The Abuse of Drugs: Education, Prevention and Treatment Considerations

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Drugs, per se, are not good or bad. There are no "bad drugs". When drug abuse or substance abuse is talked about, it is the behaviour, the way the drug is used, that is being referred to. All drugs, like most other things, can be used in ways that our society labels bad or good. These labels, though have a way of shifting – sometimes gradually, sometimes rapidly (Ray & Ksir, 1987).

Drug use is such an emotional topic in our society that we sometimes forget that it is a form of behaviour that has many things in common with other behaviours, and many of the same kinds of controlling variables. There is also a tendency to lump all drug use into a single category. Before making any headway in explaining or understanding drug use, we must be careful to specify exactly what we here talking about: who is using the drug, what drug, and so forth. We should also keep in mind that any individual drug, may have various effects, depending on who has taken it and how much has been taken.

Drug use and problems caused by drug use are probably as old as mankind. Nevertheless, the types of drugs that are most commonly used do change, as do our attitudes about those drugs. Because of several important advances in pharmacology, our society has come to view drug use as an effective and convenient way to influence our minds. The drugs that we use recreationally seem to reflect the needs of society at a given point in time. The oil boom in Nigeria in the early 70's influenced fashion in many areas, and recreational drug use is no exception.

Attempts to explain why some people use certain drugs or use them in a deviant way usually focus on what the drugs do for the individual. Psychoactive drugs can be behaviourally reinforcing, they can help an individual make a social statement about what group he or she belongs to and what groups he or she disdains.

Drug Use as a Social Problem

In the Nigeria of the 1960s, the reports on drug abuse focus primarily on the use of Indian Hemp Cannabis (Lambo, 1964; Asuni, 1963; 1964; Boroffka, 1966; Odejide, 1980).

Those who unknowingly or carelessly took Indian Hemp (a habit–forming drug) were at risk of becoming enslaved by the drug. The unscrupulous sellers of these drugs were thus assured of a steady market for them, while the addicts were forced to continue to endanger their own health and perhaps to undermine their own mental and moral strength. That is one major reason why the habit–forming drug was responsible for the admission of the users into psychiatric institutions. In fact some researchers especially psychiatrists in Nigeria believe that the drug "precipitates varying degrees of abnormal human behaviour as well as frank psychosis (Asuni, 1963; Boroffka, 1966; Johnson, 1972; Oviasu, 1976).

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Odejide (1980) reported that in Oviasu's (1976) study, 6.9% of the sample of new patients admitted into the hospital had abused Indian Hemp. About 90% of the victims range between ages 20–25. And featuring prominently were secondary school students, law enforcement agents and artisans. This finding is similar to previous periods (Asuni, 1964 and Boroffka, 1966). In their own findings (Ogunremi and Okonofua, 1977; Oviasu, 1976; Oshodi, 1973) went a step further by finding cannabis caused panic reactions, persistent mental block, and schizophrenia.

The various studies cited above show that drugs commonly abused were dexamphetamine, Indian Hemp, Mandrax (Methaqualone 250 mgm – Diphenihydramine), Proplus (contains cafeine), Reactivan (Fencamfamin, Vitamins B1, B6 and C), Ritalin (Methylphenidate) and Soneryl (Butobarbitone). The abuse of narcotics and LSD were limited to both literate and nonliterate male drug abusers (Anumonye, 1975; Odejide, 1980).

In the 1980's there was evidence that drug abuse especially cocaine and heroine trafficking was on the increase. Industrialisation, urbanisation and doctor's overprescription of hypnosedatives and the absolute freedom to purchase drug without prescription from chemist shops and patient medicine stores have further aggravated the prevalence rate of drug abuse among the target population which includes touts, armed forces, police, students, musicians, sportsmen and women, long distance drivers, political thugs, religious groups, traffic wardens and the unemployed (Odejide, 1980; Akande, 1989).

About the mid–1980's Nigerian Society changed from one that tolerated a wide variety of individual drug use to one that attempted strict control over the use and trafficking abroad of some types of drugs (marijuana, cocaine, narcotics and heroin). This has occurred in response to social concerns about drug toxicity, dependence potential and drug–induced crime and violence. The Buhari–Idiagbon regime even imposed the death penalty on drug pushers and the current Babangida government has decreed a retrial of drug pushers already convicted outside Nigeria when back in the country. In early 1990 a National Drug Enforcement Agency (NDEA) was commissioned to develop laws that will combat drug trafficking & organised crime. These laws have a social purpose, which is to protect the society from the dangers caused by some types of drug use. The questions on the lips of every Nigerian are: "Given this effort and costs, are our drug enforcement efforts going to be effective? Will they work?" From the experiences of other countries especially the United States and Pakistan, "there is little doubt as to the answers to those questions: Enforcement definitely does work and it definitely does not work". It does not work, since it has not stopped the importation of heroin, cocaine, or marijuana or reduced drug use and addiction. For instance the decision in 1924 of the U.S Government to make heroin completely unavailable to the addicts did not work. This is more than 60 years after the Americans "can only say that the failure of that effort has been dramatic" (Ray and Ksir, 1987); "Cocaine continues to flow into the United States in spite of crop eradication efforts, arrests of smugglers, and seizures of large shipments. Marijuana is also widely available, even after "Operation Delta – 9", a 3–day nationwide search for domestic marijuana farms involving 2200 officers in August 1985; to some, the final irony of these enforcement efforts is that by keeping prices up they increase

profits for the dealers, which means more dealers and more organized crime, which means more enforcement – is needed..." (Kaplan, 1983; Ray & Ksir, 1987).

But the laws do work at another level when there is reduction in penulties for possession but large fines and long prison sentences are provided for repeated offenses of distributing drugs or for being involved in a drug–dealing organization. Despite this enforcement heroin is still available to addicts, and marijuana is still widely available. It will never be possible to win the war against illicit drugs.

Drug Education and Prevention.

As Nigerian society seeks to prevent drug abuse by limiting the availability of such drugs as heroin and cocaine, we are forced to recognize several other facts. First, as long as there is a sizeable market for these substances there will be people to supply them. Thus only if we can teach people not to want the drugs can we attack the soure of the problem.

Second, these substances will never disappear entirely, so we should try to teach people to live in a world that includes them. Third, our society has accepted the continued existence of tobacco and alcohol, yet some people are harmed by them.

Through the help of the Ministries of Social Development, Youth and Sports, and NDEA programmes on drug education and peer education among youth clubs dotted all over Nigeria, and the supervising activities of social workers and religious organizations could bring about the much desired dissemination of information on the dangers of drug abuse. However, this information should not be so clearly one sided that they could have been classified as propaganda rather than education (Olatawura et al 1978: Odejide, 1978).

The apparent goal of most drug education programmes has not been just to impart drug information but to impart only the type of information that was expected to create negative attitudes toward drug use and therefore to reduce drug taking behaviour. In other words the goal has usually been prevention of drug abuse rather than an increase in knowledge for its own sake. Judged by whether such programmes do in fact reduce drug use, most of the research indicates that they are failures (Ray and Ksir, 1987).

Stages of Prevention

The goals and methods of a prevention programme also depend on the drug–using status of those served by the programme. Borrowing an idea developed in the mental health field, drug abuse prevention theorists have discused three levels or stages of prevention. Primary prevention begins before drug use has occurred and includes the education and information programmes we usually think of when we discuss prevention. In one of the most widely cited schemes, secondary and tertiary prevention employ approaches such as crisis intervention, referral for treatment, and in institutionalization, that could be viewed as representing treatment as much as prevention programmes.

Primary Prevention of Drug Abuse:

In Nigeria the primary programmes aimed mainly at young people who have not yet tried the substances in question, or who may have tried tobacco or alcohol a few

times. As previously remarked there is a danger of introducing a large number of children to information about a number of drugs that they might otherwise never have heard of, thus arousing their curiousity about them.

Second Prevention of Drug Abuse:

In Nigeria to date, "sophisticated substance users who have not suffered seriously from their drug experience are clientele recommended for secondary prevention programmes, such clientele are either to see the medical team or brought to face the law.

The goals of such programmes are usually the prevention of the "use of other, more dangerous substances or preventing the development of more dangerous forms of use of the substances they were already experimenting with" – (Ray and Ksir, 1987, p. 324). Most higher institutions students, and other identified cases receive treatment in special units in each of the 21 States of Nigeria. For alcoholics or cocaine or heroin addicts, treatment programmes are the first order of priority. "However, once a clientele has been treated or has stopped the substance use without assistance, we enter another stage of prevention" (Ray and Ksir, 1987).

Tertiary prevention is used to characterize relapse prevention or follow–up programmes. With the commission of the National Drug Enforcemnent Agency in January 1990 in Nigeria, that will take over the burden of rehabilitation of treated cases from the family of drug abusers.

Substance Abuse Treatment

The goals, methods, and evaluation of a treatment programme for any type of substance abuse "depend to some extent on the view one has of that substance and of those who abuse it. This is true when we are talking about alcohol, heroin, or marijuana users" (Ray & Ksir, 1987).

These varying views and approaches are quite evident when one looks at the history and current practices of treating alcoholism. Various medical and behavioural approaches have been tried with varying degrees of success. Such medical approaches include detoxification by providing a nutritious diet supplemented by extra vitamins. There may be other physical problems associated with liver occlusion and altered blood circulation, and these also require symptomatic medical treatment. A common approach, which may actually be considered part of the treatment itself, is the prescription of *disulfiram* (Antabuse). Alcohol is normally metabolized in the liver through two enzymatic steps. Disulfiram inhibits the enzyme aldehyde dehydrogenaze, the second of these steps. Alcohol is then converted into acetaldehyde but further conversion is prevented and acetaldehyde builds up in the system. High levels of acetaldehyde usually produce a severe reaction: headache, nausea, vomiting, throbbing of the head and neck, breathing difficulties, and a host of other unpleasant symptoms.

Therefore, a person taking disulfiram can't take a drink without becoming ill, and this threat may be sufficient to help many people avoid the impulse to drink. It takes 2 or 3 days after a person stops taking disulfiram before a drink can be taken safely; so a person on this treatment must make a decision to stop taking the disulfiram for that length of time if he or she wants to drink.

A more widely used behavioural approach involves teaching coping skills. Some of the same behaviours that are taught in prevention programmes are used, such as rocognizing peer pressure and practicing ways to deal with it. In addition, therapists often get the patients to pay special attention to high–risk situations and teach alternative behaviours that can be used to get through those difficult times. For example, if the individual is used to having a drink or two before dinner it may be suggested that an alternative nonalcoholic drink be substituted. The idea is to help the client to manage his or her behaviour to decrease the probability to drinking. Some studies have reported positive results (Finagarette, 1986; Krill–Smith, 1985; Ifabulumuyi; 1982).

Some behaviour–management approaches have accepted *controlled drinking* as a desirable outcome and have attempted to teach methods that will limit alchohol intake (Heather & Robertson, 1981). "Such strategies as switching to drinks with lower alcohol content, keeping track of each drink taken, or even learning to recognize a target blood alcohol level have been tried" (Ray and Ksir, 1987).

One major and continuing constroversy is whether every alcoholic should be treated with total abstinence as the only goal or whether efforts to teach controlled drinking to alcoholics are also worthwhile.

The treatment of narcotic addicts has also employed various medical and behavioural approaches. This includes narcotic antagonists – when given to addicts who had been taking morphine, these drugs (nalorphine, naloxone and cyclazocine) precipitated a withdrawal syndrome immediately. And, while taking these drugs, the effects of morphine, heroin and other narcotics are blocked. The question recurs: could these narcotic antagonists be a cure for addiction? If an addict were first withdrawn from the narcotic and then given the antagonist on a chronic basis relapse should not be a problem. The use and effectiveness of methadone maintenance is accepted to some extent, although it is tightly controlled by rules and protocols in the United States.

> Methadone is a regular prescription drug available in both injectable and oral forms for pain relief. And oral methadone is considered safe and effective and its use is not available to every physician in the United States. In fact it is being allowed for use under approved protocol and by approved clinics (Trebach, 1982).

The next approach called *heroin/morphine maintenance* involves supplying addicts willingly with narcotics or if is heroin that addicts need they should be supplied with heroin and clean syringes and allowed to inject intravenously.

Again, the goals of treatment have not always been uniform, with many programmes seeking total abstinence for all narcotics, and others accepting medically prescribed and therefore controlled use of various narcotics to maintain an addict (Oyefeso, 1990).

Aside from these specialized programmes for alcohol or narcotics, most substance–abuse programmes fit into one or two general models: The residential therapeutic community, usually staffed by former substance abusers or the outpatient drug–free programmes, which are often associated with community mental health centres and employ trained counsellors, psychologists, or social workers.

Because of a large increase in the number of people seeking treatment for cocaine dependence in the late 1980s, both old and new approaches are being applied to this problem. Mandatory urine screening at 3–day intervals has been suggested as a useful monitoring device. Group therapy, support groups (groups calling themselves Cocaine Anonymous are available in many areas), and individual psychotherapy job, and family counselling are all important components of current cocaine treatment programmes. Promotion of exercise and general health consciousness fit in with current American trends and are felt to help reduce the "hunger" for cocaine. Since many cocaine users are upper calss individuals behavioural managament technique known as "contingency contracting" has neen successfully employed. In this approach, an individual who is highly motivated to stop cocaine, but who fears impulsive use, may sign a contract agreeing that using cocaine (as determined by urine test) will result in the loss of something of great significance (an automobile, a professional licence, a large cash deposit) or an automatic notification of an employer. While such contracts must be established with care, if one is freely entered into and if the contingency is sufficiently important, it can be an important aid to behavioural management.

There are some promising medical treatments that may help to alleviate the prolonged depression and irritability that occur after cocaine withdrawal. "Nevertheless, as with all other drug treatment programmes, although they are no doubt better than no treatment at all, the odds for long–term success are not great for any individual client" (Ray and Ksir, 1987).

Drug Use in Today's Society.

The Law enforcement works as a *social control* only when the society wants it to work and that occurs only when the law is in agreement with the major themes and beliefs of the sciety. This is the difficulty with considering the drug problem to be a low–enforcement problem. Until a resolution is reached about the role of drug–taking behaviour in our culture the role of law enforcement will be ambiguous.

Another component of this socio–cultural, historical approach is that *education can change patterns of behaviour,* but *only* if the education is early and is compatible with the life–style and realities of the learner. We must appreciate that the best drug prevention programmes may never mention drugs but instead emphasize life–style and coping behaviours compatible with more than occasional drug use. We must appreciate that different ages require different messages, differnt states of the country require different approaches, different socio–cultural groups require different solutions because they have different problems. Some people do use drugs because they have too many problems, some because they don't have enough.

The basic question in the area of drug use or drug abuse is one of *social philosophy*. Ray and Ksir (1987) have clearly shown the importance of this question:

> What kind of society do we aspire to, how can we increase the opportunities and specify realistic, socially integrative goals for our citizens to reach out for? The real issues and the hard ones are psychosocial and behavioural and will be solved only with that perspective. The medical problems associated with the illegal use of street drugs can easily be solved if we decide that is what we want to do. Before any actions are taken in prevention, law enforcement, or treatment, we must answer the philosophical questions about our social goals (as a nation) that the drug scene has posed for us. p. 363.

To understand the drug problem (use or misuse) in today's society, it is crucial to adjust our 'pair of spectacles' beyond drugs – to gaze beyond drugs to the wide complete view of our developing personal/social beliefs.

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Appendix.

Drug and Their Brand Names

Acetylsalicylic acid: aspirin, OTC analgestic.

Amphetamine: Benzedrine, CNS stimulant and sympathomimetic.

Angel dust: Street name for PCP.

Benzodiazepines: Class of sedative – hypnotics that includes diazepam (Valium).

Caffeine: Mild stimulant found in coffee and in OTC preparations, (esential part of Coca–Cola formula).

Cocaine: CNS stimulant and local anesthetic.

Codeine: Narcotic analgesic found in opium.

DMT: Hallucinogen.

Heroin: Narcotic analgesic; diacetylmorphine.

LSD: Hallucinogen.

Morphine: Narcotic analgesic.

OTC: Over–the–counter.

PCP: Phencyclidine, "angel dust", hallucinogen.

Phenobarbital: Luminal Barbiturate sedative–hypnotic.

Tepanil: Diethylepropion, amphetamine–like appetite suppresant.

Theophylline: Mild stimulant found in tea used to treat asthma.

Trilafon: Perphenazine, antipsychotic.

Valiuim: Diazepam, benzodiazepine sedative.

Local Government in Transition for a Democratic South Africa

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1. Introduction

That South Africa is in a period of transition is undeniable. The whole question of making local government structures more democratic i.e. the creation of unitary and non–racial cities, towns, villages and rural areas has now come under close scrutiny. Local government usually provides a wide range of services including *inter alia* water, sewerage, electricity, transport, libraries, parks, sports–grounds, housing and health. The issue of representation and democracy in local government is directly linked to this as it affects the daily activities of the local populace. Democratic local government would obviously reflect people's needs more satisfactorily and will ultimately result in the improvement of the quality of life of the local citizenry. Consequently, it has now become imperative to debate the whole issue of local government transformation and to place in on the agenda for a post–apartheid South Africa.

2. Defining Terms: Local Government/Local Authority

The term "local authority" is frequently used and misused when , municipal topics are discussed. In this regard, speed (undated:
1) observes that "local government is government in difined parts of the country i.e. cities, towns and other areas–wthin the limits of the power and functions conferred by higher authority and local authorities are the statutory bodies which are the constituent parts of local government which derive their power from a higher source and are bound by the terms and conditions upon which they are created."

3. Basic Functions of Local Government

According to Maud and Wood (1974:10) the purpose of local government "is to do for people what a group of persons, elected according to law by a majority of the citizens but on election become representative of them all, conceive to be good within the limit of their legal powers". Thus, there are two main aspects of local government that should be taken cognisance of: it is a provider of services to a local community and an instrument of democratic self–government, not a mere agent of the National State.

The basic functions of local government are the safeguarding of public health and the provision of services which are essential for communal life and various other amenities. The range of services which must be provided by local authorities, as well as those that can be provided, is wide indeed and depends to some extent, on the size of local authorites. The scope of local authority services in South Africa differs from that in England, Europe and the United States, mainly in that it does not include

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