'rational' approach to ethics is defenseless if there isn't the will to do what is right!"*
>
> ***Alexander Solzhenitsyn***

> *"Errors do not cease to be errors simply because they're ratified into law."*
>
> ***E.A. Bucchianeri, 'Brushstrokes of a Gadfly'***

> *"We live in a culture in which a whole gamut of scape goats is ready at hand – our genes, our chemistry, temporary hormonal imbalance, our inherited temper and temperament, our parents failure during our early childhood, our upbringing, our education, our social environment – together these constitute an infallible alibi!"*
>
> ***Dr John R.W. Stott***

> *It is not freedom by itself that gives dignity, since freedom can be used to demean ... Freedom and the intent to choose the good constitutes that which bestows dignity."*
>
> *Martin Robinson (2001)*

If we consider the ways in which governments are planning to implement recommendations of the **W.H.O.** based on validated research, with the growing universal availability and social engagement with alcohol and illicit drug use, there will always be resistance by some to changing the status quo. In order to introduce new laws to restrict or prohibit the distribution of alcohol and mind-altering and medically unapproved substances, in democratic societies there is a need to convince people with influence and the population in general with well-constructed arguments based on moral, social and economic principles.

In his discussion paper on *"Law and Morality"* Cormac Burke (a Professor of Modern Languages and Doctor in Canon Law, as well as a civil lawyer and member of the Irish Bar) points out that the problem facing governments in creating and implementing such laws is that in the modern world, morality and law are almost universally held to be unrelated fields. Where the term "legal ethics" is used, it is taken to refer to the professional honesty of lawyers or judges, but has nothing to do with the possible "rightness" or "wrongness" of particular laws themselves. Consequently, governments creating new legislation and government bodies involved in implementing such laws can be criticised for creating and implementing "unethical" policies without moral foundation by those with vested interests in maintaining or liberalising the freedom with which the population acquire and consume increasing quantities of alcohol and illicit drugs! (Burke, 2011)

This is a consequence of the loss of the sense of any "truth" about man, and of the banishment of the idea of the "natural law". It undermines any sense of true human rights, leaves the individual defenceless against unjust laws, and opens the way to different forms of totalitarianism. This should be easy enough to see for a person open to the truth; but many people's minds have set into superficial ways of thinking, and they will not react unless they have been led on, step by step, to deeper reflection and awareness.

Burke (2011) explains our only alternative to adopting the modernistic, individualistic and relativistic approach of "legal positivism" is to acknowledge the foundations of our laws being based on universal human principles intrinsic to "natural law":

> *The only true alternative to positivism is the view that the authority of the law derives from what man is; and that man can find within himself a measure of the rightness or wrongness of the law.*
>
> *This view of the law goes back to the most ancient times; it has been the common wisdom of the ages. Among the Romans, Cicero taught: "The rule of law is to be drawn from the inner nature of man." (Cicero: De legibus)*
>
> *And so St. Thomas Aquinas (in Summa Theologica): "Every humanly conceived law has the true character of law insofar as it is derived from the law of nature. If in some respect it diverges from the natural law, it is no longer a law but a corruption of the law"*

PERSPECTIVES ON AOD, SOCIAL 'MORALITY' AND RISK TAKING BEHAVIOURS

Byron Johnson a recognised pioneer in the field of research on religious behaviours and the incidence of various forms of crime explores the links with drug and alcohol abuse in his book entitled *'More God, Less Crime'*. In his book, he reports on an extensive literature review of more than 270 published research papers into religiosity (i.e. adherence to religious practices) and crime. Overall, he found an overwhelming amount of evidence (90% of these studies) showed a beneficial relationship between religious activities/commitment and reduction in crime. Only 9% showed mixed results and a mere 1% indicated an adverse influence of religiosity on criminal activity.

More specifically, when reviewing 97 studies on alcohol abuse and religious commitment/practices, 85 studies showed a statistically significant inverse relationship between religiosity and alcohol related offences and 10 were inconclusive, with only 2 showing an adverse result.

Similarly, in 54 studies of illegal drug use or drug abuse and religiousness, the conclusion of 50 studies found increased religiousness was linked to lower levels of drug use or abuse.

Why, you might ask, with such mounting empirical evidence of the positive link between religiousness and crime reduction (in our focus, illicit drug use and misuse of alcohol) , has there been so little acknowledgment of this growing mass of evidence? In summing up, Johnson responds to this issue with the following observations:

> *"Two possible influences emerge as reasonable explanations. First, scholars have not done a very good job of communicating these realities to the public at large. Second, persistent stereotypes, anecdotes and sweeping generalisations of religion as bad seem to be much more newsworthy than do empirical studies which are not readily accessible to the public. … The book More God, Less Crime may be a much needed corrective to these two shortcomings."*
>
> *(Johnson B.R. 2011, p81)*

Of course, the aforementioned data is not utterly new in its revelations; Stark and Bainbridge (1997), on undertaking an analysis of data on over 9,000 people in the United States who had been "picked up by police" between 1973 and 1984, showed that arrest is four times as common among those who do not attend church as among those who attend every week. This and other police and prison data they reviewed confirms that being regularly exposed to a moral framework of the (in this instance) Christian religion really can deter crime.

Furthermore, their research analysis of data from 1988 to 1991 showed that in the United States, church attendance had a relatively robust, negative effect of drinking among both liberal and conservative Protestants, but no effect among Catholics. In Canada and the United States, church attendance of Protestants had a far greater effect on abstaining from drinking alcohol among conservative Protestants (US 47%, Canada 28%) than among liberal Protestants (US 28%, Canada 17%).

Looking more closely at youth delinquency data (which may reflect on inappropriate risk taking behaviours, including illicit drug use), Stark and Bainbridge (pp 67 – 99) also found in their research that communities with a higher percentage of church attendance had significantly lower rates of delinquency (for example Provo, Utah with 96.6% of population attending religious activities regularly in 1971 had a negative correlation factor for incidences of delinquency of -0.46; whereas in the same year,

Seattle with a US low score of 28% attending churches had a negative correlation of only -0.13 in relation to juvenile delinquency, which is not statistically significant).

The researchers suggest the data shows the proportion of a given city's population participating in religious activity and sharing of a common moral set of values can have an impact on the rates of reported delinquency - that is socially unacceptable deviant behaviour. They also hypothesise that there may be a critical percentage of the population engaged in and showing commitment to religious activities and religious moral values below which this effect is minimal or not evidenced in the behaviour of youth.

Shame is moral language, it in fact can denote the heart state of one who has realised they have acted in a manner that has breached a good standard, it can be evidence of a psyche concerned, not for self or ego, but the good of the neighbour. If behaviour change producing shame vanishes from within, then we are left with few options for behaviour change, with the exception of external coercion – the very thing libertarians want to remove.

If we are approaching our laws on relativistic and individualistic principles of legal positivism, then guilt will only be viewed as an external motivator that may try to compel some ethical conformity, but if the 'law' is changed or removed, does any notion of guilt vanish too?

No imagination is needed to see where a moral-less and 'shame free' culture will lead.

Viktor Frankl (1946) 'Father' of Logotherapy, got it right when he declared the key values for a moral society: These were;

- Turn suffering into a human achievement and accomplishment
- Derive from guilt [shame] the opportunity to change oneself for the better
- Derive from life's transitory an incentive to take responsible action.

Psychologist Dr Larry Crabb (2007) stated it very well when he said ... *"Deep change requires that we correct problems arising from our responsibility to choose, not those resulting from our vulnerability to be disappointed."*

When you disconnect shame, guilt, innocence, right and wrong from a pure, 'righteous' and/or objective context, then all these states can be used to abuse in both directions. The recalcitrant and careless 'wrong doer' or to use the new genre *socio-behaviourally ill*, carries on in behaviour and decries any challenge as 'shame' based and 'esteem damaging'. On the other pole, the human being who glimpses a higher standard, and cares for their neighbours is grieved by their actions, and shame leads to positive change.

> *Among the more moderate social conservatives is Alasdair MacIntyre. MacIntyre sees the institutions to which the Enlightenment gave birth crumbling. The modern world, obsessed with liberty, has slain virtue, leaving us morally bereft, in a world of darkness. With modernity, MacIntyre argues, came an impulse to liberate the individual from 'external morality' and to replace it with an inner moral voice. "Each moral agent now spoke unconstrained by the externalities of divine law, natural teleology or hierarchical authority; but why should anyone else now listen to him?"*
>
> *We try to give our opinions moral weight by asserting rights claims, but, as MacIntyre writes, "The truth is plain: there are no such rights, and belief in them is one with belief in witches and in unicorns." As a result, he concludes "The barbarians are not waiting beyond the frontiers; they have already been governing us for quite some time."*
>
> ***Amitai Etzioni (1998)***

> *So the final conclusion would surely be that whereas other civilizations have been brought down by attacks of barbarians from without, ours has the unique distinction of training its own destroyers at its own educational institutions, and then providing them with facilities for propagating their destructive ideology far and wide, all at the public expense. Thus did Western Man decide to abolish himself, creating his own boredom out of his own affluence, his own vulnerability out of his own strength, his own impotence out of his own erotomania, himself blowing the trumpet that brought the walls of his own city tumbling down, and having convinced himself that he was too numerous, laboured with pill and scalpel and syringe to make himself fewer. Until at last, having educated himself into imbecility, and polluted and drugged himself into stupefaction, he keeled over--a weary, battered old brontosaurus--and became extinct."*

Malcolm M et al (1985)

> *'Man's potential to do good or bad, be swine or saint, are dependent on decisions, not conditions.'*
>
> VIKTOR FRANKL (1946, P 156)

INTERNATIONAL DRUG POLICY – COLLECTIVE VALUES AND REDUCING DEMAND!

If Frankl, Muggeridge and the many other authorities are correct, then social determinant evaluation and solutions, at least in relation to drug policy, need to be seriously broadened and, as we have only touched on, cannot ignore traditional values, morality and sustainable spirituality (or if you'd prefer, 'Positive Psychology') if positive change is going to be realized as further acknowledged in the following.

Again, from the evidence presenting and the limitation of current processes, these authors contend that there is a need for a wider catchment for factors in social determinants. It is important to look beyond, and we would posit, through some of the policy frameworks that may inadvertently foster the 'siloing' of both policy and practice. This not only impedes a potential seamless efficacy of government policies that embrace social determinants, but also

may limit our more complete understanding of social determinants contributors.

The Australian Institute of Health and Welfare - Australia's Health 2016 Report refers to the following complexities of taking a 'whole of government' approach:

> *In 2008, the WHO Commission on Social Determinants of Health made recommendations on what is required to close the health gap through action on social determinants (CSDH 2008). WHO suggested that countries adopt a 'whole-of government' approach to address the social determinants of health, with policies and interventions from all sectors and levels of society—for example, transport and housing policies at the local level; environmental, educational, and social policies at the national level; and financial, trade, and agricultural policies at the global level.*
>
> ***(WHO 2011)***

This same report goes on to ask some important questions about some of the potential limitations of scope and focus of analysis in the social determinants investigation. On page 138 of the same report we have the following;

> *What is missing from the picture?*
>
> *Social determinants of health act through complex and multi directional pathways. Research is focusing on better understanding the causal links between social determinants and health outcomes, and on which policies might lead to better health outcomes. Across all key determinants, evaluation of programs and interventions to identify successes in reducing inequalities is important.*
>
> *Data availability and analytical constraints limit the monitoring of social determinants and the evidence needed for policy development. The extension of reporting to include variables such as ethnicity, culture and language, social support and the residential environment would provide a more robust picture of socioeconomic position. There is also scope for linking health and welfare data to provide a broader and more comprehensive understanding of the effects of social determinants.*
>
> *Additional longitudinal data would also enable improved monitoring of gaps and gradients in health inequalities.*

As this paper has either directly stated or eluded to, it is very much in agreement with some of the target issues in the previous quote; to really understand and get better purchase on factors of social determinants, one must again, look through and beyond into the Anthropological and Affective Domains, not merely one dimensional sociological influences. Harvesting and analysis of Anthropological data is vital in constructing a better understanding of what 'ingredients' contribute to social determinants – yes culture, ethnicity and language are vital, but not as vital as the informing agencies behind them. Culture is a multi-faceted construct that includes belief systems, values, and supra-cultural elements that underpin said systems, values and the behaviours that these can produce – both 'good' and 'bad' – from a health and well-being perspective.

The misunderstanding/underrating, or worse, dismissing and omitting of some of the beneficial anthropological elements, will only add to the policy siloing, but also impede that seamless efficacy that is sought to bring positive change.

For example in the following you will begin to see some attempts to engage with the spaces we have just referred to. A current international research project exploring the variations in the concepts of addiction and change in concepts of addiction over time, in particular in the field of alcohol and other drug (AOD) use, draws on insights gained from in-depth interviews with policy makers, service providers and advocates in Australia and British Columbia. The research compares the different AOD addiction concepts articulated by professionals working in each setting and shows and clearly reveals the quandary that emerges, precisely, we would argue, because we haven't looked beyond and through the limited categories of social determinants:

> *marked dissonance between perceptions of the true complexity and variability of experiences labelled addiction, and the strategic indispensability of the term and its stabilising tendencies. Whether addiction itself exists as a meaningful independent entity, whether it should be seen as a disease, what this term means and what to do with its stigmatising effects.*
>
> ***It is difficult to escape the conclusion that among those at work in our governments and AOD services there is little faith in addiction as a unitary coherent phenomenon that can be readily addressed by dedicated narrowly conceived responses, yet this idea continues to be promulgated because strategic alternatives are absent. From where might these alternatives emerge?"***
> *[emphasis added]*
>
> ***Suzanne Fraser, National Drug Research Institute, Curtin University (2016)***

One alternative identified by Latour (2004, 2013) in general terms proposes that we reformulate our world, and our view of it, as a 'multiverse of habits'. The application of this concept could result in remaking existing policy (and its expression in services) in new more flexible, more effective and less essentialising ways.

Latour proposes that we think in terms of the fluctuations and stabilisations of habit, rather than the irreversible rigidity of essence of addiction as a disease, genetic or neurological disorder. Rather, we should be asking what happens when we create addiction as a stable problem – when we take part in 'addicting' our world (Fraser et al., 2014)

Fraser's recent interviews of professionals and support personnel in the AOD field suggest that treating addiction as a matter of concern existing within a 'multiverse of habits' means recalibrating our understanding of individual experience. Conventionally divided domains and social determinants such as cultural history and politics of colonisation of a country, family trauma, poverty and socioeconomic status of individuals need to be viewed in an integrated way. Perhaps more challengingly, adopting the concept of a multiverse of habits means understanding addiction as fundamentally influenced by multiple factors which are unbounded, and as such, are not narrowly or exclusively negative (Pienaar et al., 2015).

* * * * *

The evidence is in, we are not just a lump of clay totally moulded and shaped by our external environment, nor are we an utterly predetermined, blue-print dictated, biological machine – we are a complex recipe that includes elements, essences and measures of both.

THE RECIPE THAT IS YOU - WHAT REALLY FORMS OUR ATTITUDES/ BEHAVIOURS?

Making a really good cake is an art, but one that can be perfected if the 'rules' are followed. Those 'rules' in the culinary world are called 'recipes'.

When a recipe is followed well and all ingredients, measures and timing are followed, the cake turns out as it should. Sure, you can vary it a little for slightly different outcomes, but if too much variation is introduced, the outcomes are interesting and mostly disastrous. Some cakes may look shocking and taste OK, or just the opposite they look great but...?

Researchers are now starting to realise this reality also applies to the very complex bio-chemical unit we call the Human Being. We were designed with amazing blue print components, however also with the capacity to imprint and shape those components. Incredibly, the initial and substantial management of that shaping process has been given to the ones bringing the new human being into the world.

Almost all behavioural issues can be distilled down to the complex, but clearly evident influence of developmental environment of every human being. The 'nature and nurture' debate is over – the evidence is in, we are not just a lump of clay totally moulded and shaped by our external environment, nor are we an utterly predetermined, blue-print dictated, biological machine – we are a complex recipe that includes elements, essences and measures of both. However, the ongoing discovery of the interplay between the two continues to surprise!

> *"Research in the last few years has dramatically changed what we know about how behaviours are inherited. Today's findings show how our genes and environment work together to influence brain development throughout a lifetime.'*
>
> *Flora Vaccarino, MD, from Yale University (2011)*

The latest data emerging reveals how incredibly sensitive and interactive genetic expression and environments are in all major development phases and environments;

- In-utero environments
- The first four years of life (and the most important phase of brain development)
- The pubescent brain development (which is the second most important phase of maturation and development)
- Parental behaviour, instruction and conduct – or lack/absence thereof.
- Family constellation, parental interaction, values, behaviours, world view and the list goes on.

Whilst it has been known that genetic data, especially faulty or mutated information, can impact on physical, psychological and emotional development, what has only recently been discovered is that it is the epigenetics that is the key influencer on how genes express themselves. The epi (outer or other than) coating of DNA has as much, if not more information contained in it than the gene, but its role lies in impacting how that genetic information is released/expressed. This process/medium in the epigenetic is the space that both behaviours and environs can have significant impact.

It is beyond questions that alcohol and other drug taking at all the above mentioned developmental stages determinately impact the development of us humans, but so will moral/ethical choices, conducts, behaviours and the values or lack thereof that underpin those. This is especially true when they're repeated and re-enforced by and in the environment, i.e. relationships, conduct, instructions

and patterns etcetera, all these will also influence gene expression.

Neuroscientist, Sebastian Sueng further expounds these ideas in acknowledging that the developments in neuroscience research and plasticity of the complex human brain are now leading to hypothesising that new thoughts, external stimulus and neural activity can change the functioning and behaviours of an individual. The evidence is suggesting we have the potential to reconstruct our brains and thinking patterns is expressed in a TED talk entitled "You are your connectome" given by neuroscientist Sebastian Seung (2010).

Seung explains how neuroscience is now exploring the concept that we are an expression of our "connectome" represented by the billions of electrical connections between our genes and neural synapses. Consequently external stimulus or new thoughts may well influence these structures and change or modify our connectome and consequently the way we express ourselves and our behaviours.

Fraser (2016) illustrates how this neuroscientific research would also suggest that any approach to addiction that simplifies the relationship between brain structure and behaviours too far, such as narrow brain disease models of addiction, are obviously flawed. Participants in the international research indicated the depth and breadth of their rejection of narrow accounts of addiction, and the strength of their inclination to see addiction as caused by, and most effectively confronted through, a combination of many different elements. These AOD addiction professionals generated many, many 'differences' of addiction. They saw it as an effect of many different forces and objects, manifest in many different ways, producing many different experiences, and in need of many different responses.

An Australian participant in Fraser's research on addiction captured this perspective in this salient comment on responding to people's needs:

> *"For me, once we start using terminology like that we start looking at that manifestation of the problem, as in addiction, rather than the broad range of things either that have led the person there, which you may not have much control over now, or how the various ways that's been manifested. . . I think in many . . . of the people we see there's other issues…there is a range of things. So therefore, to go 'this person's an addict or got an addiction', my concern is [first that]. ..we're not quite clear that addictions exist in that sense. But my concern about naming and framing something like that is that some of the other stuff then seems to drop away from our consciousness, in terms of how we respond to the person."*
>
> *Fraser 2016*

In 2016 the United Nations convened its scheduled review of drug policy and the long-standing conventions around the three pillared program of Supply, Demand and Harm Reduction. However, in the relatively short time between this and its last review much of what we have written about in this paper in regard to the decline or redefining of the so called, traditional morality/ethics/values and their impact on social determinants has escalated.

The recommendations outlined in the declaration from the 2016 WHO Convention on Narcotic Drugs (See Appendix B also included in following paragraphs) is using language that seems to convey a 'conservative' care to keep communities, families, and particularly children 'out of harms way', but do the sentiments or even recommendations have sustainable and implementable capacity in policy?

What also has to be considered in the wording of recommendations and even legislation is; does the policy language permit, or even invite, an interpretive 'narrative' that enables a subjective implementation that reduces the potential impact of the policy on drug use prevention, or worse, does

it allow for recalibration of the intent of the policy which will drive drug policy into a more permissive and, in reality, demand *enhancing* agenda for the next 10 years?

Only clear and unambiguous policy frameworks, along with the same policy interpretation drivers that unequivocally found and bolster Demand Reduction and Prevention – along with drug exiting Recovery – will see the health, community and familial outcomes that drug use reducing societies can achieve.

ONE FOCUS – ONE MESSAGE – ONE VOICE TO REDUCE DEMAND, PROMOTE DRUG USE EXITING RECOVERY AND CREATE PROACTIVE PREVENTATIVE ENVIRONMENTS FOR THE EMERGING GENERATION.

The following excerpt from a United Nations Memorandum that came out in the 2016 UN General Assembly Special Session (UNGASS) into world drug problem displays language that affirms much of what has been posited here as best practice. However, again, we must look closely at not only the wording, but how it may lend itself to interpretation and by whom? As you read the following excerpt ask the questions of the wording that this paper's 'matrix' has sought, and see if it permits a 'buying' into a tacit promotion of sustained drug use or clear working toward the denial/diminishing of uptake and drug use exiting strategies/ideologies?

> *We reaffirm our commitment to the goals and objectives of the three international drug control conventions, including concern with the health and welfare of humankind as well as the individual and public health-related, social and safety problems resulting from the abuse of narcotic drugs and psychotropic substances in particular among children and young people, and drug-related crime. We reaffirm our determination to prevent and treat the abuse of such substances and to prevent and counter their illicit cultivation, production, manufacturing and trafficking;*
>
> *We recognize that, while tangible progress has been achieved in some fields, the world drug problem continues to present challenges to the health, safety and well-being of all humanity, and we resolve to reinforce our national and international efforts and further increase international cooperation to face those challenges;*
>
> *We reaffirm our determination to tackle the world drug problem and to actively promote a society free of drug abuse in order to help ensure that all people can live in health, dignity and peace, with security and prosperity and reaffirm our determination to address public health, safety and social problems resulting from drug abuse;* (page 2)
>
> *We welcome the 2030 UN Agenda for Sustainable Development, and we note that efforts to achieve the Sustainable Development Goals and to effectively address the world drug problem are*

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complementary and mutually reinforcing; We recognize, as part of a comprehensive, integrated and balanced approach to addressing and countering the world drug problem, that appropriate emphasis should be placed on individuals, families, communities and society as a whole, with a view to promoting and protecting the health, safety and well-being of all humanity; (page 3)

We reaffirm the need to address the key causes and consequences of the world drug problem, including those in the health, social, human rights, economic, justice, public security and law enforcement fields, in line with the principle of common and shared responsibility, and recognize the value of comprehensive and balanced policy interventions, including those in the field of promotion of sustainable and viable livelihoods;" (page 4)

Shane W. Varcoe

Derek Steenholdt

REFERENCES

1. Amitai Etzioni (1998) "The New Golden Rule – Community and Morality in a Democratic Society" p 15; Basic Books; New York, NY
2. Australian Institute of Health and Welfare, National Drug Strategy Household Survey 2013, cited 20 April 2016 on http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs-2013/
3. Australian Institute of Health and Welfare; Australia's Health 2016. Australia's health series No 15; cited 14 Oct 2016 at http://apo.org.au/files/Resource/aihw_19787-ah16_sept_2016.pdf pp 137-38
4. Burke Mon. C. (2011) "Law and Morality" Self-Published Paper http://www.cormacburke.or.ke/node/1108
5. Carey, G & Crammond, B Taking Action on Social Determinants of Health: Insights for politicians, policymakers and lobbyists. (July 2014) Joint publication of SDOHA, ANU & Monash University.
6. Cicero (De legibus II) "Ex intima hominis natura haurienda est iuris disciplina"
7. Carliner H, Keyes K M, McLaughlin K A, Meyers J L, Dunn E C, Martins S S (2015) Childhood Trauma and Illicit Drug Use in Adolescence: A Population-Based National Comorbidity Survey Replication–Adolescent Supplement Study, Journal of the American Academy of Child & Adolescent Psychiatry
8. Crabb, L. (2007) Inside Out, NavPress p 196
9. Dalrymple, T. (2007) Junk Medicine – Doctors, Lies and the Addiction Bureaucracy, Harriman House Ltd pp 12-13
10. Doherty, W.J. (1995) "Bridging Psychotherapy and Moral Responsibility," Responsive Community vol 5, no. 1 pp 41-52 (Winter 1994/1995)
11. DuPont, R L (2016) personal communication, April 8, 2016
12. Etzioni, A (1996) The New Golden Rule – Community & Morality In a Democratic Society BasicBooks, 387 Park Ave South, New York, NY, Page 137
13. Frankl, V. 1946 Man's Search for Meaning p 162
14. Fraser, S., Moore, D., & Keane, H. (2014). Habits: Remaking addiction. Basingstoke: Palgrave
15. Fraser S.(2016) Articulating addiction in alcohol and other drug policy: A multiverse of habits, International Journal of Drug Policy v31 (2016) 6–14; cited 10th June 2016 at www.sciencedirect.com/science/article/pii/S0955395915003229
16. FreeMyAddict (2012) Coaching families and friends on how to help an addict http://www.freemyaddict.com/shame-on-who cited 26 Feb 2016
17. Goodman, E Quotation on http://www.azquotes.com/quote/1153744 cited 11 Mar 2016
18. Johnson B.R. (2011) More God, Less Crime (Ch 5), Templeton Press
19. Latour, B. (2004a). How to talk about the body? The normative dimension of science studies. Body & Society, 10(2–3), 205–229.
20. Latour, B. (2004b). Why has critique run out of steam? From matters of fact to matters of concern. Critical Inquiry, 30, 225–248.
21. Latour, B. (2013). An inquiry into modes of existence: An anthropology of the moderns. Cambridge: Harvard University Press.
22. Mikkonen, Juha; Raphael, Dennis (2010) "Social Determinants of Health: The Canadian Facts" (http://www.thecanadianfacts.org/The_Canadian_Facts.pdf cited 26 Feb 2016).
23. Mowrer, O. Hobart (1960) "Sin, the Lesser of Two Evils,"; American Psychologist, Vol 15(5), May 1960, 301-304 http://psycnet.apa.org/psycinfo/1961-03555-001 cited 10 Mar 2016
24. Malcolm M & Geoffrey B (1985), Vintage Muggeridge: Religion and Society, Pub by Angel P, East Wittering
25. Orwell, G 1940 "Notes on the Way" published in Time and Tide, 6 April 1940
26. Pienaar, K., Fraser, S., Kokanovic, R., Moore, D., Treloar, C., & Dunlop, A. (2015). New narratives, new selves: Complicating addiction in online alcohol and other drug resources. Addiction Research & Theory, 23 (6), 499 - 509
27. Robinson, M (2001) The Faith of the Unbeliever: Grappling with the Beliefs and Unbeliefs That Shape Our Society, Monarch Books
28. Seung, S (2010) "I am my connectome" TED Talk. Cited on 15 June 2016 at www.ted.com/talks/sebastian_seung?language=en
29. Solzhenitsyn A Quoted on http://www.azquotes.com/quote/596479
30. Solar, O & Irwin,A (2010) A Conceptual Framework For Action On The Social Determinants Of Health, WHO, Geneva.

31. Stark, R & Bainbridge W S, (1997) Religion, Deviance & Social Control, Routledge, NY

32. St Thomas Aquinas (Summa Theologica) "Omnis lex humanitus posita intantum habet de ratione legis, inquantum a lege naturae derivatur. Si vero in aliquo, a lege naturali discordet, iam non erit lex sed legis corruptio": Summa Theologica (I-II, q. 95, art. 2).

33. Stutman R M (2013) 'America's Worst Drug Epidemic' Cited 16 June 2016 at http://www.nadcp.org/sites/default/files/nadcp/Cybercafe/2013/handouts/SB/SB-1.pdf

34. UN Commission on Narcotic Drugs Fifty-ninth session Vienna, 14-22 March 2016 Agenda item 9* Preparations for the special session of the General Assembly on the world drug problem to be held in 2016

35. UN Economic and Social Council, Commission on Narcotics and Drugs, Fifty-Ninth Session. Revised draft resolution submitted by the Chair (March 2016). Cited 21 June: www.unodc.org/documents/ungass2016/Documentation/ECN72016L12_rev1_e_V1601770.pdf

36. Vaccarino, F. (2011) in Nature and Nurture Work Together to Shape the Brain (News Release), Society for Neuroscience, Cited 2016 at www.sfn.org/Press-Room/News-Release-Archives/2011/NATURE-AND-NURTURE-WORK-TOGETHER-TO-SHAPE-THE-BRAIN?returnId={0C16364F-DB22-424A-849A-B7CF6FDCFE35}

37. W.H.O. (2008) Commission on Social Determinants of Health. "Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health" (PDF). World Health Organization. (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61690-6/fulltext - cited 26 Feb 2016).

38. W.H.O. (May 2013) Health in the post-2015 development agenda: need for a social determinants of health approach Joint statement of the UN Platform on Social Determinants of Health, (http://www.who.int/social_determinants/advocacy/health-post-2015_sdh/en/ cited 26 Feb 2016) page 2

39. World Health Assembly (WHA66) May 20-28, 2013 , Summary of Opening Address by Dr M Chan Cited 10 March 2016 at

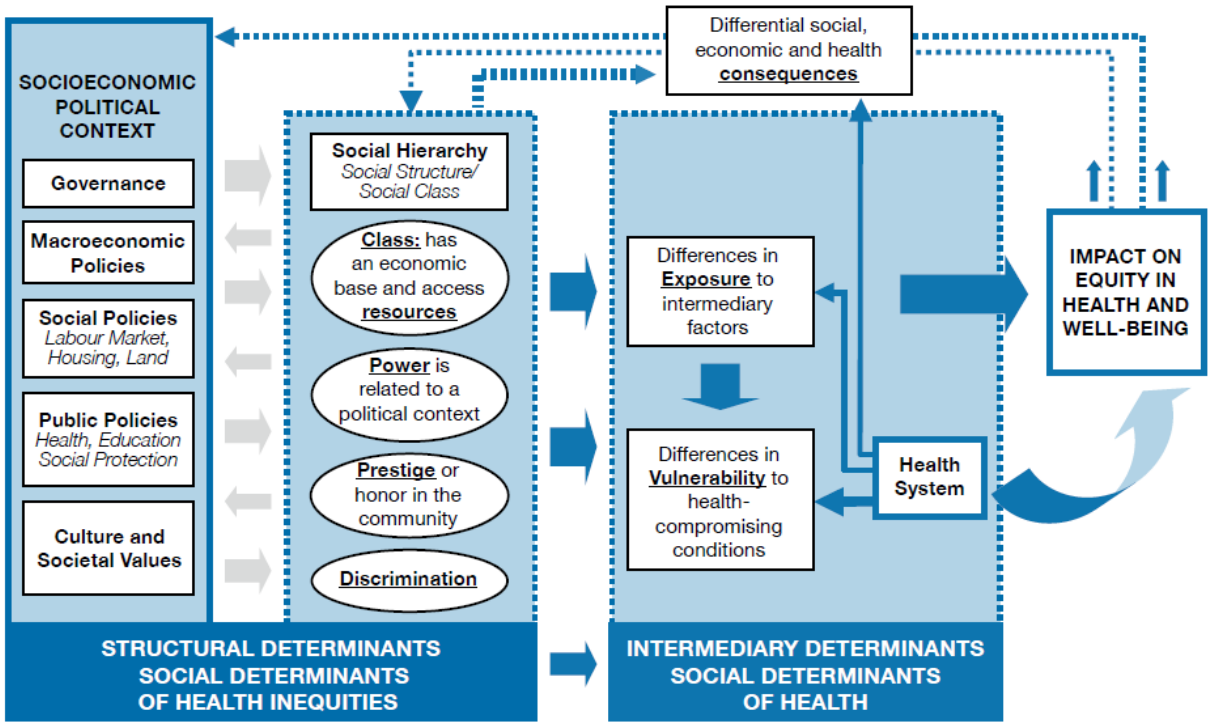
40. UN Commission on Narcotic Drugs: Fifty-ninth session - Vienna, 14-22 March 2016 Extracts from: Agenda item 9* Preparations for the special session of the General Assembly on the world drug problem to be held in 2016

APPENDIX A

A Conceptual Framework For Action On The Social Determinants Of Health,

Source: Solar, O & Irwin,A WHO, Geneva, 2010.

Figure 4. Summary of the mechanisms and pathways represented in the framework



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APPENDIX B

Extracts from the UN Commission on Narcotic Drugs Fifty-ninth session Vienna, 14-22 March 2016 Agenda item 9* Preparations for the special session of the General Assembly on the world drug problem to be held in 2016

> *We reaffirm our commitment to the goals and objectives of the three international drug control conventions, including concern with the health and welfare of humankind as well as the individual and public health-related, social and safety problems resulting from the abuse of narcotic drugs and psychotropic substances in particular among children and young people, and drug-related crime. We reaffirm our determination to prevent and treat the abuse of such substances and to prevent and counter their illicit cultivation, production, manufacturing and trafficking;*
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