
Part One - Overview and Terminology.



Our society pays far more attention to disease treatment than disease prevention. And some of the reasons for this are understandable. When medical-scientific technology saves lives, for example, the outcomes often generate hype because they are dramatic. When prevention works, however, nothing happens. The resulting non-events attract little if any attention—even though the number of people saved may be larger than the number who benefit from seemingly miraculous disease treatment. In addition, preventive interventions reduce the occurrence of other dangerous and unpleasant situations—assaults, for example, are reduced by training young people in coping skills even if the stated objective of the training is to prevent substance abuse—that might not be counted at all in tallies of disease. The bias for treatment over prevention encompasses most or all health concerns including addiction. One indicator is the [2013 budget](#) of the Substance Abuse and Mental Health Services Administration, where the Subtotal, Substance Abuse Treatment is \$1,813 million and the Subtotal, Substance Abuse Prevention is \$470 million.

Our collective awareness of the importance of prevention, including the prevention of substance use disorders, has been slowly growing; but it needs a boost if prevention is to finally become a national priority. We can all help. We can find relevant ways to add our efforts and energy to those of the dedicated professionals and volunteers who have made prevention their priority for, in some cases, decades. For substance use disorders, a route to providing this boost is mapped. In 2009 the National Research Council and Institute of Medicine published *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* (MEB Report), which presents many background issues and the state of applicable science. (Young people are the prime target for activities to prevent mental health and substance use disorders, but going forward we must take care not to overlook adults and older adults.) This [report](#) calls upon “leaders...mental health research and service provision agencies... schools... primary care...community-based organizations... child welfare and criminal justice systems” to take action and achieve change. If we are going to help raise the profile of prevention, we should first be familiar with concepts and terminology used to discuss it. The remainder of this Update addresses that need.

In use, the terms prevention and treatment overlap because people speak not only of preventing new cases of a disease but also of preventing suffering, disability, and death from the progression of diseases already established. *Primary prevention* refers to preventing new cases of disease. *Secondary prevention* refers to identifying new cases of disease as early as possible—often before the affected person notices anything is wrong—to more effectively prevent progression of the disease. (Screening for disease, for example, would be considered secondary prevention; whereas screening for risk factors would constitute primary prevention.) *Tertiary prevention* refers to preventing further discomfort and disability due to an established, diagnosed disease. Secondary

and tertiary prevention are aspects of disease *treatment* as well as [levels of prevention](#). We need to raise the priority of primary prevention. And to keep this separate from treatment, some advocates urge society to focus on *true prevention*.

Some social and environmental conditions convey such a strong predisposition to disease that reducing their influence has been called *primordial prevention*. [Poverty](#) would be an appropriate target for this approach. In contrast, some activities, such as exercise, convey benefits across all three levels of prevention. Creating social and environmental conditions that foster such activities is called [health promotion](#).

Whether or not an individual develops a disease depends upon the interplay of [risk factors and protective factors](#). These factors are generally attributed to an individual (such as the risks associated with the genetic makeup of a person whose parents are alcohol dependent) or to the physical and social environment (such as the protective influences associated with accessible, wholesome after school activities). Preventive strategies seek to reduce risk factors and/or enhance protective factors, but it is the interaction of factors that matters most. For example, an after school activity (environment) may increase the resilience of a vulnerable participant (individual).

As described in the MEB Report, [preventive interventions](#) are often classified in terms of the people they aim to reach. *Universal interventions* address the population at large; *selective interventions* target groups or individuals at increased risk; and *indicated interventions* target individuals with early symptoms that are precursors for disorder but are not yet diagnosable.

Part Two in this series will describe specific prevention targets, including underage drinking, and prevention approaches that address them. Organizers of preventive interventions want to ensure their efforts are worthwhile and need to attract funding, so they seek methods that will be [cost-effective](#). How to show programs are effective (evidence-based) will be the topic of Part Three.

Click [here](#) for Prevention Tips for Youth.

The NCADD Addiction Medicine Update provides NCADD Affiliates and the public with authoritative information and commentary on specific medical and scientific topics pertaining to addiction and recovery.