****

**CHALIMBANA UNIVERSITY**

**DIRECTORATE OF DISTANCE EDUCATION**

PDS 3212: **DRUG AND SUBSTANCE ABUSE PREVENTION**

**FIRST EDITION 2019**

**AUTHOR**: Dr Masiye Isaac Chalimbana University

School of Humanities and Social Sciences Department of Social Sciences

**Copyright**

**© 2019 Chalimbana University**

First Edition

All rights reserved

No part of this publication may be reproduced, stored in a retrievable system, or transmitted in any form or by any means, electronic, mechanical, photocopying or recording or otherwise without prior written permission of the copyright owner, Chalimbana University.

Chalimbana University

School of Humanities and Social Sciences

Department of Social Sciences

Private Bag E1

Chongwe

Zambia

Cell: ………………..

Website: …………..

# **Acknowledgements**

Chalimbana University, wishes to thank Dr. Masiye Isaac for producing this module.

Contents

**Copyright**………………………………………………………………………………………………………………………………………………i

[**Acknowledgements** ii](#_Toc26135172)

[**Assessment** iii](#_Toc26135173)

[**UNIT 1: CONCEPTS IN DRUG AND SUBSTANCE ABUSE PREVENTION AND CONTROL** 3](#_Toc26135174)

[1.1 Introduction 3](#_Toc26135175)

[1.2 Defining Drugs 3](#_Toc26135176)

[1.3 Drug Trafficking 4](#_Toc26135177)

[1.4 Drug Abuse and Addiction 4](#_Toc26135178)

[1.5 Drug and Substance Abuse Prevention 5](#_Toc26135179)

[1.6 Drug Demand Reduction 6](#_Toc26135180)

[1.7 Drug Supply Reduction 6](#_Toc26135181)

[1.8 Harm Reduction 6](#_Toc26135182)

[**UNIT 2: HISTORICAL DEVELOPMENT OF DRUG PREVENTION AND CONTROL STRATEGIES** 7](#_Toc26135183)

[2.1 Introduction 7](#_Toc26135184)

[2.2 International Perspective 7](#_Toc26135185)

[2.3 Local Perspective (Zambia) 10](#_Toc26135186)

[2.4 Contemporary Issues in Drug Prevention and Control 12](#_Toc26135187)

[**UNIT 3: DRUGS AND DRUG ABUSE** 14](#_Toc26135188)

[3.1 Introduction 14](#_Toc26135189)

[3.2 Classification of Drugs of Abuse 14](#_Toc26135190)

[3.3 Controlled Drug and Prescription Drugs 16](#_Toc26135191)

[3.4 Physiological and Socio-economic Effects of Drug Abuse 16](#_Toc26135192)

[3.5 Determinants of Drug and Substance Use 19](#_Toc26135193)

[3.6 Signs and Symptoms and Drug Abuse 20](#_Toc26135194)

[3.7 Paraphernalia for Drug Use 21](#_Toc26135195)

[**UNIT 4: DRUG USE RISK AND PROTECTIVE FACTORS** 23](#_Toc26135196)

[4.1 Introduction 23](#_Toc26135197)

[4.2 Analysis of Risk and Protective Factors for Drug Use 23](#_Toc26135198)

[4.3 Drug Use, HIV-AIDS, and Crime 26](#_Toc26135199)

[4.4 Gender Differences in Drug and Substance Abuse 26](#_Toc26135200)

[**UNIT 5: THEORIES AND MODELS OF DRUG AND SUBSTANCE ABUSE PREVENTION** 30](#_Toc26135201)

[5.1 Introduction 30](#_Toc26135202)

[5.2 Social Learning Theory 30](#_Toc26135203)

[5.3 Modified Social Stress Model (MSSM) 31](#_Toc26135204)

[5.4 Social Ecology Theory (SET). 31](#_Toc26135205)

[5.5 Cognitive Dissonance Theory 32](#_Toc26135206)

[**UNIT 6: PREVENTION EDUCATION AND PUBLIC AWARENESS INTERVENTIONS** 34](#_Toc26135207)

[6.1 Introduction 34](#_Toc26135208)

[6.2 Universal, Selective and Identified Prevention Approaches 34](#_Toc26135209)

[6.3 Drug and Substance Abuse Prevention Interactive Methods 35](#_Toc26135210)

[6.4 Family-based, School-based, Community-based and Work Place-based Prevention Interventions 39](#_Toc26135211)

[6.5 Media-based and Environmental-based Interventions 41](#_Toc26135212)

[6.6 Environmental-based interventions 42](#_Toc26135213)

[6.7 Harm Reduction Approach 42](#_Toc26135214)

[6.8 Peer Education 42](#_Toc26135215)

[**UNIT 7: DRUG AND SUBSTANCE ADDICTION COUNSELLING** 48](#_Toc26135216)

[7.1 Introduction 48](#_Toc26135217)

[7.2 Guiding Principles in Drug and Substance Abuse Counselling 48](#_Toc26135218)

[7.3 Basic Counselling Skills 50](#_Toc26135219)

[7.4 Ethical Issues in Drug Addiction Counselling 51](#_Toc26135220)

[**UNIT 8: DRUG AND SUBSTANCE ABUSE PREVENTION AND CONTROL POLICY** 59](#_Toc26135221)

[8.1 Introduction 59](#_Toc26135222)

[8.2 Core Principles of Drug Policy 59](#_Toc26135223)

[8.3 International Standards on Drug use Prevention 62](#_Toc26135224)

[8.4 International and National Drug Prevention and Control Policy and Legislation 65](#_Toc26135225)

[8.5 The UN Drug Control Conventions 67](#_Toc26135226)

[8.6 National Drug Prevention and Control Legislation and Policy 69](#_Toc26135227)

[**UNIT 9: STAKEHOLDER ENGAGEMENT AND NETWORKING** 73](#_Toc26135228)

[9.1 Introduction 73](#_Toc26135229)

[9.2 Defining a Stakeholder 73](#_Toc26135230)

[9.3 Stakeholder Engagement 74](#_Toc26135231)

[9.4 Stakeholder Mapping 75](#_Toc26135232)

[9.5 Advocacy 77](#_Toc26135233)

[9.6 Multi-sectorial Approach 78](#_Toc26135234)

[**UNIT 10: MONITORING AND EVALUATION OF PREVENTION INTERVENTIONS AND POLICIES** 83](#_Toc26135235)

[10.1 Introduction 83](#_Toc26135236)

[10.2 Defining Monitoring and Evaluation 83](#_Toc26135237)

[10.3 Reasons for Monitoring and Evaluating 84](#_Toc26135238)

[10.4 Different Kinds of Evaluation 85](#_Toc26135239)

[10.5 What should be Monitored and Evaluated? 86](#_Toc26135240)

[10.6 Who should be Involved in the Monitoring and Evaluation? 87](#_Toc26135241)

[10.7 A framework to plan monitoring and evaluation 88](#_Toc26135242)

[10.8 Monitoring, Evaluation and Project Planning 89](#_Toc26135243)

[10.9 Collecting the Information 90](#_Toc26135244)

[10.10 Analysing the Data and Using the Information you have collected 93](#_Toc26135245)

[**REFERENCES** 94](#_Toc26135246)

**MODULE OVERVIEW**

Introduction

This module starts by presenting to you key concepts that are associated with this course.It further presents historical background of how efforts to prevent and control the use of intoxicating drugs and others substances have developed over the years. The module is also designed to provide you with Knowledge and skills such as how to identify different types of drugs and their effect, how to identify drug abusers, object of drug abuse and situations of drug abuse. Emphasis has also been made on risk and protective factors that propel individual to use or not to use drugs.

Other aspect discussed in this module include;theories and models of drug and substance abuse prevention, various interventions applied for drug prevention in family, schools, work places, community and the environment, drug and substance addiction counselling and policy issues regarding prevention and control of drugs and substance abuse and trafficking. The module ends with issues of stakeholder engagement and monitoring and evaluation of prevention interventions and policies. At the end of each unit there is an activity which will help you to study.

Rationale

This course is relevant in this time and era when drug abuse and trafficking is on the rise in our country. Through discussions in this module, it is hoped that you will be able to understand issues and gain skills in drug and substance abuse prevention and be able to deal with such issues in a professional manner.

Aim

The aim of this course is to equip you with knowledge, skills and strategies for drug use /abuse prevention and control, and public awareness.

Learning Outcomes

By the end of this course, you should be able to;

1. explain the following concepts of drug trafficking, abuse and addiction.

1. describe drugs of abuse and their physiological and socio-economic effects.
2. analyse individual, family, school, community, and environmental risk and protective factors for drug abuse.
3. evaluate theories and models of drug and substance abuse prevention.
4. describe various interventions applied in prevention of drug use in family, schools, work places and community.
5. describe basic counselling skills and procedures related to drug use.
6. explain the concept and processes in drug and substance use epidemiology.
7. explain international standards on drug and substance use prevention.
8. apply various methods for stakeholder engagement and networking in the fight against drug and substance abuse in the community.
9. evaluate different types of monitoring and evaluation methods applied in drug and substance abuse prevention.

Study Skills

Group discussions and presentations

Time Frame

This course will be covered in one academic year

Need help

Call on Dr Isaac Masiye, Cell -0977896555 or email- [imasiye@yahoo.com](mailto:imasiye@yahoo.com), Whatsapp- 0977896555

Required resources

Projector

A4 plain papers

Assessment

**Continuous Assessment 50%**

One assignment 10%

One test 20%

One paper presentation (oral) 20%

**Final Examination 50%**

**Total 100%**

Reference

Bissell, L. and Royce, J. (1994). *Ethics for Addiction Professionals*. Center City, MN: Hazelden.

Corey, G., Corey, M. and Callanan, P. (1998).*Issues and Ethics in the Helping Professions. Pacific Grove*, CA: Brooks/Cole.

Herring, B. (2001). Ethical guidelines in the treatment of compulsive sexual behavior. Sexual Addiction & Compulsivity: The Journal of Treatment and Prevention, 8, 13 - 22.

Mentor Foundation, UNODCCP (2002), Lessons learned in drug abuse prevention: A Global Review, Geneva: (<http://www.mentorfoundation.org>)

Salunke, S. and Lal, D.K (2017) Multi-sectorial approach for promoting Public Health, Indian J public health, Jul-Sept; 61(3) 163-168

UNODC/WHO (2006) Monitoring and Evaluating Youth Substance Abuse Prevention Programmes, Viena: United Nations Publications

# 

# **UNIT 1: CONCEPTS IN DRUG AND SUBSTANCE ABUSE PREVENTION AND CONTROL**

## 1.1 Introduction

In this Unit, you are expected to acquaint yourself with key concepts that are associated with this course. These concepts are important because they give you background knowledge of the subject matter of drug and substance abuse prevention and control.

Learning outcome

By the end of this Unit, you should be able to;

* explain the concepts of drug trafficking, abuse and addiction.
* distinguish between drug abuse and drug addiction.
* explain what is meant by the terms physical and psychological dependence.
* discuss the three main strategies for drug prevention and control.

Time frame

You will be expected to spend 1 hour on this unit.

**Content**

## 1.2 Defining Drugs

A drug is any chemical substance, legal or illegal, natural or synthetic which when taken has physical and psychological effects on the body of the person who is taking it. The term “drug” also refers to all psychoactive substances and includes alcohol. Examples of such substances are; tobacco, cannabis, inhalants, khat, cocaine, heroin, methamphetamines, and the new psychotropic substances (NPSs).

Although alcohol is a legal and social drink, it is considered as a drug because it contains a chemical substance called ethanol. Ethanol is a drug. It causes just as many injurious effects, if not more, as most illegal drugs.

## 1.3 Drug Trafficking

Drug trafficking is a global illicit trade involving the cultivation, manufacture, distribution and sale of substances which are subject to drug prohibition laws.  Drug trafficking, also known as drug distribution, is the crime of selling, transporting, or illegally importing unlawful controlled substances, such as heroin, cocaine, marijuana, or other illegal drugs. Drug trafficking also applies to the illegal selling or transportation of prescription drugs, which has become an increasing problem in recent years.

## 1.4 Drug Abuse and Addiction

**Drug abuse** is the deliberate or non-medical use of drugs, in order to induce physical and psychological effects for the purpose other than therapeutic ones, resulting into functional impairment and adverse social consequences. The term ***substance abuse*** is used interchangeably with drug abuse. This includes alcohol, tobacco and other intoxicating chemicals such as glue, petrol, and cleaning fluids, commonly known as inhalants or solvents which are legal. These substances are popular with street children. Alcohol abuse is any alcohol use pattern which is significantly problematic (Desai et al., 2003). It occurs when an individual engages in drinking that is unsafe and harmful to him or her and to others. In other words the individual’s pattern of drinking is so excessive that it results in adverse health and social consequences to him, the family and often to those around.

Social consequences may be reflected in an individual’s enhanced tendency to engage in conflicts with friends, teachers, and other school authorities. Cognitive consequences can be seen in the individual’s lack of concentration on academic work and memory loss (Eysenck, 2002).

**Drug addiction** is a psychological and physical inability to stop consuming a chemical, drug, or substance, even though it is causing psychological and physical harm. The term [addiction](https://www.medicalnewstoday.com/info/addiction/) does not only refer to dependence on substances such as heroin or cocaine. A person who cannot stop taking a particular drug or chemical has a substance dependence.

Addiction is a chronic disease that can also result from taking medications. The overuse of prescribed opioid painkillers, for example, causes [115 deaths](https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis) every day in the United States (Adam Felma, 2018). <https://www.medicalnewstoday.com/articles/323465.php>. When a person experiences addiction, they cannot control how they use a substance or partake in an activity, and they become dependent on it to cope with daily life.

***Drug dependence***is often used as a synonym for ***drug addiction*.** However, scientists have drawn a distinction between the two. While drug addiction is characterized in part by psychological components, drug dependence is characterized only by a physiological adaptation of the body to the presence of a drug. Those who are dependent on a drug—such as an opiate used to control pain—over a prolonged period of time will experience withdrawal symptoms if the drug is suddenly stopped.

***The difference between abuse and addiction***

Abuse or misuse refers to the incorrect, excessive, or non-therapeutic use of body- and mind-altering substances. However, not everybody that abuses a substance has an addiction. Addiction is the long-term inability to moderate or cease intake. For example, a person who drinks alcohol heavily on a night out may experience both the euphoric and harmful effects of the substance. However, this does not qualify as an addiction until the person feels the need to consume this amount of alcohol regularly, alone, or at times of day when the alcohol will likely impair regular activities, such as in the morning. A person who has not yet developed an addiction may be put off further use by the harmful side effects of substance abuse. For example, vomiting or waking up with a [hangover](https://www.medicalnewstoday.com/articles/5089.php) after drinking too much alcohol may deter some people from drinking that amount anytime soon. Someone with an addiction will continue to abuse the substance in spite of the harmful effects.

## 1.5 Drug and Substance Abuse Prevention

Drug and substance abuse prevention is generally seen as an attempt to help young people to abstain, delay onset, and reduce problems resulting from use and abuse of drugs and alcohol. According to UNODC (2012:6) “drug prevention endeavours are referred to as either interventions or policies’’. An intervention refers to a group of activities. This could be a programme that is delivered in a specific setting in addition to the normal activities delivered in that setting (e.g. drug prevention education sessions in schools). However, the same activities could also be delivered as part of the normal functioning of the school (e.g. drug prevention education sessions as part of the normal health promotion curriculum).

***Health professionals*** usually define prevention as any demand-reduction activity intended to modify behaviour and so reduce the desire for drugs. In many cases, this approach is further limited to primary prevention – reducing the wish to begin taking drugs.

***Criminal-justice experts,*** politicians and probably most of the general public understand prevention to mean supply reduction. The less available a psychoactive substance, the less likely the onset of drug abuse. Examples of prevention to reduce supply include price controls and taxation, limiting access to the substance, public safety and, of course, the threat of punishment.

**Others** stress that prevention is best carried out by raising awareness and promoting ‘healthy living’ among the population at large. These activities can include public information campaigns, explicit commitments from politicians to keep the issue at the top of their agendas, and adequate financial support for prevention and teacher training.

## 1.6 Drug Demand Reduction

A term used to refer to the aim of reducing consumer demand for controlled and other drugs or substances. Demand reduction is a broad term used to encompass a range of policies and programmes seeking a reduction of the desire and preparedness to obtain and use drugs.

## 1.7 Drug Supply Reduction

A broad term used for a range of activities designed to stop the production, manufacture and distribution of illicit drugs. Production can be curtailed through crop eradication, or through large programmes of alternative development. Supply control is a term often used to encompass police and customs activities.

## 1.8 Harm Reduction

With regards to Drugs and alcohol, harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from their use, both to the individual and to the larger community. The term is used particularly in reference to policies or programmes that aim to reduce harm without necessarily requiring abstinence.

Harm reduction, also known as harm minimisation is anchored on the fact that despite our best efforts, some young people will choose to use drugs, even some illicit drugs. It does not mean that we, as individuals or as systems, condone that use. Abstinence messages in the form of support for the decision not to use drugs, or not to use drugs unlawfully, should always be a significant component of drug prevention education programmes. However, harm reduction has the important role of keeping communication about drug use open to those who may be currently using. The goal of minimising harm respects human rights, equity and discrimination issues that influence acceptance of people living with AIDS and the treatment of drug users.

Examples of harm reduction include needle/syringe exchanges to reduce rates of needle-sharing among injecting drug users, and the use of shatterproof glassware to reduce glass injuries in settings where alcohol is consumed.

**Activity**

1. Explain what is meant by the terms physical and psychological dependence.
2. Distinguish between drug abuse and drug addiction.
3. Discuss the three main strategies for drug prevention and control.

Summary

This unit has covered some of the common concepts in drug and substance abuse prevention such as the terms drug, drug trafficking, drug abuse and addiction, drug demand and supply reduction, and harm reduction. Other aspects looked at here, are the difference between drug abuse and addiction. We have also become aware of the subtle difference between addiction and dependence. However, in most drug literature the two means the same.

# 

# **UNIT 2: HISTORICAL DEVELOPMENT OF DRUG PREVENTION AND CONTROL STRATEGIES**

2.1 Introduction

As a student in this course, it is very vital for you to have a historical background of how efforts to prevent and control the uses of intoxicating drugs and others substances have developed over the years. This helps you to understands and know strategies that have worked and those that have not worked in the past and how we can develop effective strategies in the modern era.

Learning Outcomes

By the end of this Unit, you should be able to;

* describe the historical development of drug prevention and control strategies at international level.
* discuss measures taken by the government in the past to prevent and control drug trafficking and abuse in Zambia.
* explain the main provisions of the Dangerous Drugs Act No 42, and the Narcotic and Psychotropic substances Act, Cap 96.
* discuss contemporary issues in drug and substance abuse prevention and control.

Time Frame

You are expected to spend about 2 and half hours on this unit.

**Content**

## 2.2 International Perspective

Drug and alcohol abuse is one of the major world’s public health concerns. It poses a huge burden on health care systems and impedes educational achievements of young people. Therefore, its prevention is critical to the sustainability of not only good public health system but also social and economic development of the country.

Historically, the prevention and control of illicit drug or substance abuse worldwide involves both motivating and deterrent strategies (UN, 1979). The motivating strategy seeks to improve the individual’s capacity to deal with risk factors that may push him or her into drug abuse behaviour problem and also to enhance factors that may help in abstaining from drug abuse behaviour. The deterrent strategy is basically a prohibitory measure aimed at punishing those individuals who perpetuate drug trafficking and abuse behaviours. These strategies are now referred to as Drug Demand Reduction (DDR) and Drug Supply Reduction (DSR) policies.

According to National Research Council (2001), current drug policy in USA has its roots in the adoption of the Harrison Narcotics Act in 1914. Although framed as a tax measure, the goal of the statute was to suppress the non-medical use of what are called narcotic drugs (a classification that encompassed morphine, heroin, and other opiates, as well as cocaine). The effect was to criminalize the manufacture, sale, and possession of these drugs outside medical channels. An aggressive campaign of enforcement by federal authorities was deployed in the 1920s to terminate the practice of opiate maintenance by physicians and clinics. Eventually, the prohibitory approach was extended by Congress to marijuana in 1937, and during the 1930s and 1940s all state legislatures enacted a parallel set of laws. Penalties for narcotics offenses were increased in the 1950s, and new psychoactive pharmaceutical products were brought under federal control in the 1960s in an effort to suppress non-medical use of these drugs. This accumulation of federal and state anti-drug statutes was replaced in 1970 by the federal Controlled Substances Act and by parallel acts at the state level.

Until the 1970s, enforcement of this comprehensive array of drug prohibitions was the predominant instrument of the nation’s anti-drug policy. What was called the law enforcement approach was generally understood as a relatively complete policy: drugs are dangerous to the social order. Therefore, it is both just and useful to prosecute those who supply drugs and those who use them. By setting out laws against these activities and enforcing them, individuals would be dissuaded and deterred from supplying and using drugs. If some persisted despite the prohibition, it would be both just and effective to incapacitate them as threats to society.

In the late 1950s and 1960s, however, the dominance of this law enforcement model was challenged by some influential lawyers and physicians who wanted to respond to drug addiction with medical methods (including civil commitment) rather than prosecution and punishment. In their view, chronic drug use was not a wholly voluntary choice but rather a disease to which some helplessly succumbed. The disease may have had its roots in biology, in the social conditions in which people lived, or in the dependence-producing power of the drugs themselves. But whatever the sources, once these factors are present, an individual’s ability to act independently is undermined. Given this fact, it seemed both unjust and ineffective to respond to drug use among individuals as a crime. It seemed unjust because addicts were unable to decide to stop using drugs; ineffective because deterrence would fail, and incapacitation would work only as long as the restraint continued.

What they proposed as an alternative was the medical treatment of drug users. The most radical version of the approach called for drugs now banned to be legally available to addicts, their use to be regulated by physicians who could prescribe the drugs to patients under their care. For much of the 1960s, drug policy was locked in a debate between “cops and docs.” Should society continue its commitment to law enforcement, or should it shift to the medical approach?

Steps were taken in the 1970s to combine the law enforcement and medical approaches into a single framework. In 1972, Congress enacted legislation embracing one of the core positions of the proponents of the medical approach—that people with drug problems should be given incentives and assurances of confidentiality to encourage them to enter treatment. In addition, the federal government supported programs to use criminal prosecution as a lever for treatment participation. Congress also appropriated funds to support drug treatment programs. The debate between cops and docs receded in a policy environment in which both approaches were used simultaneously.

In the late 1960s and early 1970s, drug policy analysts began talking in somewhat different terms. Influenced by economic theory, they now referred to supply-reduction and demand-reduction policies. These terms became particularly prominent in the 1980s when the ONDCP was created, with its deputy directors for demand and supply reduction.

Supply-reduction strategies focused on limiting the supply of drugs that might flow to illegal markets, while demand-reduction strategies focused on reducing the demand for drugs. To some, the new idea of supply and demand policies was almost indistinguishable from the old idea of cops and docs. Supply-reduction strategies looked like law enforcement, and demand-reduction strategies looked like drug treatment. However, there were important differences in thinking about drug policy in terms of supply and demand rather than in terms of enforcement and treatment.

First, in the new conception that distinguished supply and demand approaches, law enforcement was divided into two parts. Enforcement efforts directed at drug producers and distributors were considered supply-reduction strategies, and enforcement efforts directed at drug users were considered demand-reduction strategies.

Second, new supply-reduction instruments emerged that were not enforcement activities. The idea took hold that those now engaged in the production of heroin and cocaine in Asia, South America, and elsewhere might be persuaded to stop not by the threat of crop eradication and arrest, but through subsidies supporting efforts to shift production to other, less profitable crops. Similarly, programs to improve the labour market conditions of disadvantaged youth might induce street-level drug dealers to move into legitimate employment. In addition, it was an explicit strategy of major multimodality treatment programs in the early 1970s to reduce local heroin supplies by recruiting user-dealers into treatment. Thus, crop substitution programs, youth employment programs, and programs treating user-dealers became part of the nation’s portfolio of drug control instruments.

Third, a new demand-reduction strategy, drug abuse prevention, assumed a more important place in thinking about drug policy. Of course, law enforcement already aimed to prevent drug use. Drug laws put society on notice that use of certain drugs is deviant, and enforcement of these laws sought to deter potential drug users by threatening arrest and incarceration. The new notion of drug abuse prevention brought into play efforts by schools, neighbourhood groups, and parents to persuade youth and other populations at risk that drug use is bad and dangerous. It also brought into play efforts by the military, civilian employers, and schools to deter drug use by initiating drug-testing programs and by levying noncriminal sanctions (e.g., fines, suspensions, dismissal) on soldiers, employees, and students found to use drugs.

## 2.3 Local Perspective (Zambia)

Drug and alcohol use has been in existence time immemorial, but formal attempts to prevent and control drug and alcohol abuse in Zambia dates back to colonial period. The colonial government had noted with concern that there was an apparent problem arising from illicit drug and alcohol abuse reflected by late reporting at work places, reporting for duty in a drunken state and frequent absenteeism by the workforce (Mbolela, 2009). Based on this, the government enacted The Dangerous Drugs Ordinance in 1926 in the then Northern Rhodesia (Haworth, 1983). However, this does not mean that there were no forms of social control and regulations on the use and misuse of intoxicating substances before colonial era. Infact there were serious social sanctions such as denial of marriage, respect and inheritance rights for drug abusing young people (Mukuka, 1995). At that time, the problem of drug and alcohol abuse was not very serious but the situation showed clear signs of changing. This is reflected by Nyambe (1979) who gave an account of the changing situation with respect to cannabis use before independence and in subsequent years after independence.

So the earliest form of drug and alcohol abuse prevention in Zambia was through legal response other than educational efforts, that is, the enactment of laws. In 1938, the Dangerous Drugs Ordinance of 1926 was strengthened with the inclusion of other habit-forming drugs such as morphine and cocaine (Haworth 1983). At independence in 1964, although the drug and alcohol abuse problem among the youth was still at its infancy stage in comparison to modern times, it was growing rapidly. With the spirit of political independence and freedom more and more young people got involved in alcohol intake as well.

In order to be in tandem with international regulatory legal framework, the Zambian government in 1967, replaced the previous legal provisions on drug control based on the Dangerous Drug Ordinance by the new Dangerous Drugs Act No 42 which had been prepared in accordance with the 1961 Single Convention on Narcotic Drugs(Haworth, 1983). This Act included not only the provision for the control of the importation, exportation, production, possession, sale, and distribution of dangerous drugs, but also the use of such drugs and matters incidental thereto (CAP 95). In 1971, new Dangerous Drugs Regulations were enacted in the form of a Statutory Instrument (No. 128 of 1971) to provide for the control of raw opium, coca leaves, poppy-straw, cannabis, cannabis resin and all preparations of which cannabis resin formed the base (Haworth, 1983).

In the late 1980s the economic situation in the country had hit its lowest ebb. The collapse of the economy which had started a decade earlier witnessed the emergence of unprecedented levels of drug trafficking and abuse involving some Zambian citizens. While the country was considered as a mere transit point for narcotic drugs, it became apparent that it was also becoming a consumer of drugs such as cannabis and methaqualone (mandrax) largely coming from Central Asia. This situation posed a critical challenge in terms of enforcement of the law and regulations as a way of preventing drug abuse in the country. Therefore, it called for the strengthening of prevention and control measures and establishment of special institutional framework to deal with the problem. Hence in 1985, the Dangerous Drugs (Amendment) Act No. 19 made possession of drugs such as methaqualone an offence.

Further, in 1989 the government, under President Dr. Kenneth Kaunda, recognized the social and economic menace that drug trafficking and abuse was creating in the country and enacted the Dangerous Drugs (Forfeiture of property) Act No. 7, which did not only seek to criminalize possession of property derived from drug trafficking, but also became instrumental in the creation of the Drug Enforcement Commission (DEC), through Statutory Instrument No. 87 of 1989. DEC was formed as a department under the Ministry of Home Affairs with the dual mandate of enforcing the drug law and educating the public on the dangers of drug and alcohol abuse and started its operations in 1990 (EU / DEC, 1999). Before 1990, the responsibility to deal with drug issues in the country was given to a small police squad within Zambia Police Force (Mukuka, 1995).

With DEC in place, the fight against drug trafficking and abuse was intensified (Zambia, 1992). The intensification was obviously due to the increasing levels of drug trafficking and abuse which was closely linked to economic downturns in the region during this period. For instance, methaqualone trafficking and cultivation of cannabis was on the increase, and Methaqualone had become a medium of exchange for imported manufactured goods such as motor vehicles, machinery, and groceries (Zambia, 1992). As a result of the need to intensify prevention and control efforts and to embrace international cooperation spelt out in the 1988 UN convention, government enacted the Narcotic Drugs and Psychotropic Substances Act No.37 of 1993. The Act provided for the continuation of the Drug Enforcement Commission as a special organization to fight drug trafficking and abuse; the revision and consolidation of the law relating to narcotic drugs and psychotropic substances and incorporation into Zambian law certain international Conventions governing illicit drugs. This law has remained in use to date, yet the use of illicit drugs by young people has continued to rise.

Regarding the use of alcohol, the Traditional Beers Ordinance Cap 168 was enacted in April 1930 to regulate the sale, manufacture and possession of traditional beer. This was followed by the Liquor Licensing Ordinance Cap 167 in 1959. This Act provided for the regulation of the sale and supply of intoxicating liquors; and to provide for matters incidental thereto and connected therewith. Part seven of this Act indicated prohibitory clauses such as restricting the sale of liquor to children and young people less than 18 years of age not to be employed in bars. The amendment of the Act in 1969 included the prohibition of “Kachasu” a local distilled alcohol. All these legislative measures were put in place to limit the use or abuse of alcohol. However, despite the existence of this law, young people’s involvement in alcohol consumption continued to rise.

In the 1990s, the Zambian government under President Fredrick Chiluba introduced economic liberalization and several parastatal organizations including Zambia Breweries were privatized. This led to increased availability and easy access to alcohol by many citizens including young learners, and consequently widespread consumption.

In addressing the concern of increased abuse of alcohol, in 2011 a new Liquor Licensing Act number 20 was enacted. Part four of this Act stipulates that no grant of sale of liquor licence to business owners with buildings within 300 metres of school and health facility; no grant of licence to child; no sale of liquor without licence; and no consumption of liquor in public places. Other existing pieces of legislation that related to prevention and control of harmful use of alcohol include the Penal Code Cap 87 and the Local Government Act Cap 281. However, despite all these legislative controls, consumption of alcohol by young people continued to rise in Zambia.

Regarding prevention education or sensitization activities, this has been executed mainly by three different kinds of organisations. These are the Government Ministries/Agencies, Non-Governmental Organisations and religious organisations. The Ministry of General Education (MoGE), Ministry of Health (MoH), Drug Enforcement Commission (DEC) and other leading Non-governmental (NGOs) and Faith-Based Organizations (FBOs) have been conducting drug and alcohol abuse prevention education in schools. These prevention efforts have been intensified since mid-1990s, that is, in terms of aggregate level of prevention activities, the number of organizations involved, and government’s will to fight drug abuse in the country. Aspects of drug and alcohol abuse prevention information have been included in the new school curriculum and the MoGE has established Guidance and Counselling departments in schools, which deal with, among other things, drug and alcohol abuse prevention. In addition, through its Institution of Learning programme, the Drug Enforcement Commission, a government institution responsible for drug issues in the country, conducts awareness campaigns and counselling among school learners on the dangers of drug and alcohol abuse. A number of NGOs also visit schools in order to carry out prevention activities.

However, despite considerable effort directed towards prevention activities, it appears nothing much has been achieved in preventing or reducing the problem of drug and alcohol abuse among learners in Zambia’s schools.

## 2.4 Contemporary Issues in Drug Prevention and Control

In this section, you are expected to discuss in your study groups the following current issues

* The cannabis debate (legalization vs decriminalization)
* Medical marijuana vs recreational marijuana
* Industrial hemp

Activity

1. Describe the 1970s law enforcement approach as a strategy for fight against drug trafficking and abuse
2. Describe the historical development of drug trafficking and abuse prevention and control in Zambia.
3. Explain the main provision of the Dangerous Drugs Act No 42

Summary

Historically, the prevention and control of illicit drug or substance abuse and trafficking worldwide has been motivated by two factors; namely the Motivating factors and the Deterrent factors.

The motivating factor seeks to improve the individual’s capacity to deal with risk factors that may push him or her into drug abuse behaviour problem and also to enhance factors that may help in abstaining from drug abuse behaviour, while the deterrent factor is basically a prohibitory measure aimed at punishing those individuals who perpetuate drug trafficking and abuse behaviours. These factors form the basis of past and current policies in drug and substance trafficking and abuse prevention. It is important to know these policies for you to have a better understanding and application of them.

# **UNIT 3: DRUGS AND DRUG ABUSE**

## 3.1 Introduction

Having discussed the historical development of prevention strategies in the previous Unit, we now turn to the subject of Drugs and Drug abuse. This Unit will provide you with Knowledge and skills such as how to identify different types of drugs and their effect, why people use or abuse drugs, how to identify drug abusers, object of drug abuse and situations of drug abuse. This is important in the formulation of preventive strategies.

Learning outcome

By the end of this Unit, you should be able to;

* distinguish between narcotic drugs and psychotropic substances, as well as controlled drugs and prescription drugs.
* describe drugs of abuse and their physiological and socio-economic effects.
* explain reasons why people use or abuse drugs and other substances.
* discuss signs and symptoms of drug abuse and paraphernalia associated with it.

Time frame

You will need more than two (2) hours to deal with this unit

**Content**

## 3.2 Classification of Drugs of Abuse

Drugs and other intoxicating substances can either be natural or synthetic. Drugs are classified based on their pharmacology i.e. the science that deals with the source, body distribution, effects and detoxification of drugs. One major classification of these drugs is to categorize them according to narcotics and psychotropic types.

1. **Narcotic drugs** - These are substances, which induce stupor, coma or insensibility to pain. The word “Narc” is derived from a Greek word meaning “sleep” or “Drowsy”.
2. **Psychotropic substances** - These are mood-altering drugs, which affects the central nervous system. Derived from the English word “psych”

Another way of classifying these drugs of abuse is to groups them according to their effects on the human and animal body. There are six (6) main classes, namely; stimulants, depressants, hallucinogens, opiates, inhalants and cannabis

1. **Stimulants-** These stimulate the Central Nervous System (CNS), speed up all the body processes such as respiration and digestion, banish tiredness for a time and produce feeling of alertness. Examples of these drugs and substances include Cocaine, Miraa, Amphetamines, Nicotine found in tobacco (shisha),amphetamines/methamphetamine, methylphenidate (Ritalin), and other stimulants such as diet pills.
2. **Depressants –** These are the opposite of stimulants. These substances slow down the action of the Central Nervous System (CNS). Such drugs include; Alcohol, Mandrax, Barbiturates, chloral hydrate, benzodiazepines, hypnotic sedatives, tranquilizers and other sedatives. They have a sedative effect that can last for a few minutes to several hours depending on the amount taken.
3. **Hallucinogens-** These distort the way the brain translates impulse from the sensory organs. The brain is made to alter messages about something real, producing an illusion E.g. Lysergic Acidiethylamide (LSD), Amphetamine variants (MDA, MDMA, and Ecstasy), mescaline, peyote, phencyclidine and analogs,

(iv) **Narcotics/opiates -** Narcotics dull senses and relieve pain at the same time by depressing *cerebral cortex.* They also affect the *thalamus* which is the mood regulating centre. These are derived from an opium poppy plant e.g. Heroin, morphine, methadone, pethidine, codeine, hydrocodone (Vicodin), hydromorphone, oxycodone (OxyContin), and fentanyl.

**Note;** Most of the medicines are usually given to a person before they undergo surgery (taken in the theatre), they are used as anaesthesia. However, Heroin being inthis group is just a drug of abuse.

(v) **Inhalants/solvents –**Inhalants and solvents are chemicals that can be inhaled, such as glue, gasoline, aerosol sprays, organic solvents (spray paint, hair spray, thinners), nitrites, and nitrous oxide (laughing gas). These are not drugs at all and are, in fact, legally available from a large number of retail shops. However, they are abused widely by the poorer sections of society, particularly street youth. Example of such chemical products include;

Glue, Paint thinner, Petrol, Lighter fuel, Cleaning fluids and nail polish remover. They are usually volatile at room temperature.

In terms of how they are uses, often, the chemical is placed in the bottom of a cup or container and then placed over the nose and mouth. Other methods include: soaking a rag in inhalant; placing a rag in bag or sack; placing the bag over the face and inhaling the vapours.

(vi) **Cannabis – This drug is** in three types and these are sativa, indica and ruderalis. The main ingredient is Tetra Hydro-Cannabinol (Delta 9 -THC). It can be presented in form of ***Marijuana,*** which is the dried leaves and twigs, ***hashish cake*** made from dark sticky resin of the cannabis plant and ***hashish oil*** which is compressed from the cannabis plant.Ithas characteristics of stimulants, depressants and hallucinogens and reacts differently with each individual according to their body chemistry, hence it has its own class.

## 3.3 Controlled Drug and Prescription Drugs

A ***controlled substance*** is generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as ***illicitly used drugs*** or ***prescription medications*** that are designated by law. It is a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction. The control applies to the way the substance is made, used, handled, stored, and distributed. Controlled substances include opioids, stimulants, depressants, hallucinogens, and anabolic steroids.

Prescription drug misuse is the use of a medication without a prescription, in a way other than as prescribed, or for the experience or feelings elicited. Prescription drug misuse can be dangerous if mixed together without a physician's guidance, or mixed with other drugs or alcohol.

Controlled substances with known medical use, such as ***morphine, Valium, and Ritalin***, are available only by prescription from a licensed medical professional. Other controlled substances, such as ***heroin and LSD***, have no known medical use and are illegal in most countries in the world.

Some International Conventions provide internationally agreed upon "schedules" of controlled substances, which have been incorporated into national laws, however national laws usually significantly expand on these international convention.

Some precursor chemicals used for the production of illegal drugs are also controlled substances in many countries, even though they may lack the pharmacological effects of the drugs themselves. Substances are classified according to schedules and consist primarily of potentially psychoactive substances. The controlled substances do not include many prescription items such as antibiotics.

In the USA, some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Examples include: morphine, pethidine and methadone Stricter legal controls apply to controlled medicines to prevent them from being misused, obtained illegally and causing harm

Examples of controlled drugs in Zambia include:

* Common sleeping tablets such as temazepam, valium, zolpidem, zopiclone, zaleplon.
* Painkillers such as those containing codeine, tramadol, and amitriptyline.
* Antidepressants such as citalopram, escitalopram and mirtazapine and
* Hormone Replacement Therapy such as testosterone and oestradiol.

## 3.4 Physiological and Socio-economic Effects of Drug Abuse

1. **Physiology effects of drugs of abuse**

***Stimulants***

* Physiological effects of stimulants may include: Excessive sweating, vomiting, decrease in appetite, dryness of the mouth, pupil dilation, rises of body temperature and blood pressure, increases agitation (anxiety)
* After prolonged use of large amounts of these drugs/substances, one develops insomnia (lack of sleep), paranoia and damage to the nervous system.
* Common withdrawal symptoms are severe physical and mental depression.

***Depressants***

* Depressant weaken all muscles including the heart muscle, causes dizziness and blurred vision, reduce intensity of physical and sensations, cause digestive upsets – nausea and diarrhoea, body becomes prone to pneumonia especially alcohol (cold), severe depression of respiration and all other body functions.
* After prolonged use- one develops amnesia (loss of memory), drowsiness and personality changes. Common withdrawal symptoms are convulsions, hallucinations and uncontrolled muscle spasms.

***Hallucinogens***

* These distorted senses, alteration of mental processes, hallucinations, confusion, vomiting, severe anxiety, dehydration, mental disruption.
* Common withdrawal symptoms are occasional flashbacks and depression.

***Narcotics/opiates***

* Opiated lead to drowsiness, inability to concentration, constipation, dilation of blood vessels therefore low blood pressure, suppression of pain, disruption of menstrual cycle in females, hallucinations, clammy skin, convulsions, coma, depressed sexual drive.
* Users sharing needles and syringes are at a high risk of contracting HIV/AIDS and Hepatitis B.
* Common withdrawals are watery eyes, runny nose, severe back pains, stomach cramps, Insomnia, nausea etc.

***Inhalants/Solvents***

Inhalants may give you a high for a very brief period of time. They make you feel numb for a short period of time, dizzy, confused, and they give you progressive drowsiness. They can also cause headaches, nausea, fainting, accelerated heartbeat, disorientation, vomiting, impaired judgement, and hallucinations. They can damage the brain, lungs, kidney and liver in the long term. They can also cause suffocation, convulsions, and coma.

***Cannabis***

* The effects of cannabis depend on a number of circumstances. This includes how the drug is taken, the physical and mental state of the individual, the expectations of the user from the previous experience of drug taking.
* Damages the brain function, increase of the heart rate, irritant cough, lack of sleep, distortion of senses, delusions, impairs memory, motor skills, poor personal hygiene, personality changes, reproductive and suppression of immune system, redness of the eye ball, increased appetite.

**Alcohol**

It is also important to take special note of the effects of alcohol which is mainly a depressant

The three basic types of alcoholic beverages are wine, beer, and distilled spirits (hard liquor). Fermenting and distilling fruit juices produces brandies; the addition of sugar and/or other flavourings produces liqueurs or cordials. Wine, beer, and liquor all have the same potential for intoxication and addiction. Generally speaking, a typical serving of beer, wine, or hard liquor contains an equivalent amount of alcohol, with exceptions such as fortified wines, malt liquors, wine coolers, and distilled spirits such as Ever clear, all of which have higher than average proportions of alcohol relative to other alcoholic drinks (Doweiko, 2002).

**Short-term effects.** Even low doses of alcohol significantly impair the judgment and coordination

required to drive a car safely. Low to moderate doses of alcohol can increase the incidence of a variety of aggressive behaviours, including spousal and child abuse. Moderate to high doses of alcohol cause marked impairment of higher mental functions, severely altering a person’s ability to learn and remember information. Very high doses can cause respiratory depression and death

**Long-term effects.** Continued use of alcohol can lead to dependence. Consuming large quantities of alcohol long term, especially when combined with poor nutrition, can lead to permanent damage to the brain and liver and is associated with cancers, cardiovascular disease, diabetes, and dementia (NIAAA, 2003a). Chronic abuse of alcohol can lead to addiction (alcoholism). Alcohol addiction can be characterized by increased tolerance, causing the abuser to drink greater amounts to achieve the desired effect. When an alcoholic stops drinking, he or she will typically experience symptoms of withdrawal.

**Protective effects.** Despite the many negative consequences associated with excessive alcohol use, research has consistently found that moderate alcohol use has a protective effect on the cardiovascular system; however this protective effect has been most clearly demonstrated only for older individuals and individuals otherwise at risk for cardiovascular disease (NIAAA, 2003a).

1. **Socio-economic effects of drug abuse**

Drug and substance abuse is a pervasive problem. It affects all sectors of society in all countries. In particular, It affects the freedom and development of young people, the world's most valuable asset (UNODC, 2002). It has the potential to negatively affect the social fabric of communities, hinder economic development and place additional burden on national public health care systems (Wyler, 2012).

According to NIDA (2003), drug and alcohol abuse has serious consequences in homes, schools and communities. It imposes substantial costs on users and their families, taxpayers, on the national economy and the community as a whole (Ministerial Council on Drug Strategy, 2005). At an individual level, young people who persistently abuse drugs and alcohol often experience a number of challenges ranging from health-related problems, poor social and personal relationship to contraction of HIV and AIDS.

In school, drug and alcohol abuse has negative consequences that impact on the learners’ educational experiences and management of schools. Learners who abuse drugs tend to care less about their academic work. They also easily get agitated and become violent against school authorities and fellow pupils.

The socio-economic effects of drug abuse could be summarized as follows:

* Drug abusers often experience poor interpersonal relationship with family members leading to family breakdown.
* Drug abuse may result in behavioural problems among young people such as mood changes, truancy at school and aggression.
* Pregnant women who abuse drugs may experience premature delivery and retardation of foetal development resulting in low birth weight or mental disability.
* For people in employment, drug abuse lead to loss of employment, low and poor production of goods and services through absenteeism, poor performance and damage to equipment or machinery.
* Drug abuse or dependence can lead to crime, violence, financial difficulties and debts.
* Drug abusers risk contracting HIV/AIDS through shared injection needles or having unprotected sex. In other words drug abuse is a factor in the spread of HIV/AIDS.

## 3.5 Determinants of Drug and Substance Use

People take drugs for their immediate and short-term effects. The most common reason why people use drugs is to change the way they feel. There is no simple reason as to why they might want to change the way they feel.

Factors that push individuals into drug and alcohol abuse behaviours are varied. Public Safety Canada (2009) reports that negative peer association, myths about the prevalence of illicit drug consumption, abusive parenting styles, school exclusion, academic failure, feelings of low self-worth, lack of or relaxed laws and regulations about drug and alcohol use in the community and availability of drugs and alcohol in the community influence young people to abuse drugs and alcohol.

Bourne (2005) reports that the need to fit in and engage in activities that their peers are doing may consequently lead young people to abuse drugs, especially if their peers abuse drugs.

A study done in Zambia, by Nsemukila and Mutombo (2000) identified the following factors that influence young people to abuse cannabis: cultural beliefs, traditional medical practices, perception regarding its power, peer and family pressure, feeling of fun and excitement. In addition, widespread belief among pupils, of increased intellectual capacities or perceived high academic performance in school also influences them to abuse drugs.

Boog et al. (1999) conducted a survey on drug abuse and reported that degrading economic situation, lack of social controls, peer pressure, weak parental guidance, availability of drugs and alcohol in the community were major instigating factors for increased abuse of drugs and alcohol among pupils in Zambia.

In other words reasons for young people to use drugs may be summarized as follows:

* To relax to have fun; for the euphoria;
* To feel less inhibited; to be part of a group; (peer pressure)
* Out of curiosity;
* To cope with problems;
* To relieve stress, anxiety or pain; and
* To overcome boredom.

These reasons may be grouped into broader categories as individual, family and friends, society and the environment factors.

***The individual***

Adolescence is a time of immense physical and emotional change. Young people often feel awkward and self-conscious and caught between conformity and the urge to be different. Young people may not always have the skills to deal with the stresses and pressures of life to which they are vulnerable. Drugs may be seen as a way of dealing with these issues.

***Family and friends***

Young people learn about drugs at a very early age, for example, taking medicine for childhood illness. Parents and other adults use tobacco, tea, coffee, aspirin, prescribed drugs and alcohol.

***Society***

Mixed messages from media, peers, parents, school and work often contradict or conflict with young people's experience of themselves. Different contradicting messages results in young people receive both encouragement and discouragement regarding drug use. Adolescent drug use often occurs in social settings with friends and is therefore perceived to have positive recreational outcomes amongst young people.

***Environmental***

Factors that influence drug use include: laws that control supply and availability, advertising and promotion of alcohol and drugs, often targeted at young people, and availability, where drugs are grown or traded, young people have greater access.

The prevalence of youth drug use is difficult to estimate for many reasons, as drug use is not static, it is dynamic. The impact of a drug will vary from person to person and similarly a person's use of a drug will vary over time. Most drug use by young people is experimental and will not develop into dependency. Lifestyle changes, such as finding a job or forming stable relationships can affect how long someone engages in drug use.

## 3.6 Signs and Symptoms and Drug Abuse

Early detection of drug abuse is extremely important. When a person abusing drugs is identified at an early stage, it is easier for action to be taken to prevent further abuse through prevention education and counselling. This section focuses on young people who may be abusing drugs; as such they may display more of the following behavioural traits:

***As an individual, one may exhibit the following behaviour:***

* Sudden change in personality
* Changes in attendance, and being unwilling to take part in school activities
* Decline in performance at school
* Unusual outbreaks of temper, marked swings of mood, restlessness or irritability
* spending more time away from home, possibly with friends of older age groups
* Excessive spending and borrowing
* Stealing money or goods
* Unexplained fatigue
* No interest in physical appearance
* Increased or reduced appetite
* Heavy use of colognes to disguise the smell of drugs
* Wearing sunglasses at inappropriate times (to hide red eyes)
* Chewing of onions and garlic or breath deodorants sweets or gums to disguise the smell of drugs

***Young people in groups (friendship groups) may exhibit the following behaviour:***

* Regular absence from school on certain days
* Keeping at a distance from other pupils away from supervision points (e.g. groups

which frequently gather near the gate of a school playground or sports field).

* Being the subjects of rumours about drug consumption
* Talking to strangers on or near the premises
* Stealing which appear to be the work of several individuals rather than one person (e.g. perhaps to shop lift the solvents)
* Use of coded language or jargon
* Exchanging money or other objects in unusual circumstances
* Associate with one person who is much older and normally part of the peer group

## 3.7 Paraphernalia for Drug Use

***Objects which may be associated with drug abuse behaviour:***

* Foil containers or cups made from silver foil, perhaps discoloured by heat
* Metal tins
* Spoons discoloured by heat
* Pill boxes
* Plastic cello tape or metal foil wrappers
* Small plastic or glass vials or bottles
* Twists of paper
* Straws
* Sugar lumps
* Syringes and needles
* Cigarette papers and lighters
* Plastic bags or butane gas containers (solvent abuse)
* Cardboard or other tubes (heroin)
* Stamps, stickers, or other similar items
* Shredded cigarettes and pipes (cannabis)
* Paper (about 2 inches square) folded to form an envelope (heroin)

Activity

1. Distinguish between narcotic drugs and psychotropic substances
2. Identify commonly used drugs and their effects on people
3. Explain some of the reasons why people use or abuse drugs
4. Identify the short-term effects of alcohol on the motor activities, reflexes, coordination, and the major organs of the body
5. Describe the physiological and behavioral effects of marijuana on the body (nervous, respiratory, cardiovascular, and reproductive systems)
6. Examine how alcohol, tobacco, and other drug use negatively impacts the person who uses the drug, and his or her family and friends.

Summary

You now know that drugs are classified based on their pharmacology effect. One major classification of these drugs is to categorize them according to **narcotics** and **psychotropic** types. Another way of classifying these drugs of abuse is to groups them according to their effects on the human and animal body. There are six (6) main classes, namely; stimulants, depressants, hallucinogens, opiates, inhalants and cannabis. You also know that there are what we call Controlled drug and Prescription drugs. These drugs can have a dangerous effect on our lives if not well managed.Effect may bephysiological or Socio-economic in nature. It is important for you to be able to identify situations of drug use or abuse if you are to develop lasting interventions.

# **UNIT 4: DRUG USE RISK AND PROTECTIVE FACTORS**

## 4.1 Introduction

In this Unit you will learn about factors that drive individuals to use or abuse drugs and those factors that can help them not to use or abuse drug. These factors are known as Risk and Protective factors. Identification of both risk factors and protective factors in a home, school, community and the environment is of significance to you because it is the basis for planning interventions. Let us now look at these factors in detail.

Learning outcome

By the end of this Unit, you should be able to;

* analyse risk and protective factors for drug use in the family (home) school, community and the environment.
* explain the link between drug abuse, HIV-AIDS and crime.
* discuss gender differences in drug and substance abuse.

Time frame

You will need more than two (2) hours to deal with this.

**Content**

## 4.2 Analysis of Risk and Protective Factors for Drug Use

Research has shown that in order to prevent drug and alcohol abuse among young people, two things must happen, i.e. factors that increase the risk of the problem must be identified, and ways to reduce the impact of those factors must be developed. Factors that help to prevent drug and alcohol abuse are called ***protective factors*** and those that contribute to or increase the risk of abuse are called ***risk factors.***

A protective Factor is a factor that will reduce the probability of occurrence of an event perceived as undesirable. This term is often used to indicate the characteristics of individuals or their environment which reduce the likelihood of experimentation with or misuse of drugs. For example, there is some evidence from research in developed countries that each of the following attributes is, statistically at least, 'protective' in relation to illicit drug use: being female; being of high socio-economic status; being employed; having high academic attainment; practising a religion; and being a non-smoker.

A risk Factor is a factor which increases an individual's risk of taking drugs. The factors are complex and change constantly at the individual, community and societal levels. The World Drug Report 2000 lists various contributing risk factors:

● ***Family risk factors*** (family disruption, criminality and drug abuse in the family, ineffective supervision)

● ***Peer networks*** (friends and peers are important in providing opportunities for drug use and supporting this behaviour)

● ***Social factors*** (poor school attendance, poor school performance, early drop out)

● *E****nvironmental influences*** (availability of drugs, social rules, values and norms regarding tobacco, alcohol and illicit drug use)

● ***Individual factors*** (low self-esteem, poor self-control, inadequate social coping skills, sensation seeking, depression, anxiety and stressful life events)

Knowledge of these various factors can help drug and alcohol abuse prevention practitioners to better understand the dynamics of drug use and to develop strategies that will enhance the protective factors while minimizing the risk factors. Note, however, that most individuals at risk for drug abuse do not start using drugs or become addicted. Also, a risk factor for one person may not be for another.

Another way of looking at risk and protective factors consider environmental and internal factors Environmental factors in the individual's adolescence include: [child abuse](https://en.wikipedia.org/wiki/Child_abuse), exposure to drugs, lack of supervision, [media influence](https://en.wikipedia.org/wiki/Media_influence), and [peer pressure](https://en.wikipedia.org/wiki/Peer_pressure). Drug activity in an individual's community may normalize the usage of drugs. Similarly, if an individual is placed through treatment and then placed back into the same environment that they left, there is a great chance that person will relapse to their previous behavior.

Internal factors that are within the child or personality-based are [self-esteem](https://en.wikipedia.org/wiki/Self-esteem), poor [social skills](https://en.wikipedia.org/wiki/Social_skills), [stress](https://en.wikipedia.org/wiki/Stress_(psychological)), attitudes about drugs, [mental disorder](https://en.wikipedia.org/wiki/Mental_disorder) and many others. A few more factors that contribute to teen drug abuse are lack of or poor parent to child [communication](https://en.wikipedia.org/wiki/Communication), unsupervised accessibility of alcohol at home, having too much freedom and being left alone for long periods of time.

Additionally, there is evidence that gender moderates the effect of family, school and peer factors on adolescent substance use and abuse. For example, some studies report that not living with both biological parents or having poor parent-adolescent communication is associated with substance use, especially in female adolescents.

While risk and protective factors can affect people of all groups, these factors can have a different effect depending on a person’s age, gender, ethnicity, culture, and environment. Risk and protective factors can be divided into five categories or domains: individual characteristics, school, family, neighbourhood/community and society/environment.

***Key Risk and Protective factors for drug and alcohol use***

|  |  |  |
| --- | --- | --- |
| **Categories** | **Risk factors** | **Protective factors** |
| Individual | -Inadequate life skills.  -Lack of self-control  - Low self-esteem  - Emotional and psychological problems  - Favourable attitudes towards substance abuse  - Rejection of values  - School failure  - Lack of school bonding  -Early anti-social behaviour e.g. aggression  -Some mental disorders  -Friends that use drugs and alcohol | -Impulse control  -High self esteem  - Characteristics (e.g. emotional stability, positive self-esteem).  -Bonding to societal institutions and values, particularly attachment to parents, school and religious affiliations.  -Social and emotional competence  -Friends that don’t use drugs and alcohol. |
| Family | - Parental attitudes favourable to drug use  - Poor family management  - Family history of antisocial behaviour  - Family conflict and domestic violence  - Lack of family cohesion  - Social isolation of family  • F - Lax, ambiguous or inconsistent rules  - Poor child supervision  - Unrealistic expectations | - Family sanctions against use  - Positive bonding among family  - Parenting that indicates high levels warmth and consistency  - An emotionally supportive parental/family milieu |
| School | - Academic failure  - Little commitment to school  - Lax, ambiguous or inconsistent rules  - Favourable staff and student attitudes towards drugs  • - Availability of alcohol and drugs on school premises  - Lack of school bonding | -Participation in school activities  - School bonding  - Caring and support  • - - High expectations from school  - Clear standards and rules for appropriate behaviour  - Youth participation in school |
| Community | - Community disorganization  - Laws and norms favourable to drug use  - Perceived availability of drugs  - Community disorganization  - Lack of community bonding  • L - Lack of cultural /community pride  - Community attitudes favourable to drug abuse  - Drugs readily available  - Inadequate youth services  -Presence of gangs  • -Unlicensed liquor outlets  - Selling of alcohol and tobacco products  to underage individuals | - Community cohesion  -Community norms not supportive of drug use  -Strong social networks  - Caring and supportive  - High expectations of youth  -Opportunities for youth participation in community structures |
| Society/environment | - Impoverishment  - Unemployment and underemployment  - Discrimination  • o -Pro-drug use messages in the media  - Limited enforcement of alcohol and drug use | - Media literacy  - Decreased accessibility to alcohol, tobacco and other drugs  • -Increased pricing of alcohol and tobacco through taxation  - Raised purchasing age and enforcement  -Stricter traffic laws |
| Source: (Atkinson, 2004; Hawkins, 2002; Morojele et al., 2004; NIDA, 2003; UNODC, 2002). | | |

## 4.3 Drug Use, HIV-AIDS, and Crime

Drug abuse and addiction have been linked with HIV/AIDS since the beginning of the epidemic. Injection drug use is a major factor in the spread of HIV infection through needle sharing and other sharp instruments. HIV spreads easily when infected blood is drawn up into the syringe as the user inject the drug and then shares the needle with another fellow user. Drug and alcohol use can also be detrimental to people on medication like antiretroviral medicines (ARVs), coupled with missed doses, increase the chances of treatment failure or resistance to medication. Drug and alcohol abuse can put an individual at risk for acquiring HIV since intoxication leads to poor judgment and involvement in risk behaviours. For example, for some people, drugs and sex go together. A drug user might trade sex for drugs or for money to buy drugs. Someone trading sex for drugs might find it difficult to set limits on what to do thereby reducing their commitment to use condoms or practice safer sex. Often, substance users have multiple sexual partners increasing their risk of becoming infected with HIV and other sexually transmitted infections (STIs). Both drug abuse and HIV affects the brain. Research has shown that HIV causes greater injury to the cells in the brain and cognitive impairment among methamphetamine abusers than among HIV patients who do not abuse drugs (Marcondes, et al., 2010)

## 4.4 Gender Differences in Drug and Substance Abuse

***Introduction***

People may face unique issues when it comes to drugs and substance use, as a result of both sex and gender. Sex differences result from biological factors, such as sex chromosomes and hormones, while gender differences are based on culturally defined roles for men and women, as well as those who do not identify with either category. Gender roles influence how people perceive themselves and how they interact with others. Sex and gender can also interact with each other to create even more complex differences among people. While researchers are working to strengthen research on sex/gender differences across domains of health, current evidence is limited.

***Research on Gender differences***

Research has shown that women often use drugs differently, respond to drugs differently, and can have unique obstacles to effective treatment as simple as not being able to find child care or being prescribed treatment that has not been adequately tested on women.

For example, women and men sometimes use drugs for different reasons and respond to them differently. Additionally, substance use disorders can manifest differently in women than in men. A substance use disorder occurs when a person continues to use drugs or alcohol even after experiencing negative consequences.

Some of the unique issues women who use drugs face relate to their reproductive cycles. Some substances can increase the likelihood of infertility and early onset of menopause. Substance use is also further complicated during pregnancy and breastfeeding. Pregnant women using drugs, including tobacco and alcohol, can pass those drugs to their developing foetuses and cause them harm. Similarly, new mothers using drugs can pass those to their babies through breast milk and cause them harm.

***On the use of Prescription Opioids***

Some research indicates that women are more sensitive to pain than men and more likely to have chronic pain, which could contribute to the high rates of opioid prescriptions among women of reproductive age. In addition, women may be more likely to take prescription opioids without a prescription to cope with pain, even when men and women report similar pain levels. Research also suggests that women are more likely to misuse prescription opioids to self-treat for other problems such as anxiety or tension. A possible consequence of prescription opioid misuse is fatal overdose, which can occur because opioids suppress breathing.

***On the use of Anti-Anxiety Medications and Sleeping Aids***

Women are more likely to seek treatment for misuse of central nervous system depressants, which include sedatives sometimes prescribed to treat seizures, sleep disorders, and anxiety, and to help people fall asleep prior to surgery. Women are also more likely than men to die from overdoses involving medications for mental health conditions, like antidepressants. Antidepressants and benzodiazepines (anti-anxiety or sleep drugs) send more women than men to emergency departments. Because women are also more at risk than men for anxiety and insomnia, it is possible that women are being prescribed more of these types of medications; greater access can increase the risk of misuse and lead to substance use disorder or overdose.

***On the use of alcohol***

In general, men have higher rates of **alcohol use**, including binge drinking. However, young adults are an exception: girls’ ages 12 to 20 have slightly higher rates of alcohol misuse and binge drinking than their male counterparts. Drinking over the long term is more likely to damage a woman's health than a man's, even if the woman has been drinking less alcohol or for a shorter length of time. Comparing people with alcohol use disorders, women have death rates 50 to 100 percent higher than do men, including deaths from suicides, alcohol-related accidents, heart disease, stroke, and liver disease.

In addition, there are some health risks that are unique to female drinkers. For example, heavy drinking is associated with increased risk of having unprotected sex, resulting in pregnancy or disease, and an increased risk of becoming a victim of violence and sexual assault. In addition, drinking as little as one drink per day is associated with a higher risk of breast cancer in some women, especially those who are postmenopausal or have a family history of breast cancer.

In addition, men and women metabolize alcohol differently due to differences in gastric tissue activity. In fact, after drinking comparable amounts of alcohol, women have higher blood ethanol concentrations. As a result, women become intoxicated from smaller quantities of alcohol than men. More information on sex and gender differences in alcohol use is available from the [National Institute of Alcohol Abuse and Alcoholism](https://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/women)

***On the use of tobacco***

Research indicates that men and women differ in their smoking behaviours. For instance, women smoke fewer cigarettes per day, tend to use cigarettes with lower nicotine content, and do not inhale as deeply as men. Women also may smoke for different reasons than men, including regulation of mood and stress. It is unclear whether these differences in smoking behaviours are because women are more sensitive to nicotine, because they find the sensations associated with smoking less rewarding, or because of social factors contributing to the difference; some research also suggests women may experience more stress and anxiety as a result of nicotine withdrawal than men. Risk of death from smoking-associated lung cancer, chronic obstructive pulmonary disease, heart disease, and stroke continues to increase among women—approaching rates for men. Some dangers associated with smoking—such as blood clots, heart attack, or stroke—increase in women using oral contraceptives.

***Examples of Sex and Gender Influences in Smoking Cessation***

**Sex Difference:** Women have a harder time quitting smoking than men do. Women metabolize nicotine, the active ingredient in tobacco, faster than men. Differences in metabolism may help explain why nicotine replacement therapies, like patches and gum, work better in men than in women. Men appear to be more sensitive to nicotine's pharmacologic effects related to substance use disorder.

**Gender Difference:** Although men are more sensitive than women to nicotine's addiction-related effects, women may be more susceptible than men to non-nicotine factors, such as the sensory and social stimuli associated with smoking (e.g. greater sensitivity to visual and olfactory cues as triggers and greater concern about weight gain while quitting).

*Sources: ORWH, 2015; NIDA, 2002*

Activity

1. Compare tobacco smoking patterns of men and women and the reasons for these differences.
2. Describe those factors hindering treatment of substance abuse for women.
3. Describe how drugs present a risk factor for the spread of HIV/AIDS
4. Identify and discuss family and school predisposing factors that can lead to an individual’s drug use.
5. How does drug use relate to violence and crime?

Summary

Unfortunately, it can be difficult for a person with a substance use disorder to quit. Communities can build support systems to help women access treatment as early as possible. Effective treatment should incorporate approaches that recognize sex and gender differences, understand the types of trauma women sometimes face, provide added support for women with child care needs, and use evidence-based approaches for the treatment of pregnant women. Substance abuse prevention programs targeting adolescent girls should focus on such general risk and protective factors as problem solving, refusal skills, peer influences, and self-efficacy, as well as such gender-specific risk and protective factors as communication style, coping, self-esteem, body image, perceived stress, and mood management.

# **UNIT 5: THEORIES AND MODELS OF DRUG AND SUBSTANCE ABUSE PREVENTION**

## 5.1 Introduction

Generally speaking, in relation to human behaviour, theories are used to provide a framework to understand the many factors that influence it. They help in understanding specific concerns or phenomenon existing in a particular setting (Victorian Curriculum and Assessment Authority, 2010). In case of drug and substance abuse behaviour, theories play a significant role in informing us on its determinants, effects, possible interventional measures, and guide us on how to implement and evaluate prevention interventions. This unit highlight to you a few of them. However, you are expected to read more as there are many valuable theories in this field.

Learning outcome

By the end of this Unit, you should be able to;

* discuss the following theories and their application in drug and substance abuse prevention; Social leaning theory, Modified Social Stress Model, Social Ecology theory and Cognitive Dissonance Theory.
* discuss the role social learning theory and social ecological theory in the acquisition of drug and alcohol abusing behaviour among young people.

Time frame

You will need one (1) hour to deal with this unit.

**Content**

## 5.2 Social Learning Theory

The proponent for the Social Learning Theory is Albert Bandura’s (Bandura, 1977). The Social Learning Theory, also known as Social Cognitive Theory focuses on the learning that occurs within the social context. Firstly, it proposes that young people learn social behaviours through a process of observation and imitation of the role models and the outcome or consequences of their behaviour (Dembo, 1994). Role models and perceptions of the behaviour norms serve as social influences for engagement in that behaviour.

Young people actively watch and imitate the behaviours of significant others in their life. These models include parents, teachers, peers and other adult people (Dembo, 1994). Secondly, the theory essentially purports triadic reciprocity between personal, environmental and behavioural factors. Personal factors include cognition, expectancies, beliefs and attitudes while environmental factors include contingencies of reinforcement. Behaviour factors include involvement in marijuana smoking. The behaviour depicted in young people is mostly as a result of the interaction of these three factors.

This theory has been used to explain factors that influence people to abuse drugs and other substances and the preventive strategies that can be applied. The theory has also helps to understand that, since drug and alcohol abuse behaviour in pupils is socially learnt from models such as peers, teachers, parents and the media, exposing them more to drug and alcohol abuse preventive models would help them to develop social refusal skills.

## 5.3 Modified Social Stress Model (MSSM)

The Modified Social Stress Model was developed by Rodes and Jason (1988) and modified by World Health Organization/Programme on Substance Abuse (WHO/PSA). The model postulates that when many risk factors are present in a person’s life, that person is more likely to begin, intensify and continue the use of drugs. On the other hand the more protective factors are present, the less likely a person is to be involved in drug use (Ekpenyong, 2012). The model further reveals that these two factors must be considered at the same time in order to effectively understand and prevent drug and alcohol abuse among young people, that is, risk and protective factors in an individual’s life.

The Modified Social Stress Model further identifies six major factors, namely; stress, normalization of behaviour and situations, effect of behaviour and situations, skills, attachments, and resources. Stressful situations such as emotional abuse, normalization of substance abuse behaviour such as easy access to and acceptance of alcohol in the community, and effect of behaviour and situations like sleep inducing or energy increasing effect, are viewed as factors that may increase vulnerability (risk factors), whereas skills such as decision making and assertiveness, resources (family, information and capacity to work) and attachments to significant others, are seen as factors that may reduce vulnerability to drug and alcohol abuse problem (protective factors). It therefore follows that once the risk factors are identified, action can begin on reducing the risks and strengthening the protective factors. The model does not only provide an understanding into drug and alcohol problem, it is also useful for planning and developing effective preventive interventions.

## 5.4 Social Ecology Theory (SET).

The Social Ecological Theory (SET) was developed by Berkowitz and Perkins (1986) and further expanded by McLeroy et al., (1988). The theory was used because it encompasses both individual and wider societal influences of drug abusing behaviours. SET explains the causes of drug and alcohol abuse to be within the social environment. It identifies five levels of influence on drug and alcohol abusing behaviour in young people, namely; intrapersonal factors, interpersonal processes, institutional or organizational factors, community factors, and public policy. Drug and alcohol abuse is seen as a function of the social group within which individuals interact. The theory aims at establishing the relationship of naturally existing social structures in the community to the problem of drug and alcohol use among young people. The central tenet of SET is that individual behaviours are mainly the result of socialization; and therefore to change the behaviour, the social institutions that shape it must change (Hansen, 1997). This entails that drug and alcohol abuse prevention efforts using this theory focus on changing the person’s environment rather than the person.

## 5.5 Cognitive Dissonance Theory

**REF:** ELAINE M. JOHNSON, (PhD), SHARON AMATETTI, (MPH), JUDITH E. FUNKHOUSER and SANDIE JOHNSON, (MA) ***Theories and Models Supporting***

***Prevention Approaches to Alcohol Problems Among Youth****,* from Public Health Report.

Cognitive dissonance. Much of William McGuire's work in psychology is based on Festinger's concept of cognitive dissonance, which describes a tendency of humans to harmonize expectations about people and experiences with them. In other words, we want our beliefs to be in harmony with our experiences. Cognitive dissonance theory holds that people want their personal attitudes and beliefs to be compatible with their own behavior. If they are not, there is "cognitive dissonance" that a person will want to eliminate. As a prevention technique, McGuire proposed that certain "pre-treatments" would establish or strengthen beliefs and attitudes with which a person's behavior would have to harmonize to avoid cognitive dissonance. "Cognitive inoculation" is one of these pre-treatments. He found that verbal "inoculations" had certain immunizing effects against strong counter-arguments, and strengthened the subjects' ability to defend their beliefs.

When applied to the use of alcohol and other drugs, cognitive inoculation aligns a person's beliefs and behavior with regard to these substances. For instance, if a teenager believes that drinking will diminish athletic ability, and places a high value on athletic ability, resolution of dissonance would require that the teenager either abstain from drinking or place a lower value on athletic ability. Another pre-treatment approach requires that a behavior commitment be made; the commitment often is in the form of a contract or public announcement of one's beliefs and intentions ("I will not use alcohol until I am of age"). McGuire found that a commitment made to others was stronger than a private commitment.

Activity

1. According to Modified Social Stress Model, there are six factors that must be considered in order to effectively understand and prevent drug and alcohol abuse among young people. Discuss.
2. Discuss the role albert Bandura’s social learning theory in the acquisition of drug and alcohol abusing behaviour among young people.

Summary

The main proposition of the Social Learning theory is that young people learn social behaviours through a process of observation and imitation of the role models and the outcome or consequences of their behaviour (Dembo, 1994). Hence to deal with drug and substance abuse among young people you need to expose them more to drug and alcohol abuse preventive models who would help them to develop social refusal skills. The Modified Social Stress Model postulates that when many risk factors are present in a person’s life, that person is more likely to begin, intensify and continue the use of drugs. On the other hand the more protective factors are present, the less likely a person is to be involved in drug use (Ekpenyong, 2012). This model provide an understanding into drug and substance abuse problem, and it is also useful for planning and developing effective preventive interventions.

# **UNIT 6: PREVENTION EDUCATION AND PUBLIC AWARENESS INTERVENTIONS**

## 6.1 Introduction

In the previous unit you dealt with some theories of drug and substance abuse prevention. These theories provide explanations of drug use behaviour and are useful for planning and developing effective preventive interventions. You will now learn various interventions applied in prevention of drug use in family, schools, work places, community and the environment.

Learning outcome

By the end of this Unit, you should be able to;

* discuss the three levels of service delivery for drug and substance abuse prevention, viz- aviz, Universal, Selective and Identified approaches.
* explain how you would use debate, games and role play to educate a grade nine class in a secondary school set up.
* describe main aspects of family- based, school-based, community-based work place-based drug abuse prevention education and interventions.
* describe main aspects of Media-based and Environmental-based Interventions.
* describe interventions that can be used when applying Harm reduction approach.
* discuss the benefits and costs of peer education training as a mode delivery in drug and substance abuse prevention.

Time frame

You will need more than three (3) hours

**Content**

## 6.2 Universal, Selective and Identified Prevention Approaches

The primary objective of drug prevention therefore, is to help young people, to avoid or delay the initiation of the use of drugs, or, if they have already started, to avoid that they develop disorders such as dependence (UNODC, 2012). Drug and alcohol abuse prevention also aims at reducing those factors that promote the risk of initiating drug-use behaviours and disorders, and to promote protective factors that improve resistance to risk (McGrath et al., 2006). However, in a broader sense, drug abuse prevention is aimed at providing healthy and safe development environment to young people so that they can realize their potential and live meaningful lives.

Traditionally, in terms of service delivery, drug abuse prevention was based on the concept of Public health (The Public Health Model), classified into three levels namely; primary, secondary and tertiary prevention. However, in 1994, the Institute of Medicine proposed a new framework for classifying prevention into three levels namely; universal, selective and indicated prevention, which replace the previous concepts of primary, secondary, and tertiary prevention (Institute of Medicine, 1994).

* ***Universal programmes:*** are designed for the general population, such as all students in a school and all parents in the community. These programmes include services such as establishing an infrastructure for collaboration between school staff and parents; support norms for protective parenting practices; disseminating information encouraging school or family management practices that promote school success and prevent the development of early on-set alcohol and drug use (Dishion et al, 2000). In fact school-based prevention programmes are a popular form of universal prevention among youth as schools facilitate easy access to a large part of this population. Programmes are conducted in a variety of means, including: interactive and skill development sessions or workshops, print materials, videos, media awareness, newsletters, and home visits.
* ***Selective programmes:*** target groups at risk, or subsets of the general population such as children of drug abusers and families at greater risk. Among young people, such interventions are mainly focused on young people at risk of leaving school early, dropouts, young offenders, and youth from high risk neighbourhoods. These groups are identified and supported by providing information and interventions specific to their needs. An example of a selected intervention is the *Family Check Up* that provides assessment and parenting skills for parents who have adolescents experiencing problems at school (Dishion et al, 2000).
* ***Indicated programmes:*** are designed for people who are already experimenting with drugs, and those who are exhibiting early signs of problematic substance use and/or other problem behaviours. These programmes involve giving direct professional support to young people who are using drugs or have just started using drugs in order to help them stop or abstain from the habit. Intense assistance and information is given to children and their parents. They include individual and small group counselling and case management services.

## 6.3 Drug and Substance Abuse Prevention Interactive Methods

***Introduction***

Methods are ways of carrying out planned prevention education programmes based on the strategies adopted. In other words they are techniques, activities or modes of delivering drug and alcohol abuse knowledge, attitude and skills to learners.

Studies have revealed that some methods or activities for drug and alcohol abuse prevention are less effective and counterproductive while others have shown to produce desired outcomes (Tobler and Stratton, 1997; Botvin and Griffin, 2003). Effective methods are those that are said to be highly interactive, while non-interactive methods are those with limited communication between the provider and the audience or recipients. In other words, they limit participation on the part of the learners.

Many studies on prevention methods have concluded that using interactive methods is an effective way of delivering drug and alcohol abuse prevention education. Tobler et al., (1999) defines interactive programmes as those with higher degree of active participation by all learners. These methods or activities include: small group discussions, role-play, educational games, cooperative learning, demonstrations, brainstorming, modeling, homework assignments, drama, motivational interviewing, behaviour rehearsal, debate and peer education. Less interactive methods include Lectures, use of ex-addicts, use of scare tactics, large group discussions, use of brochures posters and campaign T-shirts, video shows depicting negative consequences of drug use and display of drugs that are commonly used.

For example Bangert-Drowns (1988) who conducted a meta-analysis of 33 school-based programmes found that programmes that used lectures as their only intervention had less influence on attitude change than those which used small group discussion. Similarly, a study conducted by Yamada et al. (2014) to evaluate the effectiveness of small group discussions in drug abuse prevention in Japan, found that more learners acquired skills to prevent drug abuse by participating in small group discussions than in a lecture.

The strength of interactive methods is that they encourage the development of interpersonal competence skills such as negotiating and drug refusal skills and identification of negative influence or peer pressure. Interactive methods are used to stimulate active participation by the audience. They also allow practice of interpersonal competencies and desired behaviour.

**Examples of interactive methods**

***Role Play***

Role-play is a simulation exercise where a person takes on assumed roles in order to act out a scenario in a contrived setting. The method emphasizes the social nature of learning, and sees cooperative behavior as stimulating learners both socially and intellectually.Note thedifference between role play and drama. Role play has no script and drama has a script.

Role plays are used in order to broaden personal skills; practice and reinforce new skill without fear of failure or criticism; generate solutions to conflict situations in a safe environment and considering a range of responses to particular situations. Role play also helps to experience the feelings that may accompany decisions; stimulates interest in the topic; increases involvement on the part of the learner and it helps learners embed concepts, practice appropriate skills and develop positive attitudes and values.

***Group discussion method***

It is a method in which groups of learners are assigned to discuss a certain topic within certain limit. Although discussion can be conducted with larger groups, smaller groups are more desirable and encourage learners to give their own views through open participation. In other words Small group discussion method is also known as Circular Response technique. In the circle response the facilitator proposes a question to members of the group seated in a circle. Each person, in turn expresses his/her response. No one is allowed to speak a second time until all have had a turn.

The benefits of group discussion are many. First,Learners think constructively while interacting with the rest of the group. They practice analysis and evaluation skills or examine opinions. Group discussions teach interpersonal skills such as understanding and communication. Learners learn from each other and thus encouraging team work. In addition to this, the method helps build up leadership, speaking and listening skills in learners; learners express their views or opinions orally on certain issues, thus they are actively involved in processing information and ideas. Above all it involves sharing of ideas and experiences solving problems, participating in making decisions and promoting tolerance and understanding.

***Games***

A game is a competitive activity with a prescribed setting constrained by rules and regulations. The basic characteristic of a game is that it must have a goal, which is to win and must be competitive. Such games must be educational games.

According to Alfarah, Schunemann and Akl, (2010), an educational game is a type of experiential learning where the learner ***“engages in some activity, looks back at the activity critically, abstract some useful insight from the analysis and puts the results to work”***

General objective of games in prevention education is to present factual information, facilitate peer interaction and teach critical thinking. The advantage of the use of games is that they facilitate internalization of concepts by stimulating cognitive processes; learners use multiple senses as part of experiential learning; they motivate learners to learn actively; they may improve long-term retention of information and they increase problem-solving skills and foster understanding of complex systems

***Motivational interviewing (MI)***

Motivational interviewing is a guided therapeutic approach that helps people think collaboratively about their motivations and commitment to change (Miller and Rollnick, 2009).It is suitable for early adolescence up to young adults. This method requires that small groups of youths with high risk factors are organized according to their interests and willingness to discuss drug abuse issues. The facilitator encourages them to speak and make decisions to live a drug free life.

Some of the benefits of MI are that MI groups engages them about their personal experiences, then validates those experiences while eliciting ideas about how adolescents can change and make healthy choices. MI allows the client’s values, opinions, and arguments for change to be the most important component of the discussion. It can be used for youth who do not use drugs and alcohol and those who may be using them. MI also works for youth who are at risk or come from disadvantaged or cultural-minority backgrounds.

***Case study***

This is a technique that uses information regarding a real life situation presented to the group members, who analyze all the aspects of the problem and offer a solution. Learners are expected to study the case material and generate the illustrated principles and questions from the specifics. The main purpose of using this method is to analyze and solve a problem The advantages of using case study method are that learners learn a process of information analysis. It provides for a high level of cognition learning. The learner is fully involvement and he or she is actively applying their learning and cases tend to be more interesting and often easier to follow because they are drawn from real situations.

***The Workshop method***

This method entails a group of people with common interest under the leadership of several experts, to explore one or more specific aspects of the topic. The main objective of this method or mode is to gain information through experience and sharing of information. Subgroups are formed for the purpose of hearing speeches, seeing demonstrations, discussing various aspects of the topic, studying, working, practicing and evaluating.

***Debate***

Debate as a teaching method is a form of communication which can train learners in critical thinking and creativity. Learners learn how to express themselves. When used in drug and alcohol abuse prevention education, debate can enhance necessary skills for development of self- esteem, assertiveness, self- expression and gaining deeper knowledge about on the subject matter.

The main purpose of using debate in drug abuse prevention education is to promote critical thinking in dealing with peer pressure persuasions into drug abuse involvement and advertisements. This helps learners to counteract such pressures.

The benefits of debate include giving learners critical thinking to evaluate ideas of others. Learners will research on the topic they are debating on, i.e. learning about it, think about what they will propose, and think about the argument of their opponents. Learners will communicate and advocate. They will express their ideas to others openly. They will listen to what others have to say, and listen with understanding. Lastly they will be able to learn how others make decisions.

***Lecture method***

Unlike all other methods discussed here, this is a less interactive method. It is also known as Oral Exposition method. Lecture method is the mostly adopted and commonly used traditional method. In this type of teaching method dominate that of the learners in the classroom. Learner’s involvement and participation is not all that very obvious. Instead, they are mostly passive and emphasis is, rather placed on teacher’s activities than the learner’s activities. The main objective of this method is to gain basic factual information on drug and alcohol abuse prevention issues

This method requires a qualified person to give a prepared oral presentation. However, lecture method has its own advantages. It is probably most useful for giving a general introduction to a topic area, giving broad overviews of content which is then followed by use of other methods. It is suitable for audience of any kind and size. It provides a good way to present new information and materials. Facts can be presented in an orderly way. Some people tend to learn easily by listening than by reading. A skilful speaker can easily stimulate and motivate the participants to further study and inquiry.

## 6.4 Family-based, School-based, Community-based and Work Place-based Prevention Interventions

1. **Family-based prevention intervention**

The prevention of drug abuse should start inside the family unit as early as possible. There are many obvious benefits of home based drug prevention education including self-awareness, and the enhancement of parent-child communication skills and family bonding. Parental supervision and involvement are critical in adolescents. Parents must not only have a plan to educate their children on the dangers of drug use and abuse, but they must also establish and enforce family rules. This includes creating an effective system of monitoring their children's activities.

Family-based prevention programs can strengthen protective factors among young children by teaching parents better family communication skills, appropriate discipline styles, firm and consistent rule enforcement, and other family management approaches. Research confirms the benefits of parents providing consistent rules and discipline, talking to children about drugs, monitoring their activities, getting to know their friends, understanding their problems and concerns, and being involved in their learning.

The importance of the parent-child relationship continues through adolescence and beyond" (National Institute of Drug Abuse, 2003).

1. **School-based prevention interventions**

Education for drug abuse prevention in schoolsmay be defined as the educational programmes, policies, procedures and other experiences that contribute to the achievement of broader health goals of preventing drug use and abuse. Education for drug abuse prevention should be seen to include both formal and informal health curricula, the creation of a safe and healthy school environment, the provision of appropriate health services and support as well as the involvement of the family and the community in the planning and delivery of programmes.

***The components of a school-based drug abuse prevention education and intervention programme***

The educational components of a school drug abuse prevention programme are the following:

* **A programme based on the guiding principles for school-based education for drug abuse prevention** as set out in chapter 2 that forms a core component of the school curriculum and focuses on equipping young people with information about drugs, the life skills necessary to enable them to deal with different situations without turning to drugs, the ability to resist pressure to use drugs and an understanding of what drugs are.
* **A safe and supportive school environment** made possible by a set of clearly communicated policies and procedures that provides care, counselling and support for all students and ensures a cooperative approach among staff, students, parents, and related professionals, agencies and the police.
* **Strategies for ensuring that all members of the school community contribute to and support school policies** and procedures for dealing with drug matters
* **Appropriate professional development** and training for relevant staff
* **Information and support for parents**, in particular parents of students involved in illicit and other unsanctioned drug use
* **Mechanisms for continuous monitoring and review** of the school’s approach to education for drug abuse prevention and incident management The intervention components of a school drug abuse prevention programme are:
* **Policies and procedures for dealing with drug incidents** based on the guiding principles for school-based education for drug abuse prevention (see chapter 2) that consider the student’s whole life and the degree to which he or she is in control of his or her actions and decisions

* **Plans for initial and long-term responses to drug incidents** aimed at protecting the health of all students and the school community
* **A plan for managing drug incidents consistent with local laws** and regulations, as well as national and local school policies on drugs
* **A communication strategy for drug incidents** that ensures all staff are aware of school or system-wide procedures for contacting and responding to the media
* **A directory of professionals and agencies**, including the police, who can provide opportunities for professional development, advice and resources
* **Agreements with professionals and agencies,** including the police, to formalize and strengthen cooperative liaison and referral arrangements
* **Support for students involved in drug incidents** that ensures their continued participation in education programmes
* **Records of drug incidents**: these should be kept and due attention should be paid to the protection of the rights and privacy of all those involved

Drug abuse prevention should be addressed as early as preschool. Preschool children can benefit from learning how to handle aggression, solve problems, and communicate better so that they can avoid putting themselves at risk for drug abuse later in life. Middle and high school programs should focus on peer relationships, communication, assertiveness, drug resistance skills and developing anti-drug attitudes. School based prevention programs should be repeated often for the best level of success.

1. **Community-based prevention interventions**

Communities that make an effort to come together in the fight against drugs are sure to make an impact in the prevention of drug abuse. There are many places to establish these prevention programs including schools, churches and community based clubs.

Drug abuse is a growing problem and prevention should be a priority in all of our homes and communities. If you need help finding drug abuse prevention programs near you, you should be able to contact prevention and treatment centres or service providers.

Prevention programs work at the community level with civic, religious, [law enforcement](https://en.wikipedia.org/wiki/Law_enforcement), and other government organizations to enhance anti-drug norms and pro-social behaviours. Many programs help with prevention efforts across settings to help send messages through school, work, religious institutions, and the media. Research has shown that programs that reach youth through multiple settings can remarkably influence community norms. Community-based programs also typically include development of policies or enforcement of regulations, mass media efforts, and community-wide awareness programs.

(http://en.wikipedia.org/wiki/substance\_abuse\_prevention#cite\_note-16)

1. **Work place-based interventions**

The Rationale for Workplace Interventions Companies are increasingly becoming aware that the workplace mirrors the community and that community problems will indeed be workplace problems. Waiting until serious problems set in for the substance user and then terminating him will prove costly to the company (loss of worker’s skill and cost of retraining another worker). The impact of drug and alcohol use in the workplace is being increasingly recognised. Substance use negatively impacts upon the enterprise through accidents, absenteeism, lost productivity and health costs. It also affects the workers and their families by affecting physical well-being, destroying relationships, reducing job performance and causing health, family, legal and financial problems. Many of the problems caused by substance use at the workplace are due to intoxication and post-use impact (hangover effect), in addition to the other effects of addiction. Up to 40% of accidents at work involve or are related to alcohol use. Job fatalities linked to drug and alcohol account for as many as 15-30% of accidents. Employees with drug and alcohol dependence claim three times as much sickness benefit and file five times as many workers’ compensation claims. Substance using employees create higher safety risks from intoxication, negligence and impaired judgment. Problems with co-workers through increased work-load on the non-substance user, disputes, grievances, intimidation and violence are common problems associated with substance use at the workplace.

## 6.5 Media-based and Environmental-based Interventions

While exposure to mass media will vary from country to country and within communities it is critical to consider the influence of mass media. Efforts should be made to work with various groups within the local community and the nation, so that the messages being promoted to school students are closely linked to those in the broader community. Unhealthy messages being promoted by mass media need to be refuted with accurate information in the course of planned activities for students. Mass media can also be very powerful in setting the social agenda and facilitating an environment where difficult issues are desensitised and easier to confront.

## Environmental-based interventions

## Much of what we know regarding environmental – based interventions has focused on preventing alcohol-related problems in licensed establishments. However, it is clear that some environmental prevention approach are appropriate for addressing drug use and related concerns for a number of reasons (Miller, Holder and Voas, 2009). First, there is evidence that environmental context, both physical space of the event and social characteristics, can increase or decrease drug use and behavioural risks (Miller, Holder and Voas, 2009). Environmental approaches focus on changing the social, economic and physical environment (Oncioiu, et al. 2018). For further information on the environments interventions, the following web sites may be consulted;

## - https:www.ncbi.nlu.nih.gov-pmc-article-pmc2834248

## -www.paliticheantidroga.gov.it-media-environmental-substance-use-pre..

## 6.7 Harm Reduction Approach

The harm reduction approach to treatment meets the young person where they are at in life. Harm reduction could be described as an approach to working with substance users that fundamentally accepts a reduction in use or associated harms as valid treatment goals. It is accepted that in order to eliminate any possible harms occurring due to substance use, abstinence would be the desired outcome. However, it should be noted that some people may present as either unwilling or unable to change their behaviour. Harm reduction initiatives have been developed to work specifically with people who engage in problematic substance use.

**Examples of harm reduction initiatives include;**

* Needle exchange programmes
* Availability of condoms
* Methadone maintenance programmes

Within the wider public health sphere harm reduction interventions that affect everyone in society are present which affect everyone in society, such as;

* Drink driving limits
* Seat belt laws
* Smoking ban

## 6.8 Peer Education

**From: DrugInfo Clearinghouse 2006 *Prevention Research Quarterly: current evidence evaluated* Australian Drug Foundation409 King Street, West Melbourne, Victoria 3003 Australia www.druginfo.adf.org.au**

**The history of peer education**

Peer education is not a new phenomenon. Similar initiatives can be traced to Aristotelian times (Wagner 1982). In the 1950s, peer education programs were conducted in different parts of the

world (for example, Europe, Canada, the United States of America and Australia) with the aim of

delivering, communicating and educating hard to reach populations of young people with health

and social related messages. In the 1960s, peer education-related projects were developed at

Minnesota University to assist disadvantaged young people in their studies. More recently, peer education projects focusing on smoking prevention among young people have been developed (Morgan & Eiser 1990; Wiist & Snider 1991) as well as projects within the drug and alcohol

sector (Hansen & Graham 1991; Rhodes 1994). In recent years, peer education has been applied in the fields of prevention of sexually transmissible infections (for example, HIV/AIDS), sex education and prevention of bullying within schools (Borgia, Marinacci & Schifano 2005; Mellanby, Newcombe, Rees *et al.* 2001; Naylor & Cowie 1999; Ward*,* Hunter & Power 1997). Currently, peer education is experiencing substantial popularity in both developed (for example, Australia) and developing countries (for example, Zambia). It has been found to be a useful means of reaching “hidden populations” (MacDonald 2003) and providing them with essential information.

**Defining peer education**

The use of educators of similar age or background to their students to convey educational messages to a target group. Peer educators often work by endorsing 'healthy' norms, beliefs and behaviours within their own peer group or 'community', and challenging those which are ‘unhealthy’.

Bleder (2001) defines peer education as ***a process of sharing information among group members with similar characteristics, with the aim of achieving positive health outcomes****.* In the context of drug and alcohol field Broadbent (1990) indicates that peer education involves *“****young people teaching other young people about drug issues****.* In addition, it involves training and supporting members of a specific group (such as drug users) in order to encourage a desirable behavioural change among members of the same group.

**Aims / objective of peer education**

The general aims of conducting peer education are to reach hidden population and provide them with:

* ***Knowledge and awareness -*** to provide group members with factual and accurate information regarding particular issues, such as effects of drugs, harm-reduction strategies, sources of help, or legal issues
* ***Skills* -** to provide potential users with refusal skills, strategies to response to drug-related problems; that is, within the family or with friends, to make informed decisions and basic first aid solutions
* ***Behaviour* -** to delay the age of drug-intake initiation, to reduce or prevent drug or alcohol use, reduce harm and prevention of young people’s transition to the use of “hard drugs” such as heroin or cocaine (McDonald *et al.* 2003)

**Rationale for peer education**

Peer Education has been proved to be effective in drug and substance abuse prevention because, firstly, peers are traditional providers of information to their peers. Young people tend to talk with their peers about most subjects. Secondly, peer education programmes are both school-based and community-based. They are flexible and can be used in a variety of setting and in combination with other activities and programmes. Another reason why peer education programme work is that it can provide strong benefit to peer educators themselves such as leadership and communication skills. It is economical or cost effective. It is cheaper in terms of payment to peer educators than to adult professionals.

From a review of the literature, it appeared that there are many justifications for the use of peer

group education. The following is a summary of the main reasons.

* ***Credibility****-* The peer education approach draws on the credibility that young people have with their peers. Research findings indicate that people are more likely to listen and adopt messages if they assume that the messenger is similar to them and faces the same concerns
* ***Cost effective****-* Peer education initiatives can be relatively inexpensive to operate and can be more cost effective than other interventions requiring health professional input (Turner & Shepherd 1999). This can be attributed to the fact that payment to peer educators is lower than to adults.
* ***Peer education is empowering and beneficial for those involved***- Peer educators tend to be self-motivated in instructing their peers on given topics and, consequently, obtain personal benefits from their involvement (Health Education Authority 1993). This, in turn, empowers educators involved in such programs, as they are actively educating and informing others about a specific issue (Parkin & McKeganey 2000; Turner & Shepherd 1999).
* ***Access to hard-to-reach populations***- In contrast to school-based adult education, in which messages are delivered within classrooms, peer education-related projects are more flexible and can be set in different environments. Thus, they can reach specific populations that would not be available,
* ***Peers can reinforce learning through on-going contact***- Research findings suggest that ongoing contact between the peer educators and the targeted group can reinforce learning (Jay, DuRant, Shoffitt *et al.* 1984). This could have a significant impact in terms of drug education and the modelling of positive behaviour (McDonald *et al.* 2003)
* ***Peer educators act as good role models****-* As mentioned earlier, peer education relies on Bandura’s Social Learning Theory (1971) and on the importance of modelling. Klepp Halper & Perry (1986) argue that “… the role of peer educators is to serve as a positive role model… [and they] enhance the program’s applicability by modelling appropriate behaviours” (cited in Turner & Shepherd 1999).

**The role of peer educators**

Peer educator’s role usually involves provision of factual information, facilitation of interactions between group members and counselling of group members. In some instances, peer educators also have previous drug experience and this can have an impact on current users in terms of facilitating optimism for a better future. For instance, Peer educators who once used drugs can provide the opportunity to share similar experiences and a sense of relief to others.

**Implementation of peer education programme**

Some practical activities that can be conducted by peer educators include:Co-teaching or guest lecturing during a drug abuse prevention session in school, presenting a theatre piece or role play at a community or school functions or other event and leading a group discussion in the in planned group sessions. Other activities are dissemination of resources e.g. fact sheet, leaflets, brochures and other IEC materials, Working with sports facilitators such as coaches to educate team members and doing educational outreach through everyday conversations in different social setting

These researchers list four common approaches to peer education programs:

• ***Planned group sessions* -** In this traditional approach, peer educators inform group members in a didactic or interactive way about health related issues.

• ***Dissemination of resources*-** This is a commonly employed peer education approach, specifically within the drug and alcohol sector. Peer educators impart practical information (for example, leaflets, and fact sheets) to young people. This information may include first aid or harm reduction-related issues. This approach is more practical when the aim is to access a specific target group that would be more difficult to access through other formats of peer education (McDonald *et al.* 2003).

• ***Opportunistic interactions*-** This alternative, informal approach provides the opportunity for peer educators to have an impact on young people within different settings and social networks through everyday conversation. This approach is based on the notion that peer educators’ knowledge, beliefs and behaviour gradually diffuse to their friends and they in turn will convey this information to others (McDonald *et al.* 2003).

• ***Using popular culture as a means to approach young people*-** McDonald *et al.* (2003) highlight the fact that popular culture could have significant impacts on young people. Thus, by using popular culture, program designers can change behaviours (for example, drug use) and provide young people with practical information (through websites, for example).

**Limitations and criticism of peer education programmes**

In this section the focus moves to an examination of the limitations, criticisms and other important issues associated with peer education. Four related areas are discussed.

* ***Lack of theoretical roots***

One of the main criticisms regarding peer education relates to the fact that it does not have clear roots within a specific theory or school of thought (Backett-Milburn & Wilson 2000; Shiner 1999; Turner & Shepherd 1999). By the use of such theory, the link between a program’s strategy, the actual process employed and intended outcomes would be clearer (Green 2000). However, at present “peer education … seems to be a method in search of theory rather than the application of theory to practice” (Turner & Shepherd 1999).

* ***Dissemination of information and the notion of empowerment***

Peer educators are provided with skills, information, authority and resources in order to carry out their duties. They are responsible for the dissemination of information within relevant peer networks (for example, drug users, students, ravers). Milburn (1995), however, questions the authenticity of this empowerment process. Do peer educators have the power to determine the nature and the type of information being delivered, or are they acting as the voice of adult workers that have ultimate responsibility for the information disseminated? If adult workers are really directing this process, is the label “peer education” appropriate? Perhaps peer education programs are simply strategies for promoting adult-related agendas through the voice of members of specific groups; groups in which adults are not members. Consequently, it has been argued that an indirect channel has been created to influence young people (Milburn 1995; Parkin & McKeganey 2000). This issue may influence an educator’s motivation, and thus it could have a negative effect on their performance and on the way they deliver the information. Therefore, it is recommended to evaluate and monitor the manner in which young educators deliver the information to their group members.

**Programme design**

In Walker and Avis’s (1999) paper “Common reasons why ‘peer education’ fails”, the authors argue that such programs frequently fail due to factors related to design and implementation. These factors are:

• Lack of clear and realistic aims and objectives for the project

• Inconsistency between the project design and the external environment constraints, which should dictate the project’s design (Walker & Avis 1999). For instance, for a project that follows the “just say no” path, a focus on young drug users would be an indication of an inappropriate design

• Lack of investment in peer education, both social and financial. Given that many practitioners view peer education as a “cheap strategy” to deliver preventative information, projects’ budgets are likely to be small. This may influence the quality of training, level of satisfaction of the educators themselves (for example, if they are underpaid), and the quality of materials used. Indeed, there is also some criticism that peer educators are under qualified for their roles. This type of criticism highlights the need for intensive guidance and counselling that extends beyond the current training phase (Walker & Avis 1999).

• Lack of appreciation that peer education is a complex process to manage and requires highly skilled personnel. Given that there is no formal and accredited training program for peer education project designers, many of them have frequently made mistakes in the design and implementation of projects.

Activity

1. Describe the drug prevention strategies used in higher institutions of learning and the effectiveness of these programs
2. Explain how you would use debate, games and role play to educate a grade nine class in a secondary school set up
3. Discuss the limitations of using peer education training as a mode delivery in drug and substance abuse prevention.
4. Identify and discuss interventions that can be used when applying Harm reduction approach

Summary

You have learnt that traditionally, in terms of service delivery, drug abuse prevention was based on the concept of Public health model of primary, secondary and tertiary prevention. However, in 1994, the Institute of Medicine proposed a new framework which talk about universal, selective and indicated prevention,

You have also learnt that there are a number of interactive methods that have proved to be effective in drug abuse prevention, such as role play, debate, games small group discussions and many others. Some methods are more effective than others. It is up to you to select the method that best suit the situation. Other notable interventions discusses are harm reduction and peer education training

# **UNIT 7: DRUG AND SUBSTANCE ADDICTION COUNSELLING**

## 7.1 Introduction

We cannot talk about drug and substance abuse prevention without the subject of counselling. Counselling is a special kind of intervention. It is described as a special kind of helping relationship, in which there is a counsellor who is congruent helping a counsellee who is incongruent, to deal with a difficult situation, a problem to be solved or a decision to be made. In this unit, you will learn about basic moral principles (ethics) upon which drug and substance abuse counselling is based. These principles apply to other types of counselling as well.

Learning outcome

By the end of this Unit, you should be able to;

* explain how you can apply the principles of Beneficence, Non- Maleficence and Veracity.
* describe basic counselling skills and procedures related to drug use.

Time frame

You will need one (1) hour for this unit

**Content**

## 7.2 Guiding Principles in Drug and Substance Abuse Counselling

Meara et al (1996) describes 6 basic moral principles that form the foundation of ethical decision making in professional counselling, and these are: autonomy, beneficence, non-maleficence, justice or fairness, fidelity and veracity

The basic moral principles for drug and substance abuse counselling include the following:

***Autonomy***

This refers to the promotion of self-determination of the freedom of client to choose their own direction. Counselling on drug and substance abuse should empower the client to make appropriate decisions, and take necessary actions in a therapeutic relationship. This enables the client to resolve his or her issues and cope with their situation. A professional counsellor behaves in a way that enables the right of another person to choose their own action.

***Beneficence***

This refers to promoting good for others. Alcohol and Drug Abuse counselling programmes should respect the dignity and promote the welfare of clients and should be geared entirely for the client’s well-being. Ideally counselling contributes to the growth and development of client and whatever counsellors do should be judged against this criterion.

***Non- Maleficence***

This means avoiding doing harm which includes refraining from actions that risk hurting clients either intentionally or unintentionally. Hence, professional counsellors have a responsibility to avoid engaging in practices that cause harm or have the potential to cause harm. Alcohol and Drug Abuse counselling programmes should refrain from harming the client either physically or emotionally.

***Justice or fairness***

This means providing equal treatment to all people and that everyone regardless of age, sex, race, ethnicity, disability, socio-economic status, cultural background, religion or sexual orientation is entitled to equal access to health services. Alcohol and Drug Abuse counselling programmes should be fair and impartial to all clients in the provision of services.

***Fidelity***

Fidelity means that professional counsellors make honest promises and honour their commitment to those they serve. This entails fulfilling one’s responsibilities of trust in a relationship. Fidelity also involves creating a trusting and therapeutically relationship were people can search for their own solutions.

***Veracity***

This means truthfulness. Unless counsellors are truthful with their clients, the trust required to form a good working relationship will not develop

***Other ethical issues*** to consider have been discussed elsewhere within this module. This include issues of confidentiality and informed consent. Regarding confidentiality, ***c***lients must be accorded privacy during counselling on Drug and Substance Abuse. The counsellor must communicate clearly the extent of confidentiality offered to the client. The issues presented in the counselling session should be treated with confidentiality unless they pose a life threat to the client or other persons or if a client commits any action that contravenes the law. Drug and Substance Abuse records should be maintained in a confidential manner and therefore, any access to shall be bound by the rules of confidentiality. Informed consent on the other hand entails that the client has a right to be informed about programmes on Alcohol and Drug Abuse, procedure, goals and benefits so as to make an informed decision on whether or not to participate.

**Evaluation, assessment and interpretation of clients’ results**

Personnel in the Alcohol and Drug Abuse programmes will use assessment instruments as one component of the Drug and Substance Abuse process, taking into account the clients’ personal and socio-cultural context. They will only utilize those testing and assessment services for which they are competent and take reasonable measures to ensure their proper use.

## 7.3 Basic Counselling Skills

Professional counselling is a working relationship or a vehicle of helping people to get more from life. A counsellor applies a number of skills in helping the individual. The communication skills of attending, listening, empathy and probing are some of the essential skills in counselling

**i, Attending skills**

* ***Warmth and sensitivity to the client*** – E.g. create a safe atmosphere or environment for the client. Establish *rapport* and attune to the perspective of the client. Rapport will help the client to feel free, at easy and take away anxiety.
* ***Immediacy*** *–*When something is going on with the client or the counsellor during counselling, it must be brought out immediately. However, it must be done diplomatically so as not to sour the relationship.
* ***Minimal encouragers-*** *-*This is the use of ‘uuh’, ‘yes’, ‘tell me more about it’ or nodding

the head. It indicates that you are with the client and listening attentively. It will also encourage the client to speak out.

* ***Respect (Unconditional positive regard)*** - Accept and respect the client the way they are with their potentials and limitations. A counsellor can show acceptance by having sincere positive facial expressions, friendly tone of voice and genuine interest in the client. Have a non-judgemental attitude towards the client. Do not impose your own opinion, values faith and attitudes on the client.
* ***Genuineness (congruence)*** – Be honest with yourself and with the client. Your approach should not be mechanical but humane. Be able to share appropriate timed and relevant persona reactions and experiences.
* ***Foster trust*** – Assure confidentiality, promote openness and obtain consent when you begin to engage in a counselling relationship. Show genuine interest and help the client to feel safe being with you. Fostering trust will help deepen the working alliance.
* ***Other attending techniques-*** When counselling someone, bear in mind the **SOLER** technique
* ***S*-** Face client (squarely)
* **O-** Adopt an open posture
* **L-** Lean towards the client
* **E-** Eye contact
* **R-** Relaxed

**ii,** **Listening**

This is the basic tool used to gather information about the client. **Active listening** involves listening to the client’s actual words, the factual information, and minute details such as choice and emphasis of words, and misuse of words. It also involves listening to the mood, the feelings and the underlying messages that are conveyed through the actual words that the client uses. Clients send messages through their non-verbal behaviour also. This includes;

* Body behaviour e.g. Body movements, posture and gestures
* Facial expressions e.g. twisted lips, frowns, twinkles, smile
* Voice tone, e.g. pitch, voice level and intensity, pauses fluency
* General appearance, egg type of dress, walking mannerisms

**iii, Empathy**

Empathy is actually defined as putting yourself in another person’s situation by understanding one’s problem without necessarily being sympathetic. It is understood as accurately understanding what the client is telling you and then sensitively communicating back your understanding in the language attuned to the client’s needs It involves clarifying the client’s concerns, and communicating this understanding to them so that they might discover new meanings and perceptions in relation to their problem situation.

**iv, Probing/Questioning skill**

Probing is a verbal skill used to help a client to talk about him/herself concretely and specifically. Probing questions are use to seek clarifications. Questions help to keep conversation during counselling. There are ‘open ended’ and ‘closed ended’ questions. Open ended questions encourage the client to talk and tell his or her story, particularly at the start. Close ended questions allow you to establish factual details quickly but only use the when appropriate. Avoid interrupting the clients unnecessarily, asking long, complex questions, using jargon words etc.

v **Self- disclosure**

Self-disclosure is revealing information about yourself in order for the client to think of an alternative of how his or her problem can be handled. However, the counsellor ought to open up only what is relevant about him/herself to the problem of the client.

vi, **Other skills include:** reflecting, paraphrasing, summarizing, confronting

## 7.4 Ethical Issues in Drug Addiction Counselling

***Introduction***

Ethics is a term that can imply lofty, philosophical discussions, far removed from the everyday world. In reality, workers in the substance abuse treatment field are constantly faced with ethical dilemmas on an individual as well as a societal level. Ethics is an intellectual approach to moral issues, a philosophical framework from which to critically evaluate the choices and actions people take to deal with various aspects of daily living (National Association of Social Workers, 1997).

Working in the substance abuse treatment field presents dilemmas relating to personal beliefs, judgments, and values. The history of how society views persons with addictions is fraught with emotion, misperceptions, and biases that have affected the care of drug abusers. For example, it is not unusual in a health care setting for a patient to be perceived negatively just by being labelled a drug abuser. Because of the highly charged emotional nature of the substance abuse treatment field, providers should possess the tools to explore ethical dilemmas objectively. By doing so, and by examining their own reactions to the situation, providers can proceed with the most ethical course of action.

***A Basic Set of Core Ethical Guidelines for Addiction Treatment Professionals***

By Bill Herring, LCSW (*Originally published in "Counsellor: The Magazine for Addiction Professionals", March/April 2002*)

The ability to recognize and respond appropriately to ethical dilemmas encountered while treating addictive disorders is a complex task that cannot be taken for granted by even experienced counsellors. Full caseloads and busy schedules provide few opportunities for in-depth examinations of ethical dilemmas that often demand an on-the-spot decision. This article sets forth a pragmatic set of principles that can help counsellors to evaluate ethically challenging situations. While these ethical principles are relevant to almost any counselling situation, this article focuses on how they apply to the treatment of substance and behavioural addictions.

Numerous written codes of ethical conduct exist to guide the many different counselling professions. These documents may be more useful for giving clients and the public an assurance of the ethical parameters of professional behavior than in providing counsellors with a useful frame of reference for dealing with day-to-day dilemmas. There is also an important difference between merely abiding by rules of conduct and embodying the ideals contained within them (Coale, 1998; Tjeltvelt, 1999). A set of common principles derived from these various codes must be sufficiently broad enough to take into account the rich variety of practice settings, counselling theories and treatment approaches in which addiction counsellors operate. Any less inclusive formula for determining whether a counsellor’s behavior is ethically appropriate requires knowledge of the context in which it occurs. For example, vigorously challenging a client's beliefs or behaviours may be ethically justifiable under one set of circumstances but not another (Tjeltveit, 1999). Similarly, different counsellors may respond to an identical ethical dilemma in very distinct yet equally justifiable ways.

What follows are six core ethical guidelines that are sufficiently broad and context-free to serve as a useful frame of reference in day-to-day counselling practice. These six guidelines are to provide informed consent; to operate in a competent and theoretically sound manner; to insure confidentiality of client information; to maintain appropriate relationship boundaries; to utilize adequate consultation; and to honour diverse personal and cultural values (Corey, Corey and Callanan, 1998).

* **Informed Consent**

Informed consent is a fundamental bedrock of ethical practice, because it helps to assure the client's autonomy in matters that affect the entire course and direction of counselling. Counsellors may not always fully appreciate the lengths they must go in order to insure that important decisions about treatment issues are truly made from a basis of informed choice. Rather than being a one-time event, informed consent is an on-going collaborative effort between client and counsellor for establishing and continuously monitoring the goals and strategies of counselling as well as the roles, rights and responsibilities of all parties. (Tjeltveit, 1999)

A client has a right to know which treatment modalities an addiction counsellor typically recommends, such as group therapy, couples therapy, family therapy, and medication, support group attendance, and so forth. Counsellors often don't take the time to explicitly discuss the expected benefits and potential risks of their services, as well as any alternative treatment approaches that may be available to the client. Informed consent also includes information about the anticipated duration of treatment and any situations that could result in a counsellor prematurely terminating services. In addition, clients should know the policy for resolving disputes as well as all pertinent financial aspects of the counselling relationship; counsellors should also be open to discussing their background and theoretical orientation (Houston-Vega and Nuehring, 1997). This is so much information that a counsellor may choose to convey it by a combination of verbal and written means.

A client's informed consent is not in itself sufficient to determine whether a counsellor’s behavior is ethical. It's conceivable that clients might be willing to give their approval to any number of ethically inappropriate behaviours, so a counsellor needs other core principles to guide the ethical decision-making process.

* **Competence and Established Theory**

A counsellor has an ethical responsibility to practice only within the scope of his or her professional competence. Some typical indicators of competence include education, experience, training, and certification (Pope and Vasquez, 1998). Competence in one clinical area doesn't necessarily translate to another. Counsellors with extensive experience treating general psychiatric disorders aren't necessarily competent to meet the specific needs of addicted clients, just as addiction counsellors without advanced training don't always adequately recognize signs of psychiatric disorders. Cross-referral between such specialists is necessary in such situations.

One often-overlooked component of competency is a counsellor’s ability to clearly describe the theoretical basis for providing a particular clinical service. Just because a client's case turned out all right doesn't necessarily justify a counsellor’s actions if they otherwise lack adequate theoretical support. It is important to do the right thing for the right reason, not just for the right result. Counsellors operating without the benefit of a clear theory are likely to rely too much on a combination of intuition, habit, consensus and personal preference (Herring, 2001, Tjeltveit, 1999, Corey, Corey and Callanan, 1998). Clients deserve the knowledge and right to accept or reject treatment that represents a particular theoretical orientation. In the absence of information to the contrary, clients will assume that whatever form of counselling they are receiving is the only available or appropriate choice.

* **Confidentiality**

Another core ethical principle is for a counsellor to vigilantly guard against unauthorized disclosure of client information. The assurance of confidentiality is a fundamental guarantee, but it is not an absolute one. Several ethical dilemmas involving confidentiality commonly arise in the treatment of addictive disorders:

* **Maintaining Appropriate Boundaries**

The next core concept of ethical counselling involves the complex area of maintaining appropriate professional boundaries. Most counsellors know that there are ethical risks to developing relationships outside of the therapeutic role, such as counselling a friend or pursuing business or social interactions with clients. These types of dual relationships can impair a counsellor’s objectivity or unintentionally exploit a client's dependence (Pope and Vasquez, 1998). Yet some subtle boundary issues present ethical dilemmas that are neither obvious nor easily avoidable.

* **Honouring Diverse Values**

All of the preceding ethical principles involve some specific actions for a counsellor to take. However, the ethical dimension of counselling goes far beyond merely abiding by a procedural checklist. An ethical counsellor consistently demonstrates respect for the client as a person by honouring diversity and appreciating the degree to which his or her personal values influence the entire process of counselling. Since counsellors are in the business of helping clients change some aspect of their lives, the great ethical challenge is to effectively guide the process and direction of this change without undermining the client's autonomy. This ethical use of a counsellor’s influence is a skill that cannot be taught as much as developed.

Since every person's view of the world represents a unique combination of diverse personal and cultural perspectives, it is inevitable that counsellors will sometimes hold views that are very different from their clients. No counsellor is ethically justified in assuming that the way he or she views life is the way everybody else does, is the right way, or is the only way. However, some counsellors act as if the way to avoid imposing their personal values is to simply not talk about them. But biases don't lose their influence just because they're not discussed; in fact they often become less amenable to change. It is often more ethically beneficial for a counsellor to invite discussion about his or her personal values while conveying an ability to respect and work with many alternative positions. A counsellor doesn't need to be neutral about his or her values in order to be non-judgmental (Coale, 1998; Tjeltveit, 1999).

When a client and a counsellor hold fundamentally incompatible value orientations, the counsellor should either refer the case or strive to help the client achieve the goals of counselling within the context of the client's value system rather than attempting to change those values. If a counsellor finds it necessary to attempt to modify a client's values, this should be done to no more extent than is necessary to address that client's particular focus of treatment.

Counsellors often avoid initiating discussion with clients about the ethical dimensions of clinical issues. Sometimes this reluctance stems from the fear of appearing moralistic, but it also reflects a general tendency of the counselling profession to be ethically inarticulate. It takes considerable effort and skill to engage in thoughtful dialogue about the ethical aspects of life, but doing can have great benefit for clients whose history of addiction is marked by diminished personal integrity. While this does not guarantee a positive clinical outcome, it does foster the kind of therapeutic environment for a client to utilize the counselling experience to its fullest potential.

These guidelines are not an exhaustive review of every ethical issue related to addictions counselling and they cannot substitute for a counsellor’s knowledge of his or her professional code of conduct. Many clinical situations require a more detailed examination of the ethical issues involved or compliance with specific codified procedures, such as guidelines for research involving human subjects. Although counsellors almost always operate within ethical parameters, these principles can serve as a helpful reminder of some of the important points to consider when evaluating the proper ethical stance to take when dealing with the many complexities of addictions counselling.

* **Duty to Warn/Protect**

It is widely accepted that counsellors have a general obligation to warn or protect people whom a client places in imminent harm. The right to confidential treatment is therefore balanced by the need to insure the safety of others. The beginning of the counselling relationship is the most appropriate time for a client to learn about these limits on confidentiality as well as any safeguards necessary to protect others, such as policies on notifying law enforcement personnel if a habitual DUI offender drives to a counselling appointment while intoxicated.

Clients who inject drugs or engage in sexually risky behavior while chemically impaired may expose others to the risk of HIV infection. Courts have not generally applied duty-to-warn standards to these situations (Houston-Vega and Nuehring, 1997). Balancing the counsellor-client relationship with the protection of at-risk populations is a very complex and emotionally charged situation. Counsellors should inform clients about their policy for dealing with HIV-related confidentiality issues, educate clients about the health risks of their specific sex and drug practices, communicate any concerns that arise during the course of treatment, offer to help communicate information to partners, and consult with colleagues as appropriate.

* **Minors and Families**

All states require counsellors to report situations in which minors are in danger of harm, although specific state statutes differ (Corey, Corey and Callanan, 1998). As most counsellors know, it can be difficult to distinguish potential from probable risk. For instance, a client who admits to blackouts may deny that she places her children in any danger. A counsellor who decides not to notify the designated reporting agency in such a situation should document the basis for this decision in the clinical record. Consultation in these situations is again extremely valuable in helping a counsellor maintain much-needed clinical objectivity.

Counsellors who treat minors for substance use disorders need to clearly establish the extent to which parents have the right to information that is disclosed by their children. A minor may be reluctant to talk honestly if confidentiality boundaries are not clear, and the therapeutic alliance may be crippled if a counsellor who is unclear on the limits of confidentiality later provides information to parents. Counsellors should be familiar with federal law on confidentiality of alcohol and drug abuse records for minor clients (Confidentiality of Alcohol and Drug Abuse Patient Records, 1998) as well as any applicable state laws, and should seek professional consultation whenever questions arise.

A major ethical concern that arises when counselling couples or families is how to deal with the emergence of secrets that so often accompany addictive disorders. For example, consider the situation that could arise when providing marital counselling to a couple if a husband who attends a session by himself announces that he's relapsed on cocaine but is unwilling to admit this to his wife. A counsellor who keeps this information secret is not fostering a climate of honesty. On the other hand, revealing information that a client reasonably presumed would remain confidential will damage that client's trust, while threatening to summarily end treatment if the client isn't honest with his spouse is a form of coercion and potential abandonment. This again points to the necessity of informed consent: whatever approach a counsellor takes in response to these types of situations needs to be thoroughly discussed at the beginning of the counselling relationship so that all clients are aware of the consequences of disclosure (Corey, Corey and Callanan, 1998; Herring, 2001).

* **Counsellor Self-Disclosure**

In order to maintain appropriate clarity of roles, a counsellor should only reveal intimate personal information when doing so is clearly relevant to the client's treatment goals, carefully tailoring this information to the client and paying close attention to how such sharing affects the clinical relationship (Bloomgarden, 2000). Consultation with colleagues and supervisors can help insure that the true purpose for disclosing personal information is to meet the emotional needs of the client rather than the counsellor. One helpful guideline is for a counsellor to reveal information about a personal life problem only well after it has been resolved, and not while it is an ongoing issue (Hunter and Struve, 1998).

* **Touch**

Since a significant proportion of clients with addictive disorders have a history of childhood trauma (Briere, 1992), even a simple act of touch can convey a variety of ethically ambiguous messages. The history of addiction support is replete with reassuring hugs. It's very important for a counsellor who engages in any form of physical contact with clients to have a highly developed sense of boundaries and an astute awareness of the clinical implications of this behavior. The initial stages of the therapeutic relationship may not provide sufficient emotional safety to insure that a client can discuss any uncomfortable feelings involving counsellor touch (Hunter and Struve, 1998).

* **Sexual Attraction**

Sexual involvement with a client constitutes a profound ethical violation with severe emotional consequences. However, occasional sexual feelings are not in themselves either unethical or even particularly abnormal in the context of an intimate therapeutic relationship (Pope and Vasquez, 1998). Counsellors must acknowledge and appropriately process the existence of these feelings when they emerge in order to successfully understand and redirect them. The presence of intense preoccupation or sexual fantasies involving clients’ needs to be forthrightly discussed in consultation and supervision.

* **Recovery Boundaries**

Counsellors who have successfully dealt with addictive disorders in their own lives can often relate to their clients with profound understanding, empathy and clarity. However, they may also be overly devoted to the treatment approach they personally found successful (Johnson, 2000). For instance, counsellors who are strongly 12-step oriented may discount non-abstinence models for addressing substance abuse, such as risk reduction strategies,

which threatens to place clients into a one-size-fits-all philosophy of care.

A counsellor who is candid about being "in recovery" may give clients hope and reduce the shame that inevitably accompanies addiction. However, too much disclosure can be intrusive and distracting for some clients, and can even inadvertently generate unrealistic expectations or a sense of inadequacy (Bloomgarden, 2000). Counsellors should therefore carefully reveal information about their personal addiction experience only in as much detail as is necessary to meet a compelling and clearly defined clinical need.

A counsellor who is treating clients with substance use disorders should not be unsuccessfully fighting the same battle. Sustained abstinence from addictive behavior is an inescapable ethical responsibility for anybody working in this field. Counsellors with less than several years of recovery time may easily lose objectivity when dealing with clients whose clinical picture mirrors their own personal experience. Heightened levels of consultation and supervision are highly advisable in such circumstances.

Nobody is immune to relapse, regardless of the length of time in recovery. A counsellor who reverts to a previous pattern of addictive behavior must face the ethical dilemma of whether to limit, suspend or terminate clinical duties. Abruptly withdrawing services from a client due to this (or any other) form of counsellor impairment is likely to be deeply disruptive to the client's healing process (Bissell and Royce, 1994). Clients in such situations must be given the opportunity to continue counselling with another provider. There is no one answer to the problem of counsellor relapse that is completely satisfying. In this regard the difference between a temporary "slip" that can result in increased self-awareness and an unrestrained relapse may be useful in determining a counsellor’s overall level of clinical impairment. These decisions should be made in a process of supervision and consultation so that the counsellor is not relying on his or her personal judgment which may be impaired.

All counsellors who are in recovery from addictive behavior must establish whatever safeguards are necessary to insure the maintenance of a personal program of sobriety. This may include establishing boundaries around support group meetings that clients are asked not to attend. It is not ethically appropriate for counsellors in 12-step recovery to sponsor their own patients or chair meetings where they are employed (Bissell and Royce, 1994).

Supervision

The next core ethical concept is for counsellors to have a structured process for discussing formulations, interventions, reactions and inevitable difficulties with supervisors and colleagues. There is a heightened need for supervision and consultation for counsellors who are working on the outer limits of either personal competence or established theory (Corey, Corey and Callanan, 1998). For example, a counsellor attempting to implement a new technique should utilize close supervision until it becomes fully integrated into his or her set of skills.

An unfortunate reality that not all clinical supervisors have adequate experience or knowledge in the treatment of addictive disorders. In such cases a counsellor needs to seek out additional sources for case consultation. One solution is to set up and utilize informal telephone and e-mail networks which can be established fairly easily with colleagues and contacts made through professional affiliations. When consultation is not available for discussing a clinical or ethical dilemma, a counsellor should document in the clinical record a summary of the relevant issues as well as any action taken in response to it.

Activity

1. Describe the concept of beneficence and non-maleficence applied in drug and substance abuse counselling
2. What are attending skills and how do they contribute to the drug and substance abuse counselling process
3. How would you use the concept of self- disclosure in a counselling relationship

Summary

We have learnt that the basic principles guiding drug and substance abuse counselling are autonomy, beneficence, non-maleficence, fairness, fidelity and veracity. They form the basis of ethical decision making in professional counselling. In professional counselling, a number of skills are applied and these include; attending skills, listening skills, empathy, probing skills, reflecting, and paraphrasing skills. This unit has also discussed ethical concerns such as informed consent, confidentiality, and other ethical behaviours that are vital to the smooth engagement in the counselling process.

# **UNIT 8: DRUG AND SUBSTANCE ABUSE PREVENTION AND CONTROL POLICY**

## 8.1 Introduction

This unit outlines policy issues regarding prevention and control of drugs and substance abuse and trafficking. You will learn about the core principles of drug policy, International Standards on Drug use Prevention, International and National Drug Prevention and Control Policy and Legislation, The UN Drug Control Conventions, local Drug Prevention and Control Legislation and Policy

Learning outcome

By the end of this Unit, you should be able to;

* explain the core principles of drug policy as outlined by The International Task Force on Strategic Drug Policy (2006).
* discuss the international standards for drug prevention as expounded by the UNODC international standard document.
* discuss salient features of the three United Nations treaties that together form the international law framework of the global drug control regime.
* describe the Narcotic and Psychotropic Act Cap 96 and explain the significance of this Act.

Time frame

You will need more than two (2) hours

**Content**

## 8.2 Core Principles of Drug Policy

***(From: International Task Force on Strategic Drug Policy (2006), A New Approach to Reduce***

***Drug Demand)***

***Introduction***

The uniqueness of each culture and community must be respected when designing drug policy and programmes; however, certain core cross-cultural principles emerge. These core universal principles include:

1. **The Three Pillars of Successful Drug Policy**

Demand reduction is supported by three interrelated pillars, namely ***drug prevention and education;*** ***drug treatment; and drug enforcement/interdiction.*** Every drug policy and plan should consider what impact it will have on reducing and preventing drug demand.

**i*) Drug prevention and education*** - Foremost among these are drug prevention and education, which aims to stop drug demand before it starts by preventing first drug use from ever occurring. This is the key, long-term solution that will reduce the pool of future drug users and thereby strip demand. The main goal of positive prevention is to build healthy and safe youth, families and communities – it is “for life” and not just “against drugs.” This is done by building upon community and family factors that prevent drug use and reducing and eliminating risk factors correlated with using drugs. Prevention also works to intervene and redirect early drug use to more positive and healthy activity – preventing first use from becoming regular use.

**ii) *Treatment -*** Treatment focuses on those with drug use problems and addictions to break the cycle of drug use and lead to more positive lifestyles. Treatment can take numerous forms, from community-based support group sessions to intensive, inpatient professional care. The goal should be eventual drug abstinence to restore individual health, dignity and public safety.

**iii) Enforcement/Interdiction-** Supply reduction disrupts drug markets, increases or maintains high prices and lowers availability or prevents availability growth. Law enforcement can support both prevention and treatment by serving as a deterrent to first drug use and leverage for treatment participation. Laws are one of the most visible signs of community norms. To maintain respect, the justice system must ensure that legal consequences rationally correspond to the level of seriousness of the offense. Consequences can range from required drug education attendance, monitored abstinence and treatment, community service and fines to imprisonment for more serious and dangerous drug criminals. Targeted enforcement can work to reduce drug demand at the local level by eliminating open-air drug use and markets and directing early users into effective intervention and prevention programs. Enforcement also can require those with drug problems to participate in treatment programs and maintain abstinence through drug testing, together with appropriate sanctions.

1. **A Global Drug Prevention Plan and Commitment Is Needed**

Many nations have joint drug enforcement-related treaties and goals, but few have comprehensive multinational drug prevention plans or treaties in place. A global drug prevention strategy, applying the principles and goals of this plan, should be approved by the UN and regional and multinational bodies. This effort should be spearheaded by NGOs with experience in youth and drug prevention. It must be supported at the top levels but implemented and tailored at the local community levels. Funding should be directed to the local level with resources widely available in many languages.

**c) Nations and Communities Must Have Comprehensive Multilevel Prevention Plans**

National, regional and community plans should be developed with widespread input from citizens, youth and experts to deal comprehensively with the drug problem. The United Nations developed a ten-year plan, and the Caribbean has a five-year plan. Rio de Janeiro and the Prevention Cities South American initiative also have strong plans in place. The prevention plan must establish drug prevention as a priority and coordinate interaction. National plans also must include international prevention coordination. Prevention plans must be based upon a clear assessment and diagnosis of the community drug problem and be designed to meet local needs. The decision-making process must be inclusive and solicit the voices of NGOs, youth, parents and community groups. High-level leadership is needed to support prevention as a priority and to keep the issue up front.

**d) Prevention Must Have a Communitarian Base**

Drug prevention is best developed and delivered at the local community level, based upon local needs and assets. Community organization and commitment through an open participatory process ensures coordination and cultural adaptation of prevention that works. Drug prevention is a communitarian effort, and the local community can instil and reinforce values and norms conducive to a healthy lifestyle. The Preventive Cities initiative, promoted in Latin American countries, is a prime example of prevention coordination at the local level. The local community must be strengthened and valued.

**e) A Clear and Unambiguous Message Must Be Communicated**

National, state and local norms of behavior must be established, clearly communicating societal values and goals. Youth must both see and hear a consistent message that drug use is wrong and unacceptable and that liberty and dignity can only come with freedom from chemical impairment of reason and will. A positive culture must be supported and developed.

**f) Effective Prevention Is Positive and Forward Looking**

Prevention strives for life filled with freedom and human dignity and opportunity. It is not just a reaction against drugs – it is for life. Prevention looks to form a culture that will encourage and support youth to live healthy, safe and positive lives. There is an important role for the faith community.

**g) A Multi-Faceted and Multi-Disciplinary Response Is Needed**

The drug problem is multi-faceted, and it requires cooperation and coordination from diverse disciplines – youth, parents, sport coaches, media and entertainment, health, education, medical, treatment, employers, clergy, law enforcement and counselling professionals must all work together.

**h) A Commitment to the Future Must Be Made**

The drug problem did not appear overnight, and patience and perseverance is needed. Effective prevention requires a continuous and sustained commitment and resource flow, with full coordination and review. Misleading quick fixes, such as legalizing drugs, are illusions and only exacerbate problems.

**i) Evaluation and Assessment Are Important Tools**

Policies and programs must be results-driven and demonstrate that they reduce demand. Research is an important tool to measure success and need. Policies and programs must be based upon scientific data, evidence and facts and be cost effective. Without control and accountability, programs will not succeed. The evidence base and research must be expanded for all activities.

**j) Respect for Human Rights Is Critical**

A humanitarian approach is needed with the goal of building healthy societies where individuals can attain their hopes and aspirations by using their will and reason to its fullest ability by preventing the use of toxic chemicals that impair and cloud this ability. In addition to protecting and setting the drug user at liberty, the human rights of non-users must be protected and valued. Where drug use is rampant, the rights of non-users are deprived to the extent that citizens cannot even walk the street safely or sleep at night in peace. Draconian drug policies with harsh penalties for minor offenses, lack of civil rights, unfair and unjust trials and police practices also violate human rights. Everyone has the right to live in a safe and drug-free community. It is a gross violation of human rights and individual dignity for society to promote policies that accept, encourage and/or enable some degree of the use, abuse and/or addiction to drugs. By definition, drug dependence and addiction impair or override individual free will by altering brain chemistry. Any policy that would attempt to contain drug problems by allowing a proportion of the population to remain chemically or psychologically enslaved to drugs is inhumane. Such a policy makes society an accomplice to the degradation of the individual user and the source of a dangerous mixed message of drug toleration to youth.

Policies that often enable drug use go under misleading clinical sounding names such as “medicalization” of drugs or “harm reduction.” These policies undermine drug prevention and work for normalization and acceptance of drug use. Any positive aspects of these strategies are already incorporated into the three pillars of demand reduction. Known users may have progressive plans to become liberated from drug use – as long as a continuum is set and followed through. Drugs are not a private matter – individuals are interdependent, and everyone pays the cost and faces the risk of persons with impaired minds and bodies.

**k) Prevention Should Be Inclusive and Not Leave Anyone Behind**

Drugs are an equal opportunity destroyer, and every child is at risk. No one can be certain when nondependent drug use will cross over into regular abuse and addiction. The chemicals in the drugs are the same for rich and poor alike. It is an elitist view that certain genetically superior people are not at risk for addiction and should be allowed to use drugs.

## 8.3 International Standards on Drug use Prevention

***Introduction***

There was a time when drug prevention was limited to printing leaflets to warn young people about the danger of drugs, with little or no resulting behaviour change. Now, science allows us to tell a different story. Prevention strategies based on scientific evidence working with families, schools, and communities can ensure that children and youth, especially the most marginalized and poor,

grow and stay healthy and safe into adulthood and old age. For every dollar spent on prevention, at least ten can be saved in future health, social and crime costs.

These global International Standards summarize the currently available scientific evidence, describing interventions and policies that have been found to result in positive prevention outcomes and their characteristics. Concurrently, the global International Standards identify the major components and features of an effective national drug prevention system. It is our hope that the International Standards will guide policy makers worldwide to develop programmes, policies and systems that are a truly effective investment in the future of children, youth, families and communities. This work builds on and recognizes the work of many other organizations (e.g. EMCDDA, CCSA, CICAD, Mentor, NIDA, and WHO 2) which have previously developed standards and guidelines on various aspects of drug prevention.

***The UNODC International Standards Document***

***(Refer to the UNODC International Standards Document)***

***Summary of the UNODC Standards***

1. **INFANCY AND EARLY CHILDHOOD** 
   1. Interventions targeting pregnant women with substance abuse disorders
   2. Prenatal and infancy visitation
   3. Early childhood education
2. **MIDDLE CHILDHOOD** 
   1. Parenting skills programmes
   2. Personal and social skills education
   3. Classroom environment improvement programmes
   4. Policies to keep children in school
3. **EARLY ADOLESCENCE** 
   1. Prevention education based on personal and social skills and social influence
   2. School policies and culture
   3. Addressing individual psychological vulnerabilities
   4. Mentoring
4. **ADOLESCENCE AND ADULTHOOD** 
   1. Brief intervention
   2. Workplace prevention programmes
   3. Tobacco and alcohol policies
   4. Community-based multi-component initiatives
   5. Media campaigns
   6. Entertainment venues

***International principles for drug abuse prevention***

***(Source: National Institute on Drug Abuse)***

These drug abuse prevention guidelines have emerged from the common elements found in research on effective prevention programs. Organizations involved in prevention education can use these principles to help them plan, select and deliver drug abuse prevention programmes and activities at the family, school and community levels in their localities.

1 Prevention programs should enhance protective factors and reverse or reduce risk factors (Hawkins et al. 2002).

2 Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol); the use of illegal drugs (e.g., marijuana or heroin); and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs (Johnston et al. 2002).

3 Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors (Hawkins et al. 2002).

4 Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness (Oetting et al. 1997).

5 Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information (Ashery et al. 1998).

6 Prevention programs can be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behavior, poor social skills, and academic difficulties (Webster-Stratton 1998; Webster-Stratton et al. 2001).

7 Prevention programs for elementary school (*Pre-school*) children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. Education should focus on the following skills (Ialongo et al. 2001; Conduct Problems Prevention Work Group 2002b): i.e. self-control; emotional awareness; communication; social problem-solving; and academic support, especially in reading.

8 Prevention programs for middle (*Primary*) or junior high and high school (*Secondary*) students should increase academic and social competence with the following skills (Botvin et al.1995; Scheier et al. 1999): i.e. study habits and academic support; communication; peer relationships; self-efficacy and assertiveness; drug resistance skills; reinforcement of antidrug attitudes; and strengthening of personal commitments against drug abuse.

9 Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community (Botvin et al. 1995; Dishion et al. 2002).

10 Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone (Battistich et al. 1997).

11 Community prevention programs reaching populations in multiple settings—for example, schools, clubs, faith-based organizations, and the media—are most effective when they present consistent, community-wide messages in each setting (Chou et al. 1998).

12 When communities adapt programs to match their needs, community norms, or differing cultural requirements, they should retain core elements of the original research-based intervention (Spoth et al. 2002b), which include:

• **Structure** (how the program is organized and constructed);

• **Content** (the information, skills, and strategies of the program); and

• **Delivery** (how the program is adapted, implemented, and evaluated).

13 Prevention programs should be long-term with repeated interventions (i.e., booster programs) to reinforce the original prevention goals. Research shows that the benefits from middle school prevention programs diminish without follow-up programs in high school (Scheier et al. 1999).

14 Prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behavior. Such techniques help to foster students’ positive behavior, achievement, academic motivation, and school bonding (Ialongo et al. 2001).

15 Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills (Botvin et al. 1995).

16 Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings of up to $10 in treatment for alcohol or other substance abuse can be seen (Pentz 1998; Hawkins 1999; Aos et al. 2001; Spoth et al. 2002a).

## 8.4 International and National Drug Prevention and Control Policy and Legislation

***(From: Jesma, M. (2011) the development of international drug control: lessons learned and strategic challenges for the future, Global Commission on Drug Policy)***

***The foundations of international drug control***

The construction of an international legal framework has gone through several stages in the

past century since in February 1909, when the International Opium Commission brought together twelve countries in Shanghai to discuss options for international controls on the opium trade. The first 1912 Hague Opium Convention and the treaties negotiated subsequently in the League of Nations era were more regulatory than prohibitive in nature, aimed to control the excesses of an unregulated free trade regime, substantially regarding opium. Restrictions were imposed on exports to those countries in which national laws had been introduced against nonmedical use of opiates, but there were no treaty obligations to declare drug use or cultivation illicit, let alone to apply criminal sanctions.

The early series of conventions in effect established administrative import and export regulations for opiates, cocaine and, from 1925, cannabis, without criminalising the substances, users or growers of the raw materials. The United States and China, the most ardent “prohibitionists”, both walked out of the 1925 International Opium Convention preparatory negotiations, because in their view sufficiently restrictive measures would not be imposed.

Efforts by the United States to outlaw the production and nonmedical use of alcohol and drugs

were viewed sceptically by traditional colonial powers, particularly France, Great Britain, Portugal and the Netherlands, all of which operated lucrative drug monopolies in overseas possessions. Not only did they control the lucrative Asian opium market, these four nations supplied the pharmaceutical market in Europe and the United States. Opium, morphine, heroin and cocaine were all widely used in medicinal preparations. The cocaine market increased exponentially during World War I when the drug was used as a local anaesthetic on hundreds of thousands of soldiers and as a means of enduring the horrors of trench warfare. For pharmaceutical companies in The Netherlands, Germany and Great Britain it was one of the most profitable products during the war. Most of the raw material came from Dutch coca plantations in Java, at the time part of the Dutch East Indies colony, as well as some shipments originating from Peru.

Culturally, most of Europe had a perspective at odds with the Christian fundamentalism prevalent at the time in the United States. As noted in 1931 by the influential commentator Walter Lippmann, twice Pulitzer Prize winner and advisor of President Woodrow Wilson: “To the amazement of the older nations of the earth, we have…enacted new legal prohibitions against the oldest vices of man. We have achieved a body of statutory law which testifies unreservedly to our aspiration for an absolutely blameless…life on earth.” He pointed at the criminogenic effects of prohibition at the time, attributing the “high levels of lawlessness” to “the fact that Americans desire to do so many things which they also desire to prohibit.” Stories about gangs and mafia expanding control over entire cities did little to inspire European policy makers at the time. “The unenforceable laws that attempted to prohibit alcohol, gambling, drugs and commercialized sex also made risks small for the host of politicians, police officers, and gangsters profiting from the newly created illegal markets. America had clearly become a land of criminal opportunity by the 1920s. …The repeal of alcohol prohibition was a notable but rare admission in America that moral ideals are no match for human ingenuity and human nature.” The alcohol prohibition regime lasted from 1920 to 1933,4 the period the United States was busy trying to replicate internationally the same model for other psychoactive drugs via the League of Nations. Despite concerted efforts, the lofty aspirations to export this policy were to remain largely unfulfilled until after World War II.

After repealing alcohol prohibition in 1933, the United States continued its international drive

on other drugs. As the UN World Drug Report noted, the 1936 Convention was “the first to make certain drug offences international crimes” but was only signed by 13 countries and only came into effect during World War II, when “drug control was certainly not top priority for most countries”. Only after the war, under the United Nations system, was the necessary political atmosphere created, enabling the globalisation of the prohibitive anti-drug ideals. Having emerged from the war as the dominant political, economic and military power, the United States was in the position to shape a new control regime and apply the required muscle to impose it on other nations. As a report to the Canadian Senate sums up: “Beginning in an era of morally tainted racism and colonial trade wars, prohibition-based drug control grew to international proportions at the insistence of the United States.” The United States’ representative to the conference to negotiate the Single Convention in 1961 confirmed: “For more than half a century, the United States had been advocating the international control of narcotic drugs. On the initiative of the United States, the International Opium Commission had met at Shanghai in 1909; it had been largely responsible for the conclusion, three years later, of the first International Opium Convention, signed at The Hague.” He also “recalled that the idea of a Single Convention had been a United States initiative.”

## 8.5 The UN Drug Control Conventions

**(From Jelsma and Armenta (2015) The UN Drug Control Conventions 5th edition WW.TNI.org)**

There are three United Nations treaties that together form the international law framework of the global drug control regime:

* The Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol;
* The Convention on Psychotropic Substances, 1971, and
* The Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

The purpose of these treaties is to establish internationally applicable control measures with the aim of ensuring that psychoactive substances are available for medical and scientific purposes, while preventing them from being diverted into illegal channels. The treaties also include general provisions on the trafficking and use of psychoactive substances.

The 1961 and 1971 Conventions classify controlled substances in four lists or Schedules, according to their perceived therapeutic value and potential risk of abuse. Included in an annex to the 1988 Convention are two tables listing precursor chemicals, reagents and solvents which are frequently used in the illicit manufacture of narcotic drugs and psychotropic substances. This treaty also significantly reinforced the obligation of countries to establish criminal offences in order to combat all aspects of the illicit production, possession and trafficking of psychoactive substances.

* ***The 1961 Single Convention on Narcotic Drugs***

The idea of having a Single Convention was once again an initiative of the United States, a country determined to impose a hard line on drugs on the rest of the world. The purpose of the 1961 United Nations Single Convention on Narcotic Drugs was to replace the previous international agreements that had been reached since the International Opium Convention in a not very systematic manner. It includes new provisions that did not appear in the previous treaties, and thus creates a unified, universal system of drug control. This system is clearly intolerant and prohibitionist concerning the production and supply of narcotic drugs, except for their production and supply for medical and scientific purposes.

The 1961 Single Convention expanded existing control measures to cover the cultivation of plants from which narcotics are derived. These provisions placed an especially heavy burden on the traditional producer countries in Asia, Latin America and Africa where the cultivation and widespread traditional use of opium poppy, coca leaf and cannabis were concentrated at the time. The Single Convention set the target of abolishing traditional uses of opium within 15 years, and traditional uses of coca and cannabis within 25 years. Given that the Convention entered into force in December 1964, the 15-year period for gradually eliminating opium use came to an end in 1979, while the 25-year deadline for coca and cannabis expired in 1989. Traditional practices including religious use and the widespread “quasi medical” use of the three plants had to be abolished.

The Single Convention created four lists or Schedules of controlled substances and established a process for including new substances in the Schedules without the need to modify the text of the treaty’s articles. The Convention’s four Schedules contain more than one hundred substances, which are classified according to the different degrees of control to which they must be subjected.

* ***The 1971 Convention on Psychotropic Substances***

The idea of negotiating this new treaty was to respond to the diversification of drug use, with the objective of controlling a whole new range of psychoactive substances (which became fashionable in the 1960s) such as amphetamines, barbiturates, benzodiazepines and psychedelic drugs, which were likewise classified in four Schedules.

During the negotiations on the1971 Convention on Psychotropic Substances, it became evident that pressure was being exerted by the large pharmaceutical industry in Europe and the United States, which feared that its products would be brought under the same strict controls as those established by the Single Convention. The need for a new treaty was argued on the basis of a (scientifically questionable) distinction between the ‘narcotics’ controlled by the 1961 Convention and the so-called ‘psychotropic substances’, an invented concept without a clear definition. According to an employee of the UN Division of Narcotic Drugs and secretary of the Technical Committee of the Plenipotentiary Conference at the time: ***“The most important manufacturing and exporting countries tried everything to restrict the scope of control to the minimum and weaken the control measures in such a way that they should not hinder the free international trade…”***Compared to the strict controls that the Single Convention’s Schedules imposed on drugs derived from plants, the 1971 treaty established a less rigid control structure, except for Schedule

Schedule I includes substances said to pose a serious risk to public health, which are not currently recognised by the Commission on Narcotic Drugs (CND) as having any therapeutic value. These include synthetic psychedelics such as LSD and MDMA, commonly known as Ecstasy. Schedule II includes amphetamine-type stimulants considered to have limited therapeutic value, as well as some analgesics and dronabinol\* or tetrahydrocannabinol (THC), an important ingredient in cannabis. Schedule III includes barbiturate products with fast or average effects, which have been the object of serious abuse despite being therapeutically useful, as well as flunitrazepam and some analgesics such as buprenorphine. Schedule IV includes some weaker barbiturates such as phenobarbital, other hypnotics, hypnotic anxiolytics, benzodiazepines and some weaker stimulants.

* ***The 1988 Convention***

The 1988 Convention came about in the framework of the political, historical and sociological context of the 1970s and 1980s, leading to the adoption of more repressive measures. The increase in demand for cannabis, cocaine and heroin for non-medical purposes mainly in the developed world gave rise to large-scale illicit production in the countries where these plants had traditionally been grown, in order to supply the market. International drug trafficking quickly became a multi-billion-dollar business controlled by criminal groups. This rapid expansion of the illicit drug trade became the justification for intensifying a battle that soon became an all-out war on drugs. In the United States, which was the fastest-growing market for controlled substances, the political response was to declare war on the supply from abroad rather than analysing and addressing the causes of the burgeoning demand at home.

The term “war on drugs” was coined in 1971 by President Richard Nixon, making drugs (including their use) “public enemy number one” for the US. The first target in this war was Mexico, a country that had supplied the 1960s counter-cultural revolution with huge quantities of illegally-produced cannabis, and by 1974 had also become the main source of heroin for the US market. But the first military counternarcotic operations in this war took place in the Andes, with the deployment of US army special forces to provide training on how to destroy coca crops, cocaine laboratories and drug trafficking networks. The weakening of the fight against world communism and the end of the cold war in the late 1980s freed up large quantities of military assets that were then reassigned to the war on drugs.

In the US halfway through the 1980s the crack epidemic took off; mandatory minimum sentences were introduced and mass incarceration started – especially of young black men. It was at this time, under significant pressure from the US for the rest of the world to join it in the war on drugs, that the United Nations convened another conference to negotiate what would become the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. The treaty obliged countries to impose criminal sanctions to combat all aspects of illicit drug production, possession and trafficking. It established special measures against the illicit cultivation, production, possession and trafficking of psychoactive substances and the diversion of precursor chemicals, as well as an agreement on mutual legal assistance, including extradition. Annexed to the 1988 Convention are two tables listing precursor chemicals, reagents and solvents which are frequently used in the illicit manufacture of narcotic drugs and psychotropic substances.

## 8.6 National Drug Prevention and Control Legislation and Policy

***Introduction***

**The Narcotic Drugs and Psychotropic Substances Act – Cap 96 of the Laws of Zambia**

Section 5 of Cap 96 of the Laws of Zambia, clearly identifies the main functions of the Commission as follows:-

(a) To collect, collate and disseminate information on narcotic drugs and psychotropic

Substances;

(b) To receive and investigate any complaint of the alleged or suspected breach of the Act

and subject to the directives of the Director of Public Prosecutions, prosecute for

offences under the Act;

(c) To address and advise Government Ministries and Departments, public bodies,

companies, institutions, statutory bodies and corporations on ways and means of

preventing prohibited activities relating to narcotic drugs and psychotropic substances

and suggest measures, procedures or methods of work compatible with the proper

performance of their duties;

(d) To disseminate information intended to educate the public on evils and dangerous

effects of abusing drugs or psychotropic substances and the effects of dealing in

property acquired from drug trafficking; and

(e) To enlist and foster public support against the abuse of drugs or psychotropic substances

and in this connection, liaise with similar authorities outside Zambia.

**The Prohibition and Prevention of Money Laundering Act No. 14 of 2001 as amended by Act No.44 of 2010.**

The Drug Enforcement Commission has additional functions through the Anti-Money Laundering Investigations Unit (AMLIU). Under Act 14 of 2001 section 6, as amended by Act 44 of 2010, the Commission is mandated to perform the following functions:-

(a) To investigate financial and other business transactions suspected to be part of money

Laundering offences;

(b) To conduct investigations and prosecutions of money laundering offences;

(c) To liaise with other law enforcement agencies in the conduct of investigations and

prosecution of money laundering offences and;

(d) To cooperate with other law enforcement agencies and institutions in other jurisdictions

responsible for investigations and prosecution of money laundering offences.

**The Liquor Licensing Act 2011.**

Zambia has got laws and by-laws which are meant to regulate production, distribution, selling and buying and to some extent drinking of alcohol. The main purpose of the 2011 Liquor Licence Act is to regulate the manufacture, possession, sale and supply of intoxicating liquors; repeal and replace the Liquor Licensing Act, 1959; and provide for matters connected with, or incidental to, the foregoing.

Key provisions of the liquor licensing Act include:

* No grant of licence within 300 metres of school, health facility;
* No grant of licence to child
* No sale of liquor without licence
* No consumption of liquor in public place
* Permitted hours

Activity

1. Describe the Narcotic and Psychotropic Act Cap 96 and explain the significance of this Act
2. Identify and discuss national laws pertaining to alcohol, other drug use and abuse.
3. What are the salient elements of the 1961 Single Convention on Narcotic drugs?

Summary

This unit has described the interventions and policies that have been found to result in positive prevention outcomes by the scientific evidence and could serve as the foundation of an effective health-centred national drug prevention system. The international Standards also provide an indication as to how interventions and policies should be implemented drawing on the common characteristics of interventions and policies that have been found to yield positive outcomes.

# 

# **UNIT 9: STAKEHOLDER ENGAGEMENT AND NETWORKING**

## 9.1 Introduction

This unit deals with stakeholders in the fight against drug and substance abuse in the community. It is important that as you engage in this field, you should develop skills on how to identify stakeholder and how to engage them effectively so as to realise your prevention goals. Without strong networking ties service providers in this field may develop burnouts in the process providing prevention services. In this unit you will learn how to identify type of stakeholders relevant to your work, the benefits you can derive from them, advocacy and types of advocacy you can engage in and multi-sectorial approach to drug and substance abuse prevention

Learning outcome

By the end of this Unit, you should be able to;

* describe stakeholder engagement and its benefit in drug and substance abuse prevention
* explain different ways of carrying out advocacy in the field of drug prevention
* discuss possible challenges in the implementation of multi-sectorial approach.

Time frame

You are advised to spent an hour plus on this topic

**Content**

## 9.2 Defining a Stakeholder

In simple terms a Stakeholders is one who may be affected by or have an effect on an effort.  Stakeholders may also include people who have a strong interest in the effort for social economic, political and scientific reasons, even though they and associates are not directly affected by it.

One way to characterize stakeholders is by their relationship to the effort in question.

* ***Primary stakeholders*** are the people or groups that stand to be directly affected, either positively or negatively, by an effort or the actions of an agency, institution, or organization.  In some cases, there are primary stakeholders on both sides of the equation: a regulation that benefits one group may have a negative effect on another.
* ***Secondary stakeholders*** are people or groups that are indirectly affected, either positively or negatively, by an effort or the actions of an agency, institution, or organization.  A program to reduce domestic violence, for instance, could have a positive effect on emergency room personnel by reducing the number of cases they see.  It might require more training for police to help them handle domestic violence calls in a different way.  Both of these groups would be secondary stakeholders.
* ***Key stakeholders*** are those who might belong to either or neither of the first two groups, are those who can have a positive or negative effect on an effort, or who are important within or to an organization, agency, or institution engaged in an effort.  The director of an organization might be an obvious key stakeholder, but so might the line staff – those who work directly with participants – who carry out the work of the effort.  Other examples of key stakeholders might be funders, elected or appointed government officials, heads of businesses, or clergy and other community figures who wield a significant amount of influence.

## 9.3 Stakeholder Engagement

This is the process by which an organization involves people who may be affected by the decisions it makes or can influence the implementation of its decisions. They may support or oppose the decisions, be influential in the organization or within the community in which it operates, hold relevant official positions or be affected in the long term.

Organizations engage their stakeholders in dialogue to find out what social and environmental issues matter most to them and involve stakeholders in the decision-making process. Stakeholder engagement is used by organizations in the private and public, especially when they want to develop understanding and agreement around solutions on complex issues and large projects. An underlying principle of stakeholder engagement is that stakeholders have the chance to influence the decision-making process.

In other words, as Jeffrey (2009) puts it;

* Stakeholders should have a say in decisions about actions that could affect their lives or essential environment for life.
* Stakeholder participation includes the promise that stakeholder's contribution will influence the decision.
* Stakeholder participation seeks input from participants in designing how they participate.

***Importance of stakeholder engagement***

Engaging with stakeholders is crucial to the success of any organisation. To succeed, an organisation must have a clear vision derived from a robust strategic planning process, and an effective strategic plan or marketing plan can only come from stakeholder engagement. Key stakeholder opinions and insights are incredibly valuable in the early stages of the planning and development processes. Robust consultation adds insight into the operating environment, the marketplace, trends, user / customer need, and growth opportunities, as well as to a vision of the organisation’s future. Effective engagement helps translate stakeholder needs into organisational goals and creates the basis of effective strategy development. Discovering the point of consensus or shared motivation helps a group of stakeholders to arrive at a decision and ensures an investment in a meaningful outcome. Indeed, without internal alignment you cannot build an effective strategy or implement change.

***Benefit of stakeholder participation***

The benefits of stakeholder participation include the following:

* Providing all stakeholders with full opportunities to share their views, needs and knowledge on flood management
* Building consensus through bringing together a diverse range of stakeholders to share needs, information, ideas and knowledge and harmonize the objectives of individual groups to reach common societal goals
* Providing all stakeholders and the public with appropriate information so that they can understand the process, the issues and values
* Enabling participants to influence the outcome by including them in the process of flood risk assessment as well as in the processes of shaping, developing, identifying and implementing flood management strategies
* Enhancing understanding between stakeholder groups, thus reducing potential conflicts and promoting effective cooperation
* Building stakeholders commitment and a feeling of ownership to enhance the effectiveness of flood management strategies and individual flood management measures
* Increase sustainability of plans and associated decisions
* Bring autonomy and flexibility in decision-making and implementation

Key stakeholders in the drug abuse prevention sector may include:

* Alcohol and other drug workers
* The Police
* Area residents
* Drug users or their representatives
* Lawyers
* Local government officers
* Youth workers and the young people they work with
* Pharmacists
* School teachers
* General practitioners
* Traders.

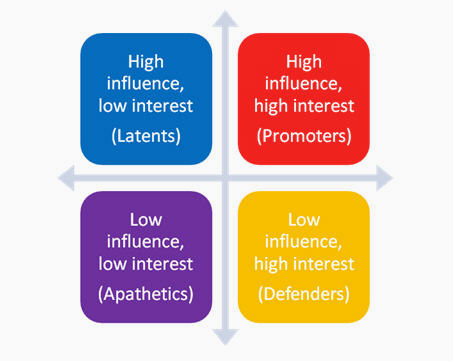
## 9.4 Stakeholder Mapping

A stakeholder map is a method or technique that allows you to see a visual representation of your organization’s various stakeholders (individual and groups), their level of interest in the organization and their importance to the organization. It usually looks like a chart. Different stakeholders or groups of stakeholders are categorized and listed on a chart according to their level of interest and the power they exert over an organization.

Let’s suppose, then, that you’ve identified all the stakeholders, and that you understand each of their concerns.  Now what?  They all have to understand what you want to do, you have to respond to their concerns in some way – at least by acknowledging them, whether you can satisfy them or not – and you have to find a way to move forward with as much support from stakeholders as you can muster.

Stakeholder analysis (stakeholder mapping) is a way of determining who among stakeholders can have the most positive or negative influence on an effort, who is likely to be most affected by the effort, and how you should work with stakeholders with different levels of interest and influence.

Most methods of stakeholder analysis or mapping divide stakeholders into one of four groups, each occupying one space in a four-space grid:



The purpose of this kind of diagram is to help you understand what kind of influence each stakeholder has on your organization and/or the process and potential success of the effort. That knowledge in turn can help you decide how to manage stakeholders – how to marshal the help of those that support you, how to involve those who could be helpful, and how to convert – or at least neutralize – those who may start out feeling negative.

An assumption that most proponents of this analysis technique seem to make is that the stakeholders most important to the success of your effort are in the upper right section of the grid, and those least important are in the lower left. The names in parentheses are another way to define the same stakeholder characteristics in terms of how they relate to the effort.

* ***Promoters***have both great interest in the effort and the power to help make it successful (or to derail it).
* ***Defenders***have a vested interest and can voice their support in the community, but have little actual power to influence the effort in any way.
* ***Latents***have no particular interest or involvement in the effort, but have the power to influence it greatly if they become interested.
* ***Apathetics***have little interest and little power, and may not even know the effort exists.

## 9.5 Advocacy

The word “advocacy” comes from the Latin ‘advocare’ and literally means ‘to call out for support’. Advocacy is defined as any action that speaks in favour of, recommends, argues for a cause, supports or defends, or pleads on behalf of others. Advocacy is an [activity](https://en.wikipedia.org/wiki/Action_(philosophy)) by an [individual](https://en.wikipedia.org/wiki/Individual) or [group](https://en.wikipedia.org/wiki/Advocacy_group) that aims to influence [decisions](https://en.wikipedia.org/wiki/Decision_making) within political, economic, and social systems and institutions. It includes activities and publications to influence public policy, laws and budgets by using facts, their relationships, the media, and messaging to educate government officials and the public. Advocacy can include many activities that a person or organization undertakes including [media campaigns](https://en.wikipedia.org/wiki/Media_campaign), [public speaking](https://en.wikipedia.org/wiki/Public_speaking), commissioning and publishing research. [Lobbying](https://en.wikipedia.org/wiki/Lobbying) (often by [lobby groups](https://en.wikipedia.org/wiki/Lobby_groups)) is a form of advocacy where a direct approach is made to [legislators](https://en.wikipedia.org/wiki/Legislator) on a specific issue or specific piece of legislation.

Ritu R. Sharma from the Academy for Educational Development describes advocacy as a tool for “putting a problem on the agenda, providing a solution to that problem and building support for acting on both the problem and the solution”. This definition expresses an important idea: In a digital and networked age, advocacy is not just about influencing public policy, but also and first of all about influencing public opinion.

As Dr. Sharma says, even if most of the time advocacy is defined as speaking on behalf of others, one of its aims must be raising the public’s consciousness about a particular issue.

The philosophy behind the social phenomena of advocacy is that advocacy is a social change process affecting attitudes, social relationships and power relations, which strengthens civil society and opens up democratic spaces”.

***Types of advocacy***

There are many different types of advocacy, including:

* Self-advocacy
* Group advocacy
* peer advocacy
* Citizen advocacy
* Professional advocacy

**Self-advocacy**

Self-advocacy refers to an individual’s ability to effectively communicate his or her own interests, desires, needs and rights. It recognises that people are experts by experience and involves them in speaking out for themselves about the things that are important to them. It means that people are able to ask for what they want and need and to tell others about their thoughts and feelings.

The goal of self-advocacy is for people to decide what they want and to carry out plans to help them get it. Self-advocacy differs from other forms of advocacy in that the individual self-assesses a situation or problem and then speaks for his or her own needs. The ultimate aim of all forms of advocacy should be to support people to self-advocate as far as they are able to.

**Group advocacy**

Group advocacy involves people with shared experiences, positions or values coming together in groups to talk and listen to each other and speak up collectively about issues that are important to them. These groups aim to influence public opinion, policy and service provision. They vary considerably in size, influence and motive. Representatives of local groups are often included on planning committees and involved in the commissioning and monitoring of health and social care services.

**Peer advocacy**

Peer advocacy refers to one-to-one support provided by advocates with a similar disability or experience to a person using services. Trained and supported volunteers often provide peer advocacy as part of a coordinated project. Peer advocacy schemes argue that they are particularly well placed to empathise with the needs of people, to approach them as their equals and to feel strongly about, and fight hard for, their needs.

**Citizen advocacy**

Citizen advocacy aims to involve people in their local community by enabling them to have a voice and to make decisions about the things that affect their lives. Citizen advocacy partnerships are long term, not time-limited, and last for as long as the citizen advocate and the individual want them to. Citizen advocates are ordinary members of the local community. They are unpaid and usually operate with support from a coordinated scheme.

**Professional advocacy**

Paid independent advocates support and enable people to speak up and represent their views, usually during times of major change or crisis. Such advocacy is issue-based and the advocate may only need to work with the person for a short time.

It is important to remember that an individual's capacity to be involved in decision-making or to instruct an advocate may fluctuate. This provides a further argument in favour of a whole-systems approach to advocacy, which maximises the chances of continuity of support.

## 9.6 Multi-sectorial Approach

***Introduction***

The use of substances that produce dependence has become a severe and worldwide health problem. Substance dependence is not only a health issue; it also has public, social, legal and governmental aspects. For this reason, antidrug efforts need to be multidirectional.The purposeof **multi-sectorial approach is t**o ensure that key sectors are actively involved in the conceptualization, designing, implementation, monitoring and evaluation of the national drug and alcohol management programme.

***Defining Multi-sectorial approach***

Multi-sectorial approach (MSA) refers to deliberate collaboration among various stakeholder groups (e.g., government, civil society, and private sector) and sectors (e.g., health, environment, and economy) to jointly achieve a policy outcome. By engaging multiple sectors, partners can leverage knowledge, expertise, reach, and resources, benefiting from their combined and varied strengths as they work toward the shared goal of producing better health outcomes. Improving public health is challenging because of the size of its population and wide variation in geography. MSA help in addressing identified health issues in focused way as it helps in pooling the resources and formulating the common objectives.

One of the major advantages is optimization of usage of resources by avoiding duplication of inputs and activities which tremendously improve program effectiveness and efficiency. Willingness at the leadership and mandate at the policy level are necessary to plan and execute the successful multi-sectorial coordination. All the major stakeholders require to share the common vision and perspective. Developing institutional mechanism is utmost requirement as it will standardize the processes of inter-sectorial coordination (ISC). Creation of public health cadre is strategic move to meet the major health challenges being faced by the health system, and it would be anchor of establishing systematic ISC. Promotion of MSA within the health system and with other ministries is seen as an important measure for effective implementation and improving efficiency.

***Advantages of Multi-sectorial Approach***

* MSA helps in addressing identified health issues in focused way as it helps in pooling the resources and formulating the common objectives.
* Moreover, as it involves multiple sectors, it encourages participatory and inclusiveness approaches.
* Due to common objectives and structured coordination among all the sectors it helps in strengthening holistic program planning and implementation.
* One of the major advantages is optimization of usage of resources by avoiding duplication of inputs and activities which tremendously improve program effectiveness and efficiency.

All these lead to avoidance of wastages of resources and improvement in the quality of services. Finally, there is optimization of outputs also.

***Implementation***

Willingness at the leadership and mandate at the policy level are necessary to plan and execute the successful multi-sectorial coordination. All the major stakeholders require to share the common vision and perspective. Developing institutional mechanism is utmost requirement as it will standardize the processes of ISC. Although the lead role is to be played by the health department but all other departments are also to be made part of decision-making to make it participatory. For smooth functioning clear cut roles and responsibilities are to be defined for all the participating stakeholders. Strategies and procedures to be defined before implementation. Monitoring and supervision are to be jointly planned so as to have coordination in the field also. There has to be an establishment of a common platform for addressing the problems and well-standardized mechanism for taking timely remedial measures in solving those problems.

***Challenges of implementation***

As it involves many departments besides that of health, there is usually lack of common understanding of different program goals and objectives. Usually, there is unawareness about existence and launching of new initiatives among the partners as most of the time information about these are not shared. Power conflicts among stakeholders also come in the way to smooth implementation of the MSA. Human resources issues like not able to sort the seniority issues with a perfect balanced delegation of administrative and financial powers and ego related problems also lead to the bottlenecks in the implementation. Planning in isolation of Health department in relation to other relevant departments with independent budgeting and fund flow mechanism lead to conflicting and duplication of efforts which hamper the smooth implementation. Partnering departments not aware about operational mechanism of other programs create barrier during implementation stage as there is a lack of opportunities for sharing the experiences.  
  
**Expected Outcomes of Multi-sectorial approach**

Measurements of the outcomes from the implementation of the MSA plan would guide in evaluation and necessary course correction. Moreover, some of these (outcomes) are;

(a) Stakeholders working in partnership for a common goal which would enhance the quality of services,

(b) Optimal utilization of good quality RCH services by the community especially adolescents and women,

(c) Easy accessibility of primary and basic quality health care services at the village level,

(d) Efforts made to formulate “Integrated Annual Action Plans” for strengthening “Intradepartmental Coordination and Communication,” resulting in a strong foundation for multi-sectorial convergence at various levels in the state.

Activity

1 What is stakeholder engagement, discuss the benefit of stakeholder engagement in drug abuse prevention

2 Discuss the role of primary, secondary and Key stakeholders in drug abuse prevention in the community

3 identify and discuss possible challenges in the implementation of multi-sectorial approach.

Summary

A stakeholders is one who has a strong interest in the effort for the benefit of the people involved although they may be not directly affected. There are different types of stakeholders depending on the closeness to the issue to be dealt with. These are primary stakeholders, secondary stakeholders and key stakeholders. The process by which an organization involves people who may be affected by the decisions it makes or can influence the implementation of its decisions is referred to as stakeholder engagement. Engaging with stakeholders is crucial to the success of the drug and substance abuse prevention.

# **UNIT 10: MONITORING AND EVALUATION OF PREVENTION INTERVENTIONS AND POLICIES**

## 10.1 Introduction

You cannot undertake a prevention programme without carrying out monitoring and evaluation activities. As a student of this course it is important that you acquire skills of M and E in order to have goal centred direction in your effort. Here, we will discuss the meaning of monitoring and evaluation, reasons for monitoring and evaluating, different kinds of evaluation, what should be monitored and evaluated, who should be involved in the monitoring and evaluation, Collecting the Information and Analysing the Data and Using the Information you have collected.

Learning outcome

By the end of this Unit, you should be able to;

* discuss the reasons for carrying out M and E on a project.
* explain different kinds of evaluation and how do they contribute to the realization of objectives of the organization.
* explain how you can use evaluation data in drug and substance abuse prevention.

Time frame

You will need and hour for this

**Content**

## 10.2 Defining Monitoring and Evaluation

**Monitoring** means keeping track of what you are doing while you are doing it, so that you can take corrective action if necessary, while **Evaluation** means finding out if you have achieved the effect on your target population that you said you would achieve, after you have finished implementing the activities.

Monitoring and evaluation mean taking a critical look at what we are doing, asking difficult questions and being prepared to address problems. It’s painful to accept that we did something badly, but only by facing up to “failures” (or let’s call them “the times when we didn’t achieve our objectives”) can there be improvement. Sometimes the only way forward is to take a step back. This involves asking how things happened as they did, examining the values and methods of the project. So monitoring and evaluation is a more formal and systematic way of doing what professionals do anyway. They reflect on what they have done and try to learn from it and do better next time. These subjective opinions and individual professional expertise can be combined with the more objective data obtained from formal monitoring and evaluation. It isn’t that formal evaluation and monitoring is somehow “better” than individual opinions. It is another way of looking at things, a different kind of information. Using all the information appropriately gives a fuller account, a “richer picture”, of what we are doing and its effects. The purpose is to improve what we do and make it more effective.

**Difference between Monitoring and Evaluation**

This distinction is not completely clear-cut, and a good evaluation will rely on good monitoring. However, the difference between ***monitoring*** and ***process evaluation*** is that monitoring usually takes place while the activity is being undertaken, while process evaluation usually takes place at the end. In any case, a good evaluation is based on good monitoring. Evaluation looks at the effects of activities. However, to know why the effects of your project have been what they have been, you will still want to know what has happened during your activities and how they were implemented. If the effects were positive, this will also be useful in replicating the activities.

Then it is conclusive to say that mmonitoring is the ongoing assessment of progress during project or program implementation. Evaluation is the performance assessment of a completed or half completed project or program. Monitoring is done by internal management whereas evaluation is done by external agencies. Monitoring occurs continuously whereas evaluation occurs in the end or at mid-term of the project or program. Monitor checks progress, take remedial actions, and update plans whereas evaluation provides broader lessons that can be applied to other programmes and projects. Usually monitoring does not provide any suggestions whereas evaluation provides suggestions.

## 10.3 Reasons for Monitoring and Evaluating

Monitoring and evaluation provide feedback on our behaviour. It is something we do all the time, although it might not be a formal process (and we do not necessarily act on it). More formal and systematic monitoring and evaluation can give better feedback. Acting on the information from monitoring and evaluation is sometimes not easy, but it is worth it, because it means that we can improve our work and meet young people’s needs more effectively. Results from monitoring and evaluating allow you to show the effectiveness of your project to your donors and stakeholders and thus secure more funding and collaboration. Finally, another good reason to monitor and evaluate is that project funding may depend on it. Donors want evidence that money is being spent on work that gets results and sometimes evaluation might be a requirement of donors or potential donors. In addition, good evidence of success in your work is invaluable in gaining general support for what you are doing. Your work depends on support from other “stakeholders”—that is, both from people and organizations that might fund your work and people and organizations that are affected in some way by your work or whose support and involvement you need. Keeping these groups on your side is easier when you have evidence that what you are doing is having a positive impact.

**Program Evaluation**

Program evaluation is defined as “the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future program development.

It is a process by which we determine whether a project is meeting its goals through the activities taking place and in the manner expected. It summarizes:

* Why we developed the project (goals)
* What it involves (project activities)
* What we expect will happen as a result of these activities (anticipated results or outcomes)
* What in fact did happen (actual results or outcomes)
* What this information tells us about the project (conclusions)

**The Uses of an Evaluation**

• To collect evidence on the effectiveness/impact of a programme.

• To be accountable to stakeholders: funders, clients, volunteers, staff and community.

• To identify ways to improve a programme: – determining what works, – what doesn’t work and why – improving the usefulness of programme materials

• To compare a programme with other programmes.

• Identifying side-effects (unanticipated outcomes)

• To assess the efficiency of a programme (cost-benefit analysis).

## 10.4 Different Kinds of Evaluation

* + 1. **Process evaluation**

Process evaluation describes what the project did and how it was done. It tries to find out if the project operated as intended. It doesn’t try to measure outcomes, but looks at the fidelity of the programme in relation to its plan. In other words, process evaluation assesses whether a project did what it said it would do in terms of process. Process evaluation is useful in taking stock of how a project went from the point of view of implementation. It is especially useful when you want to evaluate a project that replicates, in the same conditions, a project that has already been shown to be successful. If you followed the sequence of activities exactly, you can say, with a reasonable degree of certainty, that your project has been effective also. You can show that you followed the sequence of activities through a process evaluation. You should be careful, however. Even a tried and tested approach might not work in conditions different from the original ones. That is why an evaluation that looks at the effects of your project (or outcome evaluation, see below) is always useful.

* + 1. **Outcome evaluation**

Outcome evaluation tries to discover what the effect of the work has been on its intended targets. When we speak about evaluation, we are generally referring to outcome evaluation. If you go back to the examples about the differences between monitoring and evaluation, you might already see what we mean. Here’s another example of an outcome evaluation. Innovative work that hasn’t been done before will be in greater need of an outcome evaluation than work that is tried and tested.

* + 1. **Cost evaluation**

Cost evaluation (sometimes called “cost-benefit analysis”) attempts to identify the costs and benefits of a programme and compare it with the alternatives. It isn’t enough for a programme to be cheap if it is ineffective; and it isn’t enough for a programme to be effective if it is more expensive than a similarly effective alternative. Cost evaluation is not easy, because you need to have good information about the costs and the effects of your project and of other projects as well. These other projects should be similar enough in their objectives and targets to warrant a comparison. Moreover, it’s difficult to measure all the costs and benefits of a programme— many of the costs may be hidden, many of the benefits may not be obvious, some benefits may be different from what you would expect. Finally, information on the costs and benefits of other programmes might not be that easy to obtain. However, for advocacy purposes, it might be useful, from time to time, to calculate how much your activities have cost and divide this by the number of people you have reached. This is not a “real” cost evaluation, but you might be able to show how “little” achieving your objectives cost and this might be useful for advocacy purposes.

## 10.5 What should be Monitored and Evaluated?

***Monitoring***

You will need to monitor implementation from three points of view: the use of your resources and the target and the quality of your activities. It is easier to monitor if you have a clear plan of activities to start with. Monitoring the quality of activities is sometimes not straightforward, but collecting feedback from the participants and staff is a good starting point.

In general you will need to monitor implementation from three points of view:

* Use of resources.
* Target of the activities.
* Quality of the activities.

With regard to the first two, you will find that it is easier to keep track of what your project is doing if you have a clear plan to start with. The plan should indicate which activities will be implemented and should include for each activity information about when it will be implemented, for how long, with what resources (human, financial and technical) and reaching how many people. It will then be easy for you to determine how to collect the following information during implementation: When was the activity implemented? For how long? Was there a significant deviation from your plan? If so, why? How much money and how many people did you use for this activity? Was there a significant deviation from your plan? If so, why? How many people did you reach through this activity? What was their age and gender? Was there a significant deviation from your plan? Did you fail to reach somebody you wanted to reach? Did anyone drop out? If so, why? Monitoring the quality of activities is a bit more difficult. It is always very important to obtain feedback from the target group about the activity they participated in. No activity is going to be successful if the target group does not enjoy it or find it useful.

Finally, it is also very important to obtain feedback from the staff working on an activity on how they feel the activity went. A critical look at your activities, coupled with some specific information about who did and did not participate and why, and some feedback from those who did participate, can go a long way in telling you how well the project is progressing.

**Evaluating whether you have achieved your goal of preventing substance abuse**

Most projects are too small (in terms of duration/intensity/coverage/number of risk and protective factors addressed) to be able to make a measurable difference in terms of substance abuse behaviour. Substance abuse behaviour does not change in the short term. Evaluating a project in terms of substance abuse behaviour to show significant results that can be attributed to the action of the project requires external expertise and is not cheap. Therefore, it is a choice recommended only to comprehensive programmes that have been working with good coverage and intensity for a substantial period of time.

**Evaluating whether you have achieved your objectives of addressing risk and protective factors**

Your prevention activities will normally address a range of risk and protective factors. Changing the situation of your target group or community in terms of relevant risk and protective factors would therefore be the objective of your activities or project. Even if it is too difficult to demonstrate that your activities have changed substance abuse behaviour (your goal), you might be able to demonstrate that your activities have changed the situation in terms of risk and protective factors (your objective(s)). Besides recognizing important achievements, you could reasonably state that your activities have been able to contribute to the promotion of healthy lifestyles and substance abuse prevention.

**Monitoring and evaluating unintended effects**

You need to be open to information that points to results (both positive and negative) that the project did not intend to achieve. It is particularly important to follow up with people who have dropped out of your activities or whom you have not been able to reach. This could be key to understanding how to improve your activities.

## 10.6 Who should be Involved in the Monitoring and Evaluation?

Another aspect of monitoring and evaluation is deciding who will be involved and how. By “involving”, we do not mean “collecting information from”, but participating in the decision making, implementation, monitoring and evaluation process of an activity (and you could monitor and evaluate your monitoring and evaluation, too). Therefore, what you need to think about is who will participate in taking decisions about and actually undertaking the monitoring and evaluation. Should the staff and young volunteers of your organization be involved? What about an external evaluator and other stakeholders in the community? This section will try to answer these questions.

**Involving staff**

Involving staff in monitoring and evaluation is part of establishing a culture of participation, reflection and improvement in your organization. It is essential to support staff in their efforts to monitor and evaluate through training and supervision.

**Involving young volunteers and participants**

Young people who participate in prevention programmes can also be involved in monitoring and evaluating the changes among their own peer or target group. When young people are involved, it is very important that they understand why they are involved and know what their roles are.

**Involving other stakeholders**

It is good practice to involve the main project stakeholders in monitoring and evaluation: their perspective and/or resources could help. You may not want to involve everyone at all stages, but representatives of key stakeholders could be involved in the decision-making process and the larger community might be informed of the progress at key stages.

**Involving an external evaluator**

An external evaluator lends objectivity to the findings of an evaluation and can look at a project with trained and independent eyes. However, an external evaluator can be costly and there still needs to be intensive follow-up to ensure that he or she has a good grasp of the situation and chooses data collection and reporting methods that meet the needs of the organization. An external evaluator can certainly contribute to but does not guarantee a successful evaluation.

## 10.7 A framework to plan monitoring and evaluation

Monitoring and evaluation should be an integral part of (and therefore affect) all stages of the project cycle. As mentioned earlier, you need to plan your monitoring and evaluation. This section is about helping you to go about it. For the purposes of this handbook, we talk about monitoring and evaluation as if they were special kinds of activities within the project. However, monitoring and evaluation should really be an integral part of all phases of the project cycle. If you like, they should be mainstreamed into it. Here’s a picture of how we see the project cycle. There exist as many descriptions of project cycles as there are organizations on Earth, each one slightly different from the other. Ours is just another approach. However, we think that the basic concepts are generally the same and that the model sketched out below will also be useful to organizations using a slightly different one. The idea is to go through each step of the project cycle and to see how the fact that you are actually monitoring and evaluating your project will change it; in other words, how you will take monitoring and evaluation into consideration at all stages of the project cycle.



## 10.8 Monitoring, Evaluation and Project Planning

Monitoring and evaluating projects is much easier if you have clear and appropriate objectives and a clear plan of action. Preventing substance abuse would normally be your goal, while addressing different risk and protective factors would normally become your objectives. Your objectives should be S.M.A.R.T., that is, SPECIFIC (clearly identify the target group and the desired change in the target group), MEASURABLE, ACHIEVABLE, RELEVANT (address risk and protective factors pertaining to the particular target group) and TIME-BOUND. Your plan of action should include monitoring and evaluation as separate groups of activities.

***Planning your monitoring and evaluation***

To plan your monitoring, you will need to think “who”, “when” and “how” as regards (a) keeping track of the participants and the quality of each activity, and (b) analysing the results and feeding them back into the project. To plan your evaluation, it is essential to identify your evaluation needs and resources and to decide what kind of evaluation you want. Following this, it is necessary to identify what information you will collect in order to determine whether you have achieved your objectives (indicators) and how you will collect and analyse that data. An evaluation plan would include the information above, plus an indication of who would be collecting and analysing the data, how, when and with what resources.

***Monitoring, evaluation and project implementation***

Make every effort to use the information collected through the baseline assessment and through monitoring. Although it can be used later, it is really meant to help you with implementation. Every now and then, review how the monitoring and evaluation are going. Be flexible, but try not to compromise the comparability of information.

**Evaluation**

Evaluation should have started with the baseline assessment. However, even if you did not have the time or the opportunity to undertake that assessment, a process of reflection on the achievements of a project is always possible and useful, especially if you have good information from monitoring. The process of both monitoring and evaluating can basically be divided into three main steps: collecting the data, analysing them and reporting and using the information. Analysing collected data does not happen by itself and can actually be resource-intensive. Collecting and analysing data is useless if the information thus generated is not reported and used.

***Monitoring, evaluation and a new project cycle***

Evaluations are not of much use unless they lead to change. Having identified the lessons, how can they be applied in practice in this project or in others? There will be lessons for the evaluators as well. Using what has been learned can improve what happens next, both in projects and in their evaluations. We will not actually go into this stage in much detail, because this would lead into a new planning stage. However, no discussion about monitoring and evaluation would be complete without stressing that it is important that the circle be closed, using the monitoring and evaluation results to improve our activities.

## 10.9 Collecting the Information

The purpose of this section is to show you the main things to keep in mind when collecting your information (safety, confidentiality and clarity) and the possible methods you can choose from when collecting information.

Ensure the personal safety of those collecting and giving information by anticipating and avoiding dangerous situations. Ensure that confidentiality is always respected, with the exception of what the law dictates and in cases where someone might suffer harm. Establish procedures to ensure the confidentiality of information and make sure that your staff understand their importance and follow them. Inform your respondents how the information they provide will be used and how their confidentiality will be respected. Respect the wishes of your respondents. Do not ask leading questions or questions that mix different subject matters, that are unnecessarily personal or invasive or that raise expectations.

***Collecting monitoring information***

The backbone of monitoring is keeping a record of information when and as activities occur and asking participants for their feedback. If you are using a form, keep it simple, test it and find a way to encourage participants to actually use it. Sometimes you can devise ways for your young participants to create records by themselves or you can obtain information on staff feedback forms or minutes of meetings.

***Collecting evaluation information***

Data collection methods for monitoring and evaluation purposes do not differ significantly from the methods that you would use to undertake a needs assessment. The methods you can choose from, their pros and cons, and what needs to be done have been described many times in many other publications.

The table below describes data collection methods.

|  |  |
| --- | --- |
| **NAME** | **SHORT DESCRIPTION** |
| (Self-administered) questionnaire | A questionnaire offers respondents a list of questions to answer in writing. |
| Interview | In an interview, someone asks questions of individuals and records their answers. |
| Snapshot survey | This is a series of interviews that collect relatively simple data over a short timescale. |
| Case study | Case studies involve collecting detailed information about a few individuals or situations by talking in depth with a few respondents and writing about their experiences. |
| Focus-group discussion | A focus-group discussion is a group interview. A group of respondents are asked about their experiences and opinions. Focus-group members may or may not know each other already. |
| Observed discussion group | A group is given a topic to discuss and the observer records relevant points. This method lies between the more structured focus-group discussion and the less structured listening survey. |
| Listening survey | The evaluator notes the content of unstructured and unsupervised conversations. |
| (Systematic) observation | We make observations all the time—doing so systematically can provide useful monitoring and evaluation information. Participant observation is where the observer takes part in the activities of the group he or she is studying. |
| Photo analysis | Photographs are used to assist in the assessment of the parts of the programme that are being evaluated. |
| Electronic data generation | Some data generated by interaction via computer systems can be used for evaluation purposes, such as the number of visits to a website. |
| Performance | Participants act out situations (for example, situations before and after the project) and the content is noted. |
| Maps | Participants draw a map to describe physical and social interaction patterns (for example, places that are important in their lives before and after the project). |
| Opinion poll | People are asked to vote on what they think about a topic. Opinion polls can be carried out via short questionnaires and/or interviews in person or over the web or mobile phones. |

***Sampling***

If methods are about deciding how to collect the necessary information, sampling is about deciding who you will collect the necessary information from. In an ideal world, you would be able to collect information from or about your entire target group. However, in reality this is seldom possible. If you cannot obtain information from your entire target group, for example, because it is too large, you will need to obtain information from only a part of it. This is called a “sample”. The different kinds of samples used by researchers are discussed below.

***Representative sample -*** If you want to be able to use the information from the sample as a description of your larger target group, your sample should be “representative”, that is, it should be as similar as possible in terms of certain characteristics to the larger target group. It will be difficult for you to make it completely representative. However, you should take care to create a representative sample as far as the important characteristics are concerned. For example, let’s suppose that you want to obtain a picture of what young people would want your non-governmental organizations to do in your neighbourhood. It may be very easy for you to ask a few of the students in the private school down the road. However, that would hardly be a sample that is representative of your neighbourhood, which also has two large state funded schools, where youth come from very different socio-economic backgrounds and are bound to have different needs. A way to make the sample more representative would be to ask young people from all the schools and, if some schools are larger than others, ask more young people from those schools. In many circumstances, it will not be essential to have a perfectly representative sample. In the case above, it might be enough to ask the young people who are present at the youth centre on an average afternoon; that is, there is nothing special happening either at the youth centre or outside, so that would be your “normal” number and kind of participants. Simply explaining how you attempted to make the sample representative of your target group lends more credibility to your results. However, if you are conducting an evaluation with an experimental or quasi-experimental design, the representativeness of your sample becomes very important, in which case, you would probably have already enlisted the help of an expert evaluator.

***Convenience sample -*** A convenience sample contains subjects who are easy to contact. For example, suppose you wanted to get a quick idea of what club members thought about a certain proposal. You could ask the first 10 people who came through the door that evening. The problem with a convenience sample is that it is not necessarily representative of the whole population.

***Snowball sample -*** A snowball sample is one obtained by asking subjects to put you in touch with others. In this way, the sample gets bigger as you go on, like rolling a snowball. If you wanted to interview dependent drug users, but knew only two and you guessed that it would be difficult to contact others, then you could interview the two you knew and ask them to put you in touch with others whom they knew. This way, you could reach three more people and they might suggest others so that eventually you had a large enough sample. Snowball sampling is also not representative, but it is very useful when you are trying to get information about or from people who are hard to reach.

## 10.10 Analysing the Data and Using the Information you have collected

**Analysis -** You can effectively summarize quantitative data through ranges and averages. There are different kinds of averages and you should be careful to choose the one that distorts reality the least. To analyse qualitative data, you must systematize your records and reflect on them. If you have large amounts of questionnaire or interview data, you will need to “code” the answers given to your questions in order to group similar ones. Triangulate, triangulate, triangulate!

**Reporting**

Decide for whom the report is being written. Different versions may be needed for different audiences. In all versions, use clear language and illustrations. Think carefully about the conclusions and recommendations and do not draw conclusions that are not justified by the data. Written reports have an important place, but consider using different methods of reporting, such as video and drama.

ACTIVITY

1. What are the different kinds of evaluation and how do they contribute to the realization of objectives of the organization
2. Discuss how you can use evaluation data in drug and alcohol

Summary

You now clearly know the meaning of monitoring and evaluation. Monitoring means keeping track of what you are doing while you are doing it, so that you can take corrective action if necessary, while Evaluation means finding out if you have achieved the effect on your target population that you said you would achieve, after you have finished implementing the activities. Monitoring and evaluation provide feedback to what we do. For us to know whether we are achieving the goals of our efforts we need to conduct M and E. there are different types of evaluations such as process evaluation, outcome evaluation and cost evaluation. All these are important to carrying out drug and substance abuse prevention programmes

# **REFERENCES**

Bissell, L. and Royce, J. (1994). *Ethics for Addiction Professionals*. Center City, MN: Hazelden.

Corey, G., Corey, M. and Callanan, P. (1998).*Issues and Ethics in the Helping Professions. Pacific Grove*, CA: Brooks/Cole.

Herring, B. (2001). Ethical guidelines in the treatment of compulsive sexual behavior. Sexual Addiction & Compulsivity: The Journal of Treatment and Prevention, 8, 13 - 22.

Mentor Foundation, UNODCCP (2002), Lessons learned in drug abuse prevention: A Global Review, Geneva: (<http://www.mentorfoundation.org>)

Salunke, S. and Lal, D.K (2017) Multi-sectorial approach for promoting Public Health, Indian J public health, Jul-Sept; 61(3) 163-168

UNODC/WHO (2006) Monitoring and Evaluating Youth Substance Abuse Prevention Programmes, Viena: United Nations Publications

Oncioiu, S.I., Burkhart, G., Calafat, A., Duch, M., Permanhowe, P., and Foxcroft D. R. (2018) Technical report – Environmental Substance Use Prevention Interventions in Europe.

Miller, B.A., Holder, H.D.,

And Voas, R.B. (2009) Environmental Strategies for Prevention of Drug use and risk in clubs, J Subst Use. 14(1):19-38