

Drug Education and a Resilient (Re)action

by Joel H. Brown, Ph.D., M.S.W. • jhb@cerd.org

Executive Director, Center for Educational Research + Development (CERD) Berkeley, www.cerd.org, 866-Ask-CERD (275-2373)

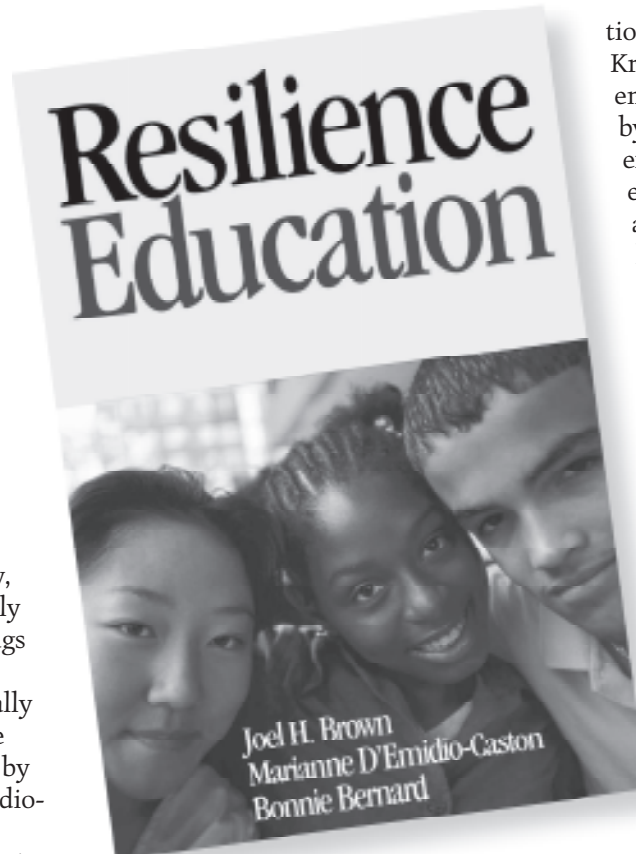
This article is a follow-up to "Drug Education and Democracy (In)action," from the Winter 1996/1997 issue of the *MAPS Bulletin*.

RIGHT HERE, RIGHT NOW, an auspicious opportunity for positive change in drug education exists. There are two reasons for cautious optimism. First, the kinds of critical discussion needed in such a flawed field are reemerging. Second, we may possibly be moving from the problematic "abstinence" or "no use" approach to one that focuses on *youth development*—a resilience (re)action.

THE RE-EMERGENCE OFA DRUG EDUCATION DISCUSSION

For the first time in over 15 years, the scope of drug education discourse is enlarging. Discussions about the challenges of drug education are taking place in both the popular culture and the scientific community. Within popular culture, discussion primarily concerns Drug Abuse Resistance Education (DARE). For many, it is now a given that DARE not only fails to prevent kids from using drugs but may actually increase such use (Wysong et al. 1994). The potentially negative "boomerang effects" of the DARE program have been exposed by many researchers (Brown & D'Emidio-Caston 1995; Brown et al. 1997; Rosenbaum & Hanson 1998). Questions have been raised related to DARE's dominance of the educational market, its profit motives, apparent programmatic reinvention, and the potential (yet ancillary) benefits of having an officer on the school site during these insecure times. Deft public relations have so far allowed DARE to continue despite these debates. Nevertheless, the fact that these issues are now being raised in the public domain says something important: based on serious evidence, a frank if not skeptical public discussion about DARE has been initiated. In addition to the DARE debate, we are now on the cusp of another type of discussion, one not yet so well known. It centers on the fact that the issues of "zero tolerance" drug education are much larger and more significant than the single program DARE. This is something that seemed impossible only a few years ago—a candid discussion addressing the following issues:

- Irregular drug education research analyses/reporting
- Overstatement of findings
- Outright misrepresentation of findings (Brown 2001b; Gorman 1998, February & March 2003)



In addition to our publications (Brown 2001b; Brown & Kreft 1998), these issues have emerged in materials published by esteemed institutions. For example, the National Academy of Science describes an availability bias—relating to how easy it is to estimate the frequency of an event by how quickly it comes to mind—as follows:

"Studies showing limited effectiveness often are difficult to publish and may remain unpublished technical reports available only in the original investigators' office" (Manski et al. 2001). The Academy finds that this research occurs in a field that "tended to overstate the effectiveness of prevention activities" (ibid, p. 213). They then specifically place

the experience of young people in these "abstinence" drug education programs into the forefront:

Brown and Kreft (1998) argue that the "no use" messages typically conveyed in universal prevention programs actually increase use among those most at risk for using. These youths are more knowledgeable about drugs and their effects than prevention curricula assume, and the naïve messages conveyed in the programs serve to create cognitive dissonance in the minds of these youths (Manski, Pepper and Petrie, 2001, p. 218).

Colleagues are more brazenly coming forward to critically discuss the under-reported evidence to which the Academy refers. Precisely such discourse occurred at the Tenth Annual Meeting of the Society for Prevention Research. Professor Dennis Gorman from Texas A & M University was discussing Project Atlas, selected by the

U.S. Department of Education to be an exemplary drug education program. As Gorman was contrasting the program's status with his finding that only one out of twenty published results were significant, the program developer entered the conference room. Gorman describes his experience: "Who was I, he demanded—'from Bryan, Texas'—to question the wisdom of those experts who considered his program exemplary (Gorman, February & March 2003)?" In short, the scientific community and the public are becoming increasingly aware of uncomfortable evidence from various unrelated sources regarding our highly irregular drug education science and its large scale programmatic failures.

PRELUDE TO A CHANGE?

The regular occurrence of such personal attacks in this field points to more than a growing discourse and knowledge base: it indicates impending change. According to Thomas Kuhn (Kuhn 1962), such incidences indicate attempts to incorporate novel evidence into the currently failing drug education paradigm. In this Kuhnian sense, the growing discussion of the various failures of the current drug education paradigm serves as "the prelude to new [paradigms]" (ibid, p. 68). For a full description of this process, see Brown 2001a. Perhaps as a result of this emerging discourse, drug education is in a state of flux and may appear to be shifting between the "no-use" programs of the past 100 years (Beck 1998) on one end and programs promoting youthful drug use on the other end. Many in the community see the "harm reduction" approach as one alternative to these two extremes. However, while harm reduction is necessary, it is insufficient. This is because harm reduction is oriented toward reducing risk, which is far different from developing an environment that is supportive of youth. There is a greater opportunity here than mere harm reduction. We can move beyond the inherent limits of a problem remediation focus (i.e. drug use, abuse, and misuse prevention) and into a focus on youth development.

In our response to these considerations, I and my colleagues at the Center for Educational Research and Development (CERD) have worked for over a decade on more than the rhetorical level. Drawing largely from sources outside of drug education (e.g. education, brain science, human development), we have developed a research-based alternative which we call "Resilience Drug Education." Resilience Drug Education neither advocates use, nor fails to recognize the realities of youthful drug-

taking decisions. In so doing, Resilience Drug Education moves beyond stiff rhetoric and applies sound principles of human development.

RESILIENCE DRUG EDUCATION

The resilience education process is fully described in the book *Resilience Education* by Brown, D'Emidio-Caston and Benard (Corwin Press/Sage Publication 2000). Resilience research from pioneers outside of drug education has serious implications for drug education. Long-term studies suggest that even under the worst circumstances (e.g. poverty, abuse, or neglect), young people will predictably grow into thriving adults when the following three "protective factors" are present:

1. Connectedness.
2. Opportunities for participation and contribution.
3. High self expectations (Benard 1987; Garmezy 1983, 1987, 1991; Resnick et al. 1997; Rutter 1981, 1985, 1987; Werner 1986, 1987, 1989, 1990, 1993; Werner et al. 1971; Werner & Smith 1977, 1982, 1992, 2001).

Evidence suggests that under even the most challenging of circumstances nearly 80% of young people thrive by mid-life when these protective factors are present. In applying the resilience process to drug education, it is clear that the most important part of drug education is the *education*, and that the most significant opportunity for positive change lies within the process itself. Facilitators at CERD implement specific approaches to locate and support the above protective factors with respect to drugs and their inherent issues (Brown 2001b) using Confluent Education skills-building practices (Brown 1972, 1975; Brown 1996; see the Winter 1996/1997 issue of the *MAPS Bulletin* for more on the basics of Confluent Education). Their approach includes:

- Learning how to strategically shuttle between individual experience, dyads, triads, small groups, and large groups.
- Providing context-specific drug information regarding substances—abstention, use, misuse, and abuse—offered during the "teachable moment."

The above strategies make opportunities for developing the protective factors visible to the educator and model them for youth. Also, without condoning drug use,

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Resilience Drug Education blends this youth-supporting process with honest, accurate and complete information, delivered not on script, but during the teachable moment. Through a caring, connected relationship, the teachable moment emerges when a young person's interest or strength is identified as a learning opportunity.

As emotional ties of connectedness between youth and adult occur, information provided during the teachable moment is more likely to be accepted and become deeply learned not because of the information *per se*, but because of its context, the caring process. By conducting exercises to help youth build interpersonal skills within this context, educators, counselors, administrators, or social workers implementing the Resilience model do more than merely provide drug education for these young people. Participants also acquire a process that can help them learn, make decisions in general, and thrive over the course of their lives. It is this process that makes Resilience Drug Education so powerful.

Resilience Drug Education represents more than just another unsupported program shift. As research emerges, supporting evidence regarding resilience and drugs indicates that the results from this approach are long term and predictive. When researcher/practitioners focused on the larger dimension—creating a resilient school—young people's drug use was significantly reduced (Battistich & Hom 1997; Battistich et al. 1991; Battistich et al. 2000). Long term results found in these studies also include positive effects on young people's school-related attitudes and motives (e.g., how much they liked school, their levels of achievement and motivation), social attitudes, skills, and values (e.g., concern for others, conflict resolution abilities, commitment to democratic values), higher test scores, higher grades in core academic subjects, more involvement in positive school and community activities and less misconduct at school than comparison students. These results support the salience, predictability, application, and development of resilience in educational systems.

Why are these findings so very important? Resilience Drug Education was born from a perspective of human development. Now, for the first time in many years, a drug education program fits in with what we know about how to construct an effective learning environment.

Resilience Drug Education enhances the overall educational landscape. This is best described by comparison. With DARE, Life Skills Training, and other similar programs, effective educational practices are sacrificed at the expense of expensive canned curricula. In otherwise

effective schools, such programs expose the serious divide between effective educational practices and the drug educational practices that were often developed by people with little or no practice, knowledge, or experience in education. Young people subsequently feel disconnected from school and adults, and the adults feel disconnected from the young people and their school. While many begrudgingly implement these programs, they suffer from knowing about effective education and simultaneously knowing that these programs are not it (Brown & D'Emidio-Caston 1995). Resilience Drug Education

requires little in the way of expensive materials. In bringing the following principles to life, Resilience Drug Education fits into and builds on what we know about effective education in general:

1. Use strategies that engage the student's intrinsic motivations.
2. Allow young people to safely experiment with making decisions.
3. Help create life goals or "dreams" that the learner endorses.
4. Create a healthy democratic educational community.
5. Encourage the exploration of emotions related to the adversity young people face (Brown et al. 2000, p. 28).

While Resilience Drug Education is presented in a context of "drug issues," its method is independent of that context. This means that although it deals specifically with drug issues, anybody can capitalize on its personal growth process component. Resilience Drug Education is flexible. It does not depend on staid curriculum, but rather focuses on mobilizing the three protective

factors that are known to be effective. It does this through interaction with the facilitator, whose professional discretion is trusted. Resilience Drug Education not only addresses the drug decisions of young people, but it is also oriented toward what we refer to as the "health of the helper" (Brown et al. 2000). By supporting the professional discretion of facilitators, Resilience Drug Education is more likely to be implemented and also more likely to have an impact that is mutually supportive of facilitator and student.

CERD has worked with concerned parents, educators, administrators, counselors, juvenile justice workers, and the medical community. Resilience Drug Education can be used with any age group above the fourth grade, in formal or informal educational settings. Support for this program has been garnered from the Graduate School of Education at the University of California at Berkeley, the University of California at Santa Barbara, and the San Francisco

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Department of Public Health, among others. CERD trainings are springing up across the country. In April 2004, a ground-breaking National Workshop was conducted in Washington, D.C.

CONCLUSIONS

In the current ambling and failed drug education environment, CERD's Resilience Drug Education offers an evidence-based, paradigm-changing alternative possessing several potential benefits:

1. Resilience Drug Education balances an environment that is supportive of youth with a directed focus on the specific protective factors and appropriate information that allow for lifelong thriving.
2. It costs little. The curriculum works with an educator's professional discretion, an *Instructor's Resilience Education Guide* and a drug information guide. With approximately four experiential training sessions spread over time, participants can incorporate Resilience Drug Education into their practice.
3. It is likely to be taken up by educators because it has a development orientation and can be incorporated into any class. Not everyone is a natural at connecting with young people, but nearly everyone can improve the process of working with them.
4. It develops an interactive, caring, connected community that offers a reasoned, scientifically-based hope for drug education. Resilience Drug Education meshes with the best of what we know about effective education and lifelong development.

Overall, Resilience Drug Education sends a critical message to young people and the adults they are working with: they are cared for. By providing accurate information that young people can verify through various sources—the Internet, youth culture, or self-exploration—a focus on resilience builds adult credibility and allows youth to positively connect with adults, further supporting their own lifelong development. This felt sense of meaning and belonging paves the way for the information to be delivered and deeply learned. A reductionist way of viewing this approach might be as follows: (harm reduction - problem remediation) + protective factor support = Resilience Drug Education.

MILEPOSTS ON THE ROAD-MAP TO CHANGE

In light of this opportunity, be wary of two issues. First, "resilience" as an alternative is a currently fashionable buzz word. Many say they are already conducting resilience-oriented work. Regrettably, what we find is that resilience is often "risk wrapped." It has been recently determined that for many, underlying the language of resilience there appears to be an adherence to a risk, deficit based, or problem remediation focus on young people (Brown, in press). "Risk wrapping" resilience worsens the situation by mis-identifying resilience. This in turn serves to preserve the risk and deficit drug education paradigm.

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Second, there is no substitute for those who are trained in the processes of Resilience Drug Education. The most significant error made when offering a reasoned alternative to drug education is the focus on information at the expense of instruction. Knowing *how* to mobilize protective factors for skills development is key. There is a shortage of people experienced in facilitating the development of a process that supports honest interaction with youth. What we tend to see is an example (i.e. "Johnny is resilient because he is connected to his teacher") serving as a surrogate for experiential facilitation (e.g. "this is *how* Johnny becomes connected with his teacher to learn how to effectively make drug decisions"). As has been described throughout this article, this is educational *process*. Actually *experiencing* the development process is what teaches this process for making drug-related decisions. The lack of such experiences when focusing on the process is called "experiential surrogacy."

"Risk wrapping" resilience and experiential surrogacy serve as signposts for the current period of changing approaches to drug education. Although encased in wide-ranging program names and words, they are the mile markers for narrowly defined, similar and failed programs. While disconcerting for some, these signposts also indicate that there is a significant opportunity for positive programs that honor youth and support a change in drug education.

It is important to continue our popular and scientific discourse. It is also important to critically examine often deceptively effective programs. Finally, it is essential to support real youth development services, such as Resilience Drug Education. In this period of change, if we endeavor to shift from a problem remediation focus to a youth development focus in drug education, we will have done much to better the lives of young people. •