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Effects of Parental Abandonment and Strife on Youth Drug Use

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Abstract

Parenting behaviour is a major contributor to youth behaviour, and has been shown to precipitate maladaptive behaviours among the youth. Parents have been shown to play a major role in the way children turn out to be later in life. When parents behave negatively, children are likely to behave the same ending up with problematic behaviours. Studies have shown that negative parental practices have produced young people involved in sexual promiscuity, poor academic performance and substance abuse. However, little has been studied on the effects of parental abandonment and strife between parents on youth negative behaviours in Kenya. This study therefore aimed to investigate the effects of parental abandonment and strife on drug use among youth at a Kenyan University. Using the descriptive research design (cross-sectional) the sample size of 407 respondents was selected at 80% power and 10% effect size using stratified random sampling techniques. The Alcohol Smoking and Substance Involvement Screening Test (ASSIST) and researcher-generated socio-demographic questionnaire were used to collect data from the respondents. Inferential statistics using ANOVA analysed the data on the Statistical Package for Social and Sciences (SPSS) version 23. The results indicated that respondents who felt rejected at home (p=0.0001), those with parents who did not spend much time with them (p=0.048) and those who felt displeased with their parents' behaviour (p=0.0001) were statistically associated with substance use. It is concluded that parental behaviour may have a negative influence on youth drug use. The study recommends that parents be made aware of the effect of their actions in abandoning children and in poor conflict management so as to forestall problematic behaviours in their children's later life.

Keywords: *Parenting, abandonment, strife, youth drug use.*

Introduction

Parents have been shown to play a major role in the way children turn out to be, later in life. For instance, when parents behave negatively, children are likely to behave in the same way, and end up with problematic behaviours later in life (Carlson, 2012). There are several ways in which youth behaviour is affected by parental practices. Parental involvement and monitoring of children have been reported to be preventative measures against drug use among adolescents (Rusby, Light, Crowley, & Westling, 2018). On the other hand, parents exhibiting neglectful behaviour have been associated with worse substance use among adolescents (Berge et al., 2016). There is therefore a higher likelihood of prevention of drug use among the youth if parents are able to be more involved and

monitor the behaviours of their children. Nevertheless, monitoring alone does not guarantee drug-free children because there are other factors that can influence the use of drugs among adolescents. Such factors include: being away from parents; peer use; media influence; and, accessibility to drugs (Ndegwa, Munene, & Oladipo, 2017).

Since parental behaviour impacts children from birth to adulthood, this study aimed to find out the impact of parental abandonment and strife, specifically on youth behaviour. Parental abandonment has been defined as consisting of "any act of commission or omission that results in harm, potential for harm, or the threat of harm to a child (0–18 years of age) even if harm was unintentional" (Lamont, 2010). In addition, parental abandonment, which has also been referred to as neglect, is considered as a form of child abuse, which impacts on behaviour not only among children and adolescents, but also extends to young adults and adults. These behaviours include: substance abuse; suicide; reckless sexual behaviour; and, intergenerational neglect, where survivors of neglect perpetuate it to their children.

Abandoned or neglected children grow into adolescents and young adults with feelings of rejection. Such feelings could influence them to engage in drug and alcohol abuse as a way of coping, which would predispose them to other mental health issues (Lamont, 2010). Additionally, child neglect predisposes individuals in early adulthood and adulthood to personality disorders (Smailes, Cohen, Brown, & Bernstein, 2001), which make it more difficult to help such an individual. In another study, it was noted that children who grow up in a home where the biological parents are not present, especially their father, are at a greater risk of abusing alcohol and other drugs (Hoffmann, 2002). Furthermore, Mandara and Murry (2006) reported the impact of father-absence on adolescent boys. Boys who come from a home without their biological parents, especially their father, were more likely to use drugs than boys who came from a home where their father was present. Consequently, parental involvement can be a protective factor against adolescent substance use. Similarly, it has been shown that the psychological effects of neglect in childhood have a prevalence rate of 59% among university students in Kenya (Mbagaya, Oburu, & Bakermans-Kranenburg, 2013).

The literature indicated significantly that negative behaviour patterns on the part of parents predicted negative behaviours on the part of the children in their adulthood. Relevant to this study were the numerous studies that demonstrated that parental neglect and conflicts are likely to predispose children and adolescents to psychosocial difficulties (Grynch & Fincham, 1990; Reynolds, Houston, Coleman & Harold, 2014). A parental conflict is considered a disagreement that leads to a greater or lesser interaction of the parents with their children (Barthassat, 2014). Whenever there is conflict between parents, it is likely to affect the children negatively and at times parents are not aware of such effects. However, different studies focused on children receiving these effects, and unfortunately, very few studies have focused on early adulthood and thus the need for this study. The objectives of this study were therefore to determine the effect of abandonment and strife among youth.

Methodology

The research approach in this study is descriptive where respondents' characteristics are described as per the results of the study. The design is appropriate because the study aimed to determine the likely behaviours,

values, attitudes and other effects that might have resulted in the lives of the students as affected by their parents. The results were analysed using ANOVA to establish the effect of the parental behaviours on the youth drug use he population for this study was the undergraduate students in one of the Private Universities in Nairobi, Kenya who were approximately 4000 in number.

A total of 407 undergraduate students were recruited into the study using stratified random sampling techniques. The representative sample size of 407 was around 10% of the general population. Gay (1983), as quoted by Mugenda and Mugenda (2003), has pointed out that a sample size that is 10% of the population is enough to generate a generalized representation of results. The population was divided into homogenous, mutually exclusive subgroups, called strata, and a sample selected from each stratum. The population in this study was divided into two campuses; then subdivided further into five strata as per the various schools/faculties in the University. The modified Alcohol Smoking and Substance Involvement Screening Test (ASSIST) and researcher-generated socio-demographic questionnaire were used to collect data from the respondents. The Statistical Package for Social and Sciences (SPSS) version 23 was used to analyse the collected data.

Ethical considerations, to ensure that the research process did not cause physical, emotional, mental and psychological or any other harm to respondents, were taken into account (Babbie, 2008). The students were given an opportunity to consent to the study, and none of them was coerced or lured into participating against their wish. Respondents were assured of confidentiality and anonymity, both verbally and in writing. Data collected was stored in safe and secure locations. Respondents were debriefed by the researchers and issues arising were dealt with in a therapeutic manner. They were also informed that the findings would be shared via peer-reviewed journals and with the funding agency in particular. Institutional approval was obtained from the Deputy Vice Chancellor, Academics Affairs of the University, and ethical approval from the same University Ethics Board.

Results

This section provides the results of the survey from the analysis done on the obtained data. Table 1 provides the frequency of responses according to the questionnaire used in the study.

Table 1: Questionnaire Responses of the Respondents

Variable	Frequency	Percentage
Gender		
Male	168	41.3
Female	239	58.7
Total	407	100.0
Age		
18-25	382	95.7
26-33	14	3.5
34-41	3	.8

Total	399	98.0
Missing	8	2.0
Respondent's Sponsorship Status		
Privately Sponsored	350	86.0
Government Sponsored	55	13.5
Total	405	99.5
Missing	2	.5
Respondent's Marital Status of Parents		
Married	220	54.1
Separated	21	5.2
Single	127	31.2
Divorced	29	7.1
Polygamous	3	.7
Blended	5	1.2
Total	405	99.5
Missing	2	.5
Respondent's Family Relationship Status		
Close	325	79.9
Distant	52	12.8
Conflicting	30	7.4
Total	407	100
Respondent's Parent/Caregiver's Relationship		
Close	314	77.1
Distant	55	13.5
Conflicting	38	9.3
Total	407	100
Respondent's Rejected at Home		
Yes	51	12.5
No	355	87.2
Total	406	99.8
Missing	1	.2
Respondent's Growing up Experience		
Unwanted/excluded	39	9.6
Unloved/unaccepted	41	10.1
Alienated	64	15.7
Others	3	.7

Missing	260	63.9
Respondent's Primary Caregiver		
Mother	253	64.7
Father	57	14.6
House-help	4	1.0
Both Father and Mother	77	19.7
Total	391	96.1
Missing	16	3.9
Respondents Suffering at Home		
Yes	355	87.2
No	51	12.5
Total	406	99.8
Missing	1	.2
Respondents Financially Neglected		
No	334	82.1
Yes	71	17.4
Missing	2	.5
Total	407	100
Respondents Emotionally Neglected		
Yes	116	28.5
No	281	69.0
Missing	10	2.5
Total	407	100
Respondent's Witnessing Parents Fighting		
Yes	114	35.4
No	263	64.6
Respondents' Affected by Parents' Conflict		
Yes	139	34.2
No	249	61.2
Missing	19	4.7
Respondents who went to Boarding Primary School		
Yes	212	52.1
No	195	47.9

Table 1 presents the frequency of social-demographic characteristics of 407 respondents. The frequency of female respondents was slightly higher (239, 58.7%) than male respondents (168, 41.3%). This is because there are more female students than male students in this University. The age distribution was grouped into three: respondents aged 18-25; aged

26-33; and aged 34-41 respectively. The frequency of respondents aged 18-25 was higher (382, 95.7%) than those aged 26-33 (3.5%) and 34-41 (0.8%). This is because most undergraduate students are usually between 18-25 years. In terms of respondent's sponsorship status, the proportion of those who were privately sponsored was higher (86.0%) than that of those who were government-sponsored (13.5%), which could be a result of the University being a private one.

The marital status of the respondents' parents shows that respondents whose parents were married were higher (220, 54.1%), compared to separated (21, 5.2%), or single (127, 31.2%). Respondents' family relationship status shows that distribution of close family relationship was higher (325, 79.9%) as opposed to distant (52, 12.8%) and conflicting family relationship (30, 7.4%). Similarly, respondents' parent/caregiver's relationship status was grouped into three categories. The frequency of close parent/caregivers status was higher (314, 77.1%), than distant (55, 13.5%) and conflicting (38, 9.3%). The frequency of respondents who did not feel rejected at home was higher (355, 87.2%) as opposed those who felt rejected at home (51, 12.5%).

Further, respondents growing up experiences were grouped into four categories; the unwanted/excluded were 39 (9.6%), unloved/unaccepted were 41 (10.1%), alienated were 64 (15.7%) and others were just 3 (0.7%). It is noted that the majority did not respond to this enquiry (63.9%). The respondents' primary caregiver was mother (253, 64%) followed by father (57, 14.6%), which is common in the Kenyan scenario. The number of those who indicated that they were suffering at home was significantly higher (355, 87.2%) than those who declined (51, 12.5%). Respondents who felt financially neglected were seen to be fewer (17.4%) than those who felt otherwise (82.1%). Respondents who responded 'Yes' to emotional neglect were 116 (28.5%), compared to 'No' response (281, 69.0%). Respondents who witnessed their parents fighting were 114 (35.4%) compared to those who did not (263, 64.6%). The results indicated that 139 of the respondents (34.2%) were affected by parents' conflict while 249 (61.2%) were not affected. Higher percentage of the respondents went to boarding school (52.1%) compared to those who went to day school (47.9%).

Association of Parental Abandonment and Drug Use

Table 2 provides the distribution of respondents' responses according to the ASSIST results.

Table 2: Distribution of key Questionnaire Responses and Tobacco Products Use

Variables	Total	Low	Moderate	High	^{2} statistics	Df	Sig
Age							
18-25	382(95.7)	311(77.9)	65(16.3)	6(1.5)	1.844	2	.764
26-33	14 (3.5)	13 (3.3)	1 (0.3)	0 (0.0)			
34-41	3 (0.8)	2 (0.5)	1 (0.3)	0 (0.0)			
Gender							
Male	168(41.3)	129(31.7)	35(8.6)	4(1.0)	5.888	1	.053
Female	239(58.7)	205(50.4)	32(7.9)	2 (0.5)			

Marital Status							
Married	220(54.3)	175(43.5)	41(10.1)	4 (1.0)	18.235	5	.051
Separated	21 (5.2)	17 (4.2)	3 (0.7)	1 (0.2)			
Single	127(31.4)	109(26.9)	18 (4.4)	0 (0.0)			
Divorced	29 (7.2)	25 (6.2)	4 (1.0)	0 (0.0)			
Polygamous	3 (0.7)	3 (0.7)	0 (0.0)	0 (0.0)			
Blended	5(1.2)	3 (0.7)	1 (0.2)	1 (0.2)			
Respondent's Primary Giver							
Mother	253(64.7)	211(54.0)	37(9.5)	5 (1.3)	6.475	3	.372
Father	57 (14.6)	41 (10.5)	15 (3.8)	1 (0.3)			
House help	4 (1.0)	3(0.8)	1 (0.3)	0 (0.0)			
Both mother and father	77 (19.7)	65 (16.6)	12 (3.1)	0 (0.0)			

Table 2 presents distribution of key questionnaire responses of the respondents and tobacco products use. In terms of age characteristics, respondents aged 18-25 had highest percentage (95.7%) compared to other age categories. Out of 382 respondents (95.7%) who use tobacco products, 311 (77.9%) of them scored low, 65 (16.3%) scored moderate, while 6 (1.5%) scored high. However, the distribution of respondent's age was statistically insignificant (p=0.764). The frequency of tobacco products use was higher among female gender (239, 58.7%) compared to their male counterparts (168, 41.3%). A higher percentage of female respondents scored low using ASSIST (50.4%), while male respondents also scored low (31.7%) in tobacco product use. The distribution of respondent's gender was significantly distributed (p=0.053).

The respondents' parents' marital status was also significantly distributed (p=0.051). However, a higher frequency of tobacco products use was noted to be among those whose parents were married (220, 54.3%) than those whose parents were divorced, widowed or never married. The next highest value after married parents is among respondents whose parents were single (127, 31.4%). The distribution of tobacco use among respondents' primary caregivers characteristics was higher among mothers (253, 64.7%) than respondents whose primary caregivers was their father (57, 14.6%), their house help (4, 1.0%), and both their father and mother (77, 19.7%). The distribution of the use of tobacco products across respondents' primary givers were insignificant (p=0.372).

To determine the association between parental abandonment and tobacco use, a one-way analysis of variance (ANOVA) was used. Table 3 gives ANOVA statistics using each of the substance uses as dependent variables and parental abandonment as a predictor variable.

Table 3: ANOVA Statistics for Tobacco

Variables	Groups	Sum of squares	df	Mean square	F	Sig
I spent more time with the house help than with my parents	Between Groups	7.707	2	3.853	2.603	.075
	Within Groups	598.047	404	1.480		
	Total	605.754	406			
Growing up, my parents were absent most of the time	Between Groups	4.777	2	2.388	1.500	.224
	Within Groups	643.322	404	1.592		
	Total	648.098	406			
Did you suffer rejection at home?	Between Groups	1.722	2	.861	8.094	.0001
	Within Groups	42.872	403	.106		
	Total	44.594	405			
Participant feeling neglected financially	Between Groups	.257	2	.128	.885	.414
	Within Groups	58.297	402	.143		
	Total	58.553	404			
Feeling neglected emotionally	Between Groups	.088	2	.044	.211	.810
	Within Groups	82.018	394	.208		
	Total	82.106	396			
My parents did not spend much time with me	Between Groups	9.459	2	4.729	3.060	.048
	Within Groups	624.453	404	1.546		
	Total	633.916	406			
I feel I was sent to boarding school too early	Between Groups	3.173	2	1.586	.943	.390
	Within Groups	679.412	404	1.682		
	Total	682.585	406			
My parents behaviour led me to use drugs in order to cope	Between Groups	13.421	2	6.710	9.549	.0001
	Within Groups	283.891	404	.703		
	Total	297.312	406			

Table 3 indicates the variance in means of parental abandonment and tobacco use between and within groups. Out of all the variables, respondents who felt rejected at home (p=0.0001), respondents whose parents did not spend much time with them (p=0.048), and respondents whose parents' behaviour led them to use drugs in order to cope (p=0.0001), were statistically significant. Other variables were reported to be insignificant to predict tobacco use. This finding implies that the probability that youth who feel rejected at home, those whose parents did not spend much time with them at home, and those whose parents'

behaviour led to the use of drugs are significantly associated with smoking tobacco products to cope. Table 4 presents the distribution of questionnaire responses and beer products.

Table 4: Distribution of Questionnaire Responses and Beer Products

Variables	Total	Low	Moderate	High	^{2} statistics	df	Sig
Age							
18-25	382(95.7)	308(77.2)	64 (16.0)	10 (2.5)	4.043	2	.400
26-33	14 (3.5)	14 (3.5)	0 (0.0)	0 (0.0)			
34-41	3 (0.8)	3(0.8)	0 (0.0)	0 (0.0)			
Gender							
Male	168(41.3)	124(30.5)	38 (9.5)	6 (1.5)	12.336	1	.002
Female	239(58.7)	209(51.4)	26 (6.4)	4 (1.0)			
Marital Status							
Married	220(54.3)	176(43.5)	38 (9.4)	6 (1.5)	28.120	5	.002
Separated	21 (5.2)	19 (4.7)	1 (0.2)	1 (0.2)			
Single	127(31.4)	105(25.9)	21(5.2)	1 (0.2)			
Divorced	29 (7.2)	27 (6.7)	2 (0.5)	0 (0.0)			
Polygamous	3 (0.7)	2 (0.5)	0 (0.0)	1 (0.2)			
Blended	5 (1.2)	2 (0.5)	2 (0.5)	1 (0.2)			
Respondent's Primary Giver							
Mother	253(64.7)	210(53.7)	37(9.5)	6 (1.5)	13.463	3	.036
Father	57 (14.6)	37 (9.5)	17 (4.3)	3 (0.8)			
House help	4 (1.0)	3 (0.8)	1 (0.3)	0 (0.0)			
Both mother and father	77(19.7)	68 (17.4)	8 (2.0)	1 (0.3)			

Table 4 presents distribution questionnaire responses of the respondents and beer products use (Tusker, Tusker Malt, Guinness, Senator, and White Cap). As regards respondents' age, respondents aged 18-25 had highest percentage (382, 95.7%) compared to other age categories. Out of 382 respondents (95.7%) who used beer products, 308 (77.2%) of them scored low, 64 (16.0%) sc ored moderate while 10 (2.5%) scored high as per the ASSIST ratings. However, the distribution of respondent's age was statistically insignificant (p=0.400). The frequency of beer products use was higher among female gender (239, 58.7%) compared to male counterpart (168, 41.3%). Higher percentage of respondents who scored low were noted among female (209, 51.4%), and that of male counterpart (124, 30.5%) in beer product use. The distribution of respondent's gender was significantly distributed (p=0.002).

The higher frequency of beer products use was noted to be among those whose parents were married (220, 54.3%) compared to other marital status then among respondents whose parents were single (127, 31.4%). Respondent's parents' marital status was also significantly distributed (p=0.002). The distribution of beer products use among respondents' primary givers was higher among respondents whose primary care givers were mothers (253, 64.7%) compared to respondents whose primary caregivers were father (57, 14.6%), house help (4, 1.0%), and both father and mother (77, 19.7%). Majority also scored low in beer product use. However, the distribution was significant (p=0.036). Table 5 indicates ANOVA statistics for beer products use.

Table 5: ANOVA Statistics for Beer Products

Variables	Groups	Sum of squares	Df	Mean square	F	Sig
I spent more time with the house help than with my parents	Between Groups	6.995	2	3.497	2.360	.096
	Within Groups	598.759	404	1.482		
	Total	605.754	406			
Growing up, my parents were absent most of the time	Between Groups	3.167	2	1.584	.992	.372
	Within Groups	644.931	404	1.596		
	Total	648.098	406			
Did you suffer rejection at home?	Between Groups	.809	2	.404	3.721	.025
	Within Groups	43.785	403	.109		
	Total	44.594	405			
Participant feeling neglected financially	Between Groups	.177	2	.089	.611	.543
	Within Groups	58.376	402	.145		
	Total	58.553	404			
Feeling neglected emotionally	Between Groups	.148	2	.074	.356	.701
	Within Groups	81.958	394	.208		
	Total	82.106	396			
My parents did not spend much time with me	Between Groups	3.766	2	1.83	1.207	.300
	Within Groups	630.146	404	1.560		
	Total	633.912	406			
I feel I was sent to boarding school too early	Between Groups	.248	2	.124	.074	.929
	Within Groups	682.336	404	1.689		
	Total	682.585	406			

My parents behaviour led me to use drugs in order to cope	Between Groups	16.189	2	8.095	11.633	.0001
	Within Groups	281.123	404	.696		
	Total	297.312	406			

Table 5 indicates the variance in means of parental abandonment and beer products use between and within groups. Out of all the variables, respondents who felt rejected at home (p=0.025) and respondents whose parents' behaviour was of concern to the respondents (p=0.0001) were seen to be significant. Other variables were not significantly associated (Ps>0.05) with beer use. The ANOVA indicates that respondents who feel rejected at home and those who worry about their parents' behaviour are more likely to use beer products to withstand the distress associated with their feelings. Table 6 presents ANOVA of Khat (Miraa) products use.

Table 6: ANOVA Statistics for Khat (Miraa/mairungi, khat, kangeta, muguka)

Products

Variables	Groups	Sum of squares	Df	Mean square	F	Sig
I spent more time with the house help than with my parents	Between Groups	.213	2	.107	.071	.931
	Within Groups	605.541	404	1.499		
	Total	605.754	406			
Growing up, my parents were absent most of the time	Between Groups	2.551	2	1.275	.798	.451
	Within Groups	645.548	404	1.598		
	Total	648.098	406			
Did you suffer rejection at home?	Between Groups	.152	2	.076	.687	.503
	Within Groups	44.442	403	.110		
	Total	44.594	405			
Participant feeling neglected financially	Between Groups	1.352	2	.676	4.751	.009
	Within Groups	57.201	402	.142		
	Total	58.553	404			
Feeling neglected emotionally	Between Groups	.486	3	.243	1.174	.310
	Within Groups	81.620	394	.207		
	Total	82.105	396			
My parents did not spend much time with me	Between Groups	4.126	2	2.063	1.323	.267
	Within Groups	629.786	404	1.559		
	Total	633.912	406			

I feel I was sent to boarding school too early	Between Groups	1.327	2	.664	.393	.675
	Within Groups	681.258	404	1.686		
	Total	682.585	406			
My parents behaviour led me to use drugs in order to cope	Between Groups	9.344	2	4.672	6.555	.002
	Within Groups	287.968	404	.713		
	Total	297.312	406			

Table 6 presents the means parental abandonment using "I spent more time with the house help than with my parents," "growing up, my parents were absent most of the time," "did you suffer rejection at home," "participant feeling neglected financially," "feeling neglected emotionally," "my parents did not spend much time with me," "I feel I was sent to boarding school too early," and "my parents behaviour led me to use drugs in order to cope" variables were statistically equal to zero or associated with Khat mean values. The analysis of variance indicates that none of the variables are scientifically related except respondents who felt neglected financially (p=0.009) and those whose parents' behaviour was of great concern (p=0.002). This suggests that youth who feel financially abandoned by parents and those who feel dissatisfied with parents' behaviour are likely to resort to Khat use to cope. Table 7 depicts distribution of questionnaire responses and other drugs respondents were using.

Table 7: Distribution of Questionnaire Responses and other Drugs

Variables	Total	Low	Moderate	High	^{2} statistics	Df	Sig
Age							
18-25	382(95.7)	371(93.0)	10 (2.5)	1 (0.3)	5.503	2	.973
26-33	14 (3.5)	14 (3.5)	0 (0.0)	0 (0.0)			
34-41	3 (0.8)	3 (0.8)	0 (0.0)	0 (0.0)			
Gender							
Male	168(41.3)	163(40.0)	5 (1.2)	0 (0.0)	1.019	1	.601
Female	239(58.7)	233(57.2)	5 (1.2)	1 (0.2)			
Marital Status							
Married	220(54.3)	216(53.3)	4(1.0)	0 (0.0)	5.143	5	.881
Separated	21 (5.2)	20 (4.9)	1 (0.2)	0 (0.0)			
Single	127(31.4)	121(29.9)	5 (1.2)	1 (0.2)			
Divorced	29 (7.2)	29 (7.2)	0(0.0)	0 (0.0)			
Polygamous	3 (0.7)	3 (0.7)	0 (0.0)	0 (0.0)			
Blended	5 (1.2)	5 (1.2)	0(0.0)	0 (0.0)			

Respondent's Primary Giver							
Mother	253(64.7)	243(62.1)	9 (2.3)	1 (0.3)			
Father	57 (14.6)	57 (14.6)	0 (0.0)	0 (0.0)			
House help	4 (1.0)	4 (1.0)	0 (0.0)	0 (0.0)			
Both mother and father	77 (19.7)	76 (19.4)	1(0.3)	0 (0.0)	3.673	3	.721

Table 7 presents questionnaire responses of respondents and other drug use scores. Among the respondents' age categories, those within ages 18-25 had highest drug use score (383, 95.7%) and majority of them (93%) scored low in other drug use. In terms of gender distribution, female respondents had the highest frequency (58.7%), majority of them (57.2%) scored low in drug use as well. Respondents whose parents were married had the largest distributions compared to other marital status (54.3%). Similarly, respondents whose primary caregivers were mother had the highest frequency (64.7%). The distribution of all the questionnaire responses and other drug use scores were evenly distributed (Ps >0.05). Table 8 depicts ANOVA statistics for other drugs respondents were using.

Table 8: ANOVA Statistics for Other Drugs Products

Variables	Groups	Sum of squares	Df	Mean square	F	Sig
I spent more time with the house help than with my parents	Between Groups	6.277	2	3.139	2.115	.122
	Within Groups	599.477	404	1.484		
	Total	605.754	406			
Growing up, my parents were absent most of the time	Between Groups	4.066	2	2.033	1.275	.280
	Within Groups	644.032	404	1.594		
	Total	648.098	406			
Did you suffer rejection at home?	Between Groups	1.086	2	.543	5.030	.007
	Within Groups	43.508	403	.108		
	Total	44.594	405			
Participant feeling neglected financially	Between Groups	.037	2	.018	.127	.881
	Within Groups	58.516	402	.146		
	Total	58.553	404			
Feeling neglected emotionally	Between Groups	.953	2	.476	2.313	.100
	Within Groups	81.153	394	.206		
	Total	82.106	396			

My parents did not spend much time with me	Between Groups	3.584	2	1.782	1.149	.318
	Within Groups	630.327	404	1.560		
	Total	633.912	406			
I feel I was sent to boarding school too early	Between Groups	.692	2	.346	.205	.815
	Within Groups	681.893	404	1.688		
	Total	682.585	406			
My parents behaviour led me to use drugs in order to cope	Between Groups	12.975	2	6.478	9.204	.0001
	Within Groups	284.355	404	.704		
	Total	297.312	406			

The analysis of variance in Table 8 above indicates that none of the variables are scientifically related (Ps>0.05) except respondents who felt neglected financially (p=0.007) and those whose parents' behaviour was of great concern (p=0.001). This implies that respondents who felt neglected financially and those whose parents' behaviour was of great concerns are likely to take other drugs to cope.

Parental Strife Influences on Drug Use among Respondents

The following data provides the results about parental conflicts and drug use among the respondents. Table 9 depicts marginal homogeneity nonparametric test between parental strife and drug use.

Table 9: Marginal Homogeneity Nonparametric Test Showing Association between Parental Strife and Drug Use

Variable	N	Mean/ Std. dev	Off-Diagonal Cases	Observed MH Statistics	MH Mean/ Std. dev.	Std. MH Statistics	Sig.
My parents behavior has led me to use drugs in order to cope	407	1.83 (1.220)	259	1041.000	708.507 (24.367)	13.646	.0001
Beer products (Tusker, Tusker Malt, Guinness, Senator, White Cap	407	1.2064 (.46201)	274	25.000	189.500 (10.665)	-15.424	.007
Wines	407	1.2138 (.45051)	297	34.000	209.000 (10.840)	-16.144	.042
Khat (Miraa/ Irungi, Chat, Kangeta, Mugoka)	407	1.0565 (.27047)	166	496.000	339.000 (14.731)	10.658	.0001

Other drugs	407	1.0295 (.18333)	266	443.000	159.500 (13.631)	-9.678	.051

Predictors: I hated it when my parents fought

Table 9 presents the marginal homogeneity test to assess the marginal frequencies of substance use: tobacco products use, beer products use, wine product use, miraa product use and other drugs as independent variables and how these variables correspond with parental conflict. From the table above, the marginal variables like "my parents behavior has led me to use drugs in order to cope" are tested to see if a significant correlation can be established with parental conflicts using "I hated it when my parents fought" as predictor. When the observed Marginal Homogeneity (MH) statistics are marched with the standard MH statistics, the independent variables are noted to be statistically correlated (P<0.05).

My parents behavior has led me to use drugs in order to cope (OMH: 1041.000; SMH: 13.646), matched with parental strife, the p level is significant (p= 0.0001). This implies that youth who feel dissatisfied with parents' behaviour are likely to use drugs. Table 10 presents a merged variable likelihood ratio test.

Table 10: Merged Variable Likelihood Ratio Test

Model	Model Fitting Criteria	Likelihood Ratio Tests		
	-2 log Likelihood	Chi-Square	Df	Sig.
Intercept Only	294.935			
Final	245.822	49.114	24	.002

Table 10 indicates that when all the substances/drugs are merged as homogeneity dependent samples, the parental conflicts are significant predictors to drug use (p=0.002).

Discussion

This study set out to determine how parental abandonment and strife affects drug use among the youth. The findings from this study indicated that there is significant statistical association between youth who experienced parental abandonment and strife with substance use.

Respondents who felt rejected at home (p=0.0001), those whose parents did not spend much time with them (p=0.048), and those who felt that their parents' behaviour led them to use drugs (p=0.0001) had significant association with tobacco products. Additionally, respondents who experienced rejection at home (p=0.025) and those who felt their parents' behaviour was of concern to them (p=0.0001) were more likely to use beer products may be able to withstand the distress associated with their feelings. Moreover, respondents who felt neglected financially (p=0.009; p=0.007) and those whose parents' behaviour was of great concern (p=0.002; p=0.001) were likely to use Khat or other drugs to cope. All these drug use problems would have been prevented if the parents were more involved in the children lives (Rusby et al., 2018). Involvement by being present could have made such respondents not to feel rejected or neglected by their parents thus preventing the risk of abusing drugs (Hoffmann, 2002). Availability by parents would also have helped them not to be affected by the parents' behaviour since the parents could have been aware of how

to handle themselves appropriately. Hence, it could have resulted in less substance use (Berge et al., 2016).

In relation to parental conflicts, there was significant association between beer products use (p=0.007), wines use (p=0.042), Khat use (p=0.0001), and other drugs use (p=0.51) for the respondents who hated it when their parents fought. The findings of this study also indicate that parental conflicts were significant predictors of all drug use among the respondents. Marital conflicts cause stress among children, which leads them to mostly seek negative ways of coping and end up developing problematic behaviours like substance abuse (Grynch & Fincham, 1990; Reynolds, Houston, Coleman & Harold, 2014).

Conclusions

In conclusion, parenting behaviour affects children either positively or negatively. The results of this study indicate that whenever children experience abandonment and conflicts from the parents, it results in influencing them to seek for ways of coping like the use of drugs. The study recommends that awareness creation is necessary for the parents so that they can become more involved in their children's lives in order to protect them from developing problematic behaviours like substance abuse later in life.

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Determinants of Alcohol Use by Students in Medical Training Colleges in South Nyanza Region, Kenya

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Abstract

Alcohol consumption is a global public health problem accounting for about 6% of mortality and 5% of disability adjusted life year's (DALYs) lost worldwide. An estimated 10-15 % of students in medical training institutions risk alcohol abuse in their lifetime. In Kenya, alcohol abuse is common among college youth though data on alcohol abuse by students in MTCs are still unclear. South Nyanza, the study area is within Nyanza Region in Kenya with high alcohol consumption with prevalence rate of 26.8% among general college students. The study sought to establish what determined alcohol use by students in MTCs in South Nyanza Region. Cross-sectional descriptive study design was used. Five colleges in the region namely: Kendu Mission School and KMTCs (Kisii, Nyamira, Migori, Homa Bay) were included in the study. A sample of 303 MTC students was recruited for the study. The study established that 113 (37.3%) of the respondents indulged in alcohol use because it was readily available within their colleges. Proximity of alcohol selling premises to their colleges was also a reason for alcohol use as reported by 135 (44.6%) of the respondents. Majority of the respondents 100 (33.0%) were introduced to alcohol use by friends. Curiosity was the main reason that made 73(24.1%) of the respondents to use alcohol for the first time. Mentorship from their tutors and peer education can help reduce alcohol use among the college students.

Keywords: *Kenya, determinants, medical training college students, alcohol use*

Introduction

Alcohol consumption continues being a global public health and social issue (Ndegwa, S., Munene, A., Oladipo, 2017). It is estimated to account for 6% of mortality and 5% of disability adjusted life year's (DALYs) lost worldwide (Francis, 2015). Globally, it is estimated that 53% of the people aged 15 years and above have ever used alcohol (Francis, 2015).

Although over a period of time there has been a significant change in the patterns of alcohol use, reports suggest increasing alcohol consumption in the developing countries in the sub-Saharan region (Acuda et al., 2011; Kinoti et al., 2013). It should

however not be lost to observers that alcohol is widely available, accepted and its use is legal to adults in these societies (Odeyemi, 2014). This is characterized by heavy alcohol drinking observed among students including those in institutions of higher education. Alcohol consumption by students in institutions of higher learning has been described as widespread, dangerous, and disruptive (Ndegwa, S., Munene and Oladipo, 2017). The increasing consumption of alcohol is a cause for concern with a possible matching rise in alcohol related problems in those regions that are most at risk (Odeyemi, 2014).

The health and social consequences of alcohol consumption include intoxication, dependence and other biochemical effects leading to disease and injury. Liver disease is the most common medical complication of alcohol intoxication (Odeyemi, 2014). According to WHO (2012), close to 320,000 young people aged between 15 and 29 years die from alcohol-related causes. This accounts for 9% of all deaths affecting that age group. Alcohol consumption is also thought to contribute to incidences of rape, crime, pervasive sexual behaviours & addictions, mental health and emotional disorders (Changalwa, 2012). It remains a major threat to the academic performance and the future lives of these college students (Eze, 2015).

The NACADA report (2012) estimates that about 30% of Kenyans aged between 15 – 65 years have ever used an alcoholic drink in their lifetime. However, Changalwa (2012) reported that up to 70% of college students were using alcohol with a notable increasing trend. Nyanza region in Kenya is one of those with a high prevalence of alcohol consumption among students. According to NACADA (2010), alcohol prevalence among students generally was highest in Western 43.3%, followed by Nairobi 40.9% and Nyanza 26.8%. Similar high alcohol consumption levels were reported among non-students with Western leading at 90.1% and followed by Nyanza at 81.5% NACADA (2010).

Considerable variations in determinants of alcohol use exist between countries, regions and institutions of higher learning. Medical training college students fall in the age group whose indicators of alcohol use could be different owing to their clinical exposure and expectation as future health professionals. However, the determinants of alcohol use among medical college students in the Nyanza Region are yet to be established. This study therefore sought to establish what determined the use of alcohol among medical college students in the Nyanza Region. This was to help inform appropriate health behavioural strategies vital for such an age group in this setting and the country at large.

Materials and Methods

The study design used was cross-sectional, carried out in five MTCs namely; Kenya Medical Training Colleges (KMTCs) Kisii, Nyamira, Homa Bay, Migori and Kendu

Bay Mission School. They are located within South Nyanza Region covering four counties i.e. Homabay, Migori, Kisii and Nyamira. A proportionate number of 330 students were recruited based on each college's student population. Systematic random sampling method using class attendance registers was employed to identify respondents following stratification by college, course and gender.

Data was collected in the month of May 2015 using a structured self-administered questionnaire. The collected data was uploaded into a computerized database using MS Excel and then exported to Statistical Package for the Social Sciences (SPSS) version 17.0 for analysis. Descriptive statistics was used to analyse the socio-demographic profile and determinants of alcohol use. The analysed data was presented in tables, bar charts and pie charts. Ethical clearance for the study was obtained from Maseno University Ethical Research Committee.

Results

Socio-demographic Information of the Respondents.

The socio-demographic information from the respondents including sex, age, religion, marital status, program and year of study, the course undertaken is summarized in Tables 1 and 2.

Table 1: Socio-demographic Information of the Respondents.

Variable	Frequency, n = 303	Percent (%)
Sex		
Male	150	49.5
Female	153	50.5
Age		
18-23	150	49.5
>23-33	153	50.5
Religion		
Christian	295	97.4
Islam	5	1.7
Others	3	1.0
Marital status		
Single	278	91.8
Married	25	8.3

Among the respondents, 153 (50.5%) were females and the mean age was 21.96 years (18-23, SD=0.4). Nearly all respondents were Christians 295 (97.4%) and majority were single 278 (91.8%).

Table 2: Education Information of the Students

Variable	Frequency n=300	Percent (%)
Program the students		
Clinical medicine	83	26.9
Nursing sciences	175	56.8
Laboratory sciences	27	8.8

Physiotherapy	12	3.9
Community Nutrition	11	3.6
Year of study		
First	80	26.0
Second	116	37.7
Third	77	25.0
Fourth	35	11.4

Among the reasons that determined alcohol use by students of the medical training colleges, the following findings were reported;

a. Availability of alcohol

Majority of the respondents 113 (37.3%) reported that they indulged in alcohol use because it was readily available within their colleges. Proximity of alcohol selling premises to their colleges was also reported to be a reason for alcohol use by 135 (44.6%) of the respondents.

b. Alcohol use by the respondents

Majority of the respondents (n=159, 52.5%) reported having ever used alcohol while in college. Eighty three (27.4%) of the respondents reported that they were still using alcoholic at the time of the study as summarised in Table 3.

Table 3: Alcohol use by students in medical Training Colleges.

Variable		Ever users N=303		Current users N=303	
		Frequency	Percentage	Frequency	Percentage
Alcoholic drinks usage	Yes	159	52.5	83	27.4
	No	144	47.5	220	72.6

c. The person introducing the students to alcohol use

Majority of the respondents 100 (33.0%) were introduced to alcohol use by friends. Family members 5 (1.7%) also introduced some as summarised in Figure 1

Figure 1: The person who introduced students to alcohol use

d. Reason for alcohol use

Curiosity (n=73, 24.1%) was the main reason that made the respondents to use alcohol for the first time. This was followed by having fun (n=37, 12.2%) and encouragement by friends (n=35, 11.6%) as summarized in Figure 2.

Figure 2: Reasons for using alcohol

e. The number of alcoholic drinks taken by students

Majority of the respondents 46 (15.2%) reported having a single bottle of alcohol drink at a time. Those who reported having three to four bottles of alcoholic drinks were 40 (13.2%) and others as summarized in Table 4

Table 4: The number of alcoholic drinks taken by students

The number of alcoholic drinks taken by students (units)	Frequency	Percentage
1 unit	46	15.2
2 units	24	7.9
3-4 units	40	13.2
5-9 units	16	5.3
10 and more units	8	2.6
Not applicable	169	55.8

f. Perceived interventions to alcohol use by the students

The respondents' perceived greater education of young people on alcohol use (n=156, 51.5%), establishment of youth groups and clubs (n=54, 17.8%), establishment of recreational facilities (n=57, 18.8%), the passage of stricter laws against alcohol (n=16, 5.3%), greater parental/tutor guidance (n=15, 5.0%) and others as shown in Figure 3.

Figure 3: The respondents' perception intervention to solve substance problem

Discussion

Majority of the respondents had ever used alcohol and some were still using alcohol at the time of the study. This was possible given that alcohol was readily available to the college students. The rampant use of alcohol among these college students could also be expected given that most of them could have been 18 years or older which is a legally accepted age for alcohol use according to the Kenya Alcoholic Drinks Control Act 2010. The findings are also consistent with the reported prevalence of alcohol use in Nyanza region (NACADA, 2010).

Ready availability of alcohol to the college students was a determinant to their alcohol use. This could have been occasioned by the close proximity of the alcohol selling premises to some of these colleges as reported by some of the respondents. This is consistent with findings in a study conducted among university students in Kenya that reported a direct influence between alcohol use and where the students resided (Ndegwa Munene and Oladipo, 2017).

Majority of the college students reported that their friends were the first to introduce

them to alcohol use. This shows the power of peer influence as a major determinant in alcohol use especially among youths. This finding was consistent with other related studies that reported peer influence playing a major role in the use of drugs (Pillai et al., 2014; "type":"article-journal","volume":"4"},"uris":["http://www.mendeley.com/documents/?uuid=0c008cd6-fa58-4ed8-886c-86d259d2a927"]}],"mendeley":{"formattedCitation":"(Pillai et al., 2014 Ndegwa Munene and Oladipo, 2017).

College duration to youthful students is mentioned as the period of increased vulnerability to stress and risk-seeking behaviours (Whitesell et al., 2013). This could explain why curiosity and being encouraged by friends as the main reasons which made students to use alcohol for the first time. The influence of peers on adolescent substance use often exists in the form of deviant peer relationships, wherein an adolescent associate with a group of people who use substances, or in the form of perceived popularity (Whitesell et al., 2013).

The study also reported that some of the students were engaging in binge drinking. This exposes the students to the negative health effects of alcohol use including impaired cognitive development, liver diseases and others (Whitesell et al., 2013, Odeyemi, 2014). Any level of alcohol use that exposes the college students to medium and high levels of negative effects of alcohol is considered a major public health problem and is common in college campuses (Iconis, 2014; Ndegwa Munene and Oladipo, 2017).

Majority of the respondents suggested greater education of young people on alcohol use as the perceived intervention to the existing problem. It is possible that most of the college students are gullibly inducted into alcohol abuse due to misconceptions or ignorance from the effects of alcohol use. They would therefore immensely benefit from sustained education and mentorship while in college. This is consistent with findings from a study in USA which established that to alleviate alcohol use among college students, peer mentoring and educational programs are important mitigating activities (Iconis, 2014).

Conclusion

The determinants attributed to alcohol use among medical college students established in this study included proximity of alcohol premises to the colleges, ready availability of alcohol in the colleges and peer influence from friends. Effective mentorship from their tutors and peer education is recommended to help reduce alcohol use among the college students.

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Policy Brief on Status of Drugs and Substance Abuse among Primary School Pupils in Kenya

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Executive Summary

Studies in Kenya indicate that drugs and substance abuse among young people in learning institutions is a growing social and public health problem. Most of these studies have, however, focused on young persons who are in high school or in higher levels of education (or older than 14 years). This presents a challenge as drug and substance abuse may begin at an earlier age. This scenario has resulted in limited evidence on drugs and substance abuse among primary school pupils. This survey therefore endeavors to assess the level of knowledge, attitudes and use of drugs and substances of abuse among primary school pupils in Kenya.

Introduction

Drugs and substance abuse is a growing socio-economic challenge that affects many societies across the globe. The challenge has particularly adversely impacted on young persons, families and communities. Some of the social effects of drug use and substance abuse include: emotional damage, antisocial behaviour, brain damage, and death. Economically, drugs impact adversely on individual productivity, leads to dependence and exacerbate poverty. Abuse of drugs and substances is associated with declines in consumption of essential goods and services such as education and health. Consequently, drug use and substance abuse tend to hamper attainment of development goals.

At the school level, use of drugs and substances of abuse among pupils impacts education processes and outcomes negatively. Drugs and substances of abuse is associated with poor academic performance, class repetition and may result in increased school dropout rates. The effects of drugs and substances of abuse on academic performance may be through several channels, including its negative impacts on overall health and cognitive ability. As an example, long term consumption of alcohol can lead to lowered levels of mental or physical function. Drugs and substances of abuse has also been associated with non-conducive learning environments. Pupils abusing drugs are more likely to engage in activities that

disrupt learning, such as violent behaviour and arson–resulting in damage and or loss of assets and lives. Drugs and substances are also known to result in low self-esteem and, on aggregate, impact negatively on the quality of education delivery and attainment. Drug use may also increase risky sexual behaviours, leading to increased exposure to HIV/AIDs and other sexually transmitted diseases.

Despite the growing demand for data, there have been studies on the status and prevalence of drugs and substances of abuse and its association with risk factors among primary school pupils. Previous studies have targeted older cohorts and more so those in high schools, colleges and universities. As a result, there has been limited evidence on knowledge of learners, especially primary school pupils, about drug use and substance abuse. Little is known about primary school pupils: age for first drug experimentation, prevalence, drug refusal skills, assertiveness, self-control and influence of parenting on drug use and substance abuse.

As a result of these gaps, the Authority conducted a survey to determine the prevalence, knowledge, attitudes and practices of drugs and substances of abuse among primary school pupils. The objective of the study of were: examine the knowledge and attitudes of drugs and substance abuse among primary school pupils in Kenya; evaluate the extent of availability and access to drugs and substances of abuse among primary school pupils in Kenya; determine the prevalence of drugs and substance abuse among primary school pupils in Kenya; document the risks and protective factors associated with drugs and substances of abuse among primary school pupils in Kenya; and establish the extent of drug refusal skills, assertiveness skills, relaxations skills, self-control skills, and influence of parenting skills among primary school going age pupils.

Findings

The survey found out that the pupils are fairly knowledgeable on the different drugs and substances of abuse. Tobacco, alcohol and bhang/cannabis were the most widely known drugs with a prevalence of 89.3%, 83.8% and 77.8%, respectively. The drugs and substances of abuse reported as most readily available to primary school pupils were tobacco (41.9%), prescription drugs (27.8%), alcohol (25.9%) and miraa/muguka (23.1%).

When asked if they were aware that their school mates and friends were abusing drugs and substances of abuse, the findings show that tobacco (16.0%), prescription drugs (13.8%), miraa/muguka (10.6%) and alcohol (9.6%) had the highest proportion of pupils reporting in the affirmative.

The pupils were also asked to mention the period when drugs and substances of abuse were being used in schools. Data showed that drugs and substances of abuse were more likely to be used during school holidays (30.0%); on their way home from school (22.0%); during weekends (21.0%); and during inter-school competitions (20.0%).

The pupils were also asked to mention the possible sources of drugs and substances of

abuse. The most mentioned sources of drugs and substances of abuse included kiosks or shops near school (28.6%), bar near school (25.7%), friends (19.3%), bought from other pupils (13.7%), and school workers (13.6%).

The assessment also sought to determine the median age of onset of various drugs and substances of abuse. From the study, the average median age of onset of at least one drug or substance of abuse was 11 years while lowest reported age of onset to drugs and substances of abuse was 4 years.

The pupils were asked to mention the drugs and other substances of abuse that they have ever used in their lifetime (ever use). The study showed that 20.2 per cent of primary school pupils have ever used at least one drug or substance of abuse in their lifetime, 10.4 per cent have ever used prescription drugs in their lifetime, 7.2 per cent have ever used alcohol in their lifetime, 6.0 per cent have ever used tobacco in their lifetime, 3.7 per cent have ever used miraa/ muguka in their lifetime and 1.2 per cent have ever used bhang/ cannabis in their lifetime.

The pupils were also asked to mention the drugs and other substances of abuse that they have used in the last 30 days (current use). The results showed that 16.9 per cent of primary school pupils were currently using at least one drug or substance of abuse, 7.2 per cent were currently using prescription drugs, 3.2 per cent were currently using tobacco, 2.6 per cent were currently using alcohol, 2.3 per cent were currently using miraa/ muguka, 1.2 per cent were currently using inhalants and 1.2 per cent were currently using heroin. Current use of bhang/cannabis and cocaine among primary school pupils was less than 1.0 per cent.

The survey also showed that drugs and substance abuse was significantly associated with class repetition and decline in academic performance. The data also shows that pupils who use at least one drug or substance of abuse are 18 per cent more likely to repeat a class. This study also found that substance abuse was associated with a 6.4 per cent decline in academic performance. Further, the study sought to determine risk factors associated with drugs and substance abuse among primary school pupils in Kenya. The findings showed that pupils from families where one or both parents/guardians use drugs or substances of abuse were more likely to use drugs or substances of abuse; pupils with knowledge of a friend or schoolmate who was using drugs or substances of abuse were more likely to use drugs or substances of abuse; pupils who were accompanying parents to events where alcohol or any drug was being served were more likely to use drugs or substances of abuse; and pupils who reported that alcohol was available in their homes were more likely to use drugs or substances of abuse.

Policy Recommendations

Tackling drug and substance abuse in the country should include a comprehensive collaborative approach involving both state and non-state actors key among them NACADA, County Governments, Ministry

of Health; Ministry of Education; parents and guardians. The survey recommended the following policy implications:

i. Sensitization on knowledge of drugs and substances of abuse and their potential harmful effects. There is need for enhanced anti-smoking and anti-drinking attitudes especially at the lower grades of classes five and six – to counter their relatively higher admiration of users of drugs and substance of abuse:

ii. Enforce guidelines on establishment/ construction of structures (including business premises) near schools;

iii. Enforce ban on sale of cigarettes in single sticks;

iv. Sensitize parents/guardians on the risks of: keeping drugs at home; being accompanied to drug consumption facilities by underage children; and involving children in sale of drugs;

v. There is need to device programmes to be commensurate with the median age for first time use of drugs and substances of abuse. Further, parents, school management, teachers and faith based programmes should be incorporated in such interventions;

vi. There is need to strengthen life skills among children to promote abstinence and delaying of drugs and substance abuse and in particular the assertiveness and refusal skills;

vii. Streamlining the policy environment in schools by promoting institutional based drugs and substance abuse prevention policies and initiatives; and

viii. Set up or kick start or support functional guidance and counselling departments with well trained teachers. This shall include provision of a counselling room and as well as establishment of sobriety clubs.

Innovations and Opportunities In Social Media For Management Of Drug And Substance Abuse In Selected Informal Settlements of Nairobi County, Kenya

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Abstract

According to the World Drug Report in 2016, there is an increasing availability of many kinds of drugs to the youth. Researchers have conducted minimal studies on the consequences social media has on Drug and Substance abuse among the youth. This research is a cross-sectional descriptive design to analyze the innovations and opportunities in Social Media for management of drug abuse in informal settlements in Nairobi County. The study is based on Social Cognitive Theory (SCT) where by individuals determine their own behavior and the Community Readiness Model which modifies social contexts to support the desired behavior. The study population was youth within Kayole North, Kayole South and Mukuru kwa Njenga slums. For this study purposive sampling, snowballing and systematic random sampling approaches were adopted. Purposive sampling was used to identify groups for the survey and was generated by focusing on the 32 groups with a membership of 460. The sample size was 210 respondents who were distributed proportionately to the selected study area(s).30 key informants from the study area were recruited. Interview guides were used to collect data from key informants and questionnaires from youth and their leaders. Qualitatively, data was described whereas quantitatively, descriptive statistics including standard deviation and frequency distribution tables were used. Multiple Regression and ANOVA were used to analyze data quantitatively. The researcher summarized the findings from the variables in each objective and the prevention strategies. Marijuana smoking in slums at 73% is the most prevalent. The youth aged 18 to 24 years have the highest levels of drug abuse rates at 73.5%.WhatsApp is the widely used social media at 54%.23.2% of the respondents agreed that social media strategies adopted had effect on prevention of drug and substance abuse in the informal settlements of Nairobi County. Government should encourage youth to use social media in a beneficial manner.

Keywords

Drug and Substance Abuse, Social Media, Youth, Informal Settlements, Prevention Strategies

Introduction

According to the World Drug Report in 2015, a major world trend is the increasing availability of many kinds of drugs to the yout h. The UNODC Youth Initiative believes that youth represent a strong force for preventing substance abuse in communities and around the world (UNODC, 2014). Study findings suggest that peer-to-peer substance use prevention via social media is a promising strategy. Given the low cost and low burden of social media as an intervening channel, schools, communities and prevention programs can use this approach even in low-resource settings (Evans, W., Andrade, W., Goldmeer, S., Smith, M., Snider, J., & Giraedo, G. 2017).

The LTE by The Mentor Foundation in the US was a pilot project and had the limited objective of demonstrating the potential of social media as a peer-to peer education tool for prevention. (Mentor Foundation, 2012) The use of media, including the mobile phone, has potential for engaging youth in civic affairs and service, micro-enterprise, and non-formal education (Evans, 2014).This study examines whether youth driven-programs that manage Drug and Substance Abuse through the use of social media can be applied to informal settlements in Nairobi County.

Social Media Use in Kenya

Social media has become one of the most active platforms for communication and networking in Kenya. The number of digital activists is growing as the middle class population grows (Zuckerman, 2008b). Majority of the Kenyans online use platforms such as Face book, Twitter, LinkedIn, Google and You tube. Kenyan bloggers have also tried to work towards more accessible information and transparency in decision making (Okolloh, 2007).

Drug and Substance Abuse and the Social Media in Kenya

Most organizations dealing with drug abuse such as NACADA and SCAD have blogs that provide a platform for exchange of information (SCAD, 2017). Few programs and packages focus on the youth. There is significant evidence that carefully planned social media campaigns can reduce substance abuse by countering false perceptions that drug use is normative and influencing personal beliefs that motivate drug use (Rono, 2011). Social media linkages may promote substance use activities amongst individuals as a result of uncontrolled discussions on prevalent drug choice among the peers within the networks as well as the dynamics as well as interpersonal dynamics among network members(Moreno, M.A., Briner, L.R. and Williams, A,2010).

Drug and Substance Abuse in Informal Settlements in Nairobi County

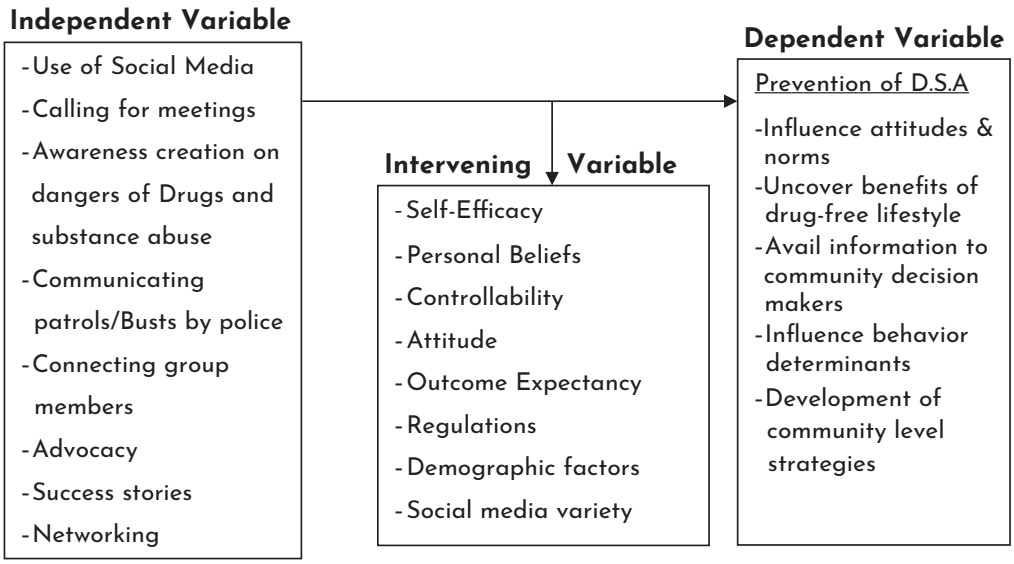
A study by Muchemi (2013) on "Effects of Drug and Substance Abuse among the Youth in the Informal Settlements within Nairobi," revealed that youth use all types of drugs and substances with those injecting themselves highly predisposed to HIV and AIDS and Hepatitis B and C. In a study by Natascha and Ute (2014) titled "Social media and its effects on individuals and social systems, there is extensively array of various understandings interrelated to usefulness of social media as a powerful source of communication and learning". Tundu (2017) conducted a research on "Social Media and the Campaign against alcoholism and Drug Abuse in State Corporations in Kenya: The case of the National Authority for the Campaign against Alcohol and Drug Abuse". The study indicated that advocacy influences the fight against Alcohol and Drug Abuse, social media provides a forum for an individual to interact. Many studies have addressed the potential positive impacts of social media (Bauer, 2007; Pleil and Zerfass, 2010; Rusinger; 2007). There is still very little understanding of how social media can be used as a campaign strategy especially in curbing the use of Drug and Substance abuse.

The study sought to analyze the innovations and opportunities in social media for management of drug abuse in selected slums of Nairobi County. Specifically, it aimed at answering questions on nature and extent of drugs and substances in the selected informal settlements in Nairobi County, benefits of social media use in prevention of drug abuse in those settlements and what challenges face the use of social media as a preventative tool against drug and substance abuse in the selected informal settlements within Nairobi County.

The study is anchored on Social Cognitive Theory, in which behavior is determined by the persons thought processes, the environment and behavior itself, where in this case, are the youth within the informal settlements. For example, youth who believe that taking a substance like cigarettes will make them more attractive, strong, recognized and even more interesting to be around with. Bandura proposed that people form habits by imitating from their immediate environment (Bandura, 1977).

It is also supported by the Community Readiness Model. The Community Readiness Model is a useful complement to social marketing efforts in that it characterizes and measures the social contexts in which individual behavior takes place and is therefore able to guide the development of appropriate community-level strategy (Kelly, J.K., Edwards, R., Comello, L.M. and Plested, B.A.2003). Despite increase in interest in the effects of social interactions, only a few scholars examined leveraging social media as an effective tool for getting youth in informal settlements involved in prevention of Drug and Substance abuse. The conceptual model is presented in

Figure 1 Conceptual Framework Model showing Interaction of Variables



Source: Researcher 2019

Methodology

Research Design

The research adopted a cross sectional survey research design. According to Kothari (2007) and Casely and Kumar (1988), A cross-section survey is best suited for this study because of its ability to understand the whole population from a part of it.

The population of interest in this study comprised of youth both in and out of school within Kayole North, South and Mukuru kwa Njenga slums. The study also recruited key informants involved with the youth at different levels.The target population is 460 youth distributed among 32 youth groups in the three wards of Kayole South, Kayole North and Mukuru kwa Njenga. Embakasi Constituency was selected purposively as it has the highest number of youth groups in Nairobi County. Using Krejcie and Morgan (1970) 210 youth were sampled from the 32 youth groups whose total membership was 460.

Data Collection

Primary data was collected by means of a questionnaire, interview schedules, observation schedule and focus group discussion guides (FGDs).

The Main modes of questionnaire administration were both face-to-face questionnaire administration, where an interviewer presented the items orally and Paper-and-pen questionnaire administration, where the items were presented on paper. Orally presented questionnaires created a rapport between the researcher and the respondents. The researcher clarified the purpose of the study thus motivating the respondent to respond to the questions.

It however impacted on the validity given that some respondents could have falsified information so as to please the researcher. Most questionnaires though were presented to be filled by the respondent.

Interviewing served well in Mukuru kwa Njenga as it built rapport between interviewer and interviewee and enhanced an environment where participants spoke more freely and openly. Due to the sensitivity of the issue of Drug and substance abuse, most interviewees saw it just as a casual talk and did not fear to openly talk about the issues. It allowed the interviewee to delve more on the issues thus generating more information for the interviewer.

It was also observed that Mukuru kwa Njenga informal settlement is crowded and lack space for any meaningful infrastructure. Tracing the groups and its members depended solely on snowballing to be connected to the groups as most of them did not have formal offices. Slum Information Development and Resource Centre (SIDAREC) acted as a link to most of the youth groups in Mukuru kwa Njenga as it provided space for meeting to most of them. The choice of disguised and uncontrolled method of observation ensured that the researcher did not raise any suspicion among the inhabitants due to the sensitivity of the issue of Drug and Substance abuse.

Focus group discussions were useful to further explore the topic of use of social media in prevention of Drug and substance abuse in the informal settlements of Nairobi. It provided a broader understanding of what the youth thought of in using social media to manage proliferation of drugs and substances in Mukuru kwa Njenga slums. They were conducted with a segment of the youth aged 15 to 24 years and the number of participants per group were 10 participants which made it possible to stimulate discussion and gain greater insights into the topic at hand.

Records of youth groups in the area of study together with minutes and membership of these groups was also scrutinized. This was important so as to know the representation and the kind of feedback from the social media platforms such as those geared towards managing Drug and Substance abuse among the youth in informal settlements in Nairobi County.

To test reliability, Cronbach's alpha was calculated by applying the following formula in SPSS;

$$\alpha = \frac{N \cdot \bar{c}}{\bar{v} + (N-1) \cdot \bar{c}}$$

By default, it is a requirement that for reliability of the study tool, ranges between 0 – 1 where by scales of 0.7 and above have been indicated to have an acceptable reliability coefficient. From the findings, a reliability coefficient of 0.830 was obtained and was considered acceptable.

Results

The demography details on gender, age, respondents' occupation and key informants' working experience were considered, analyzed and presented as shown in the following table.

Table 1 Demographic Characteristics of the Sample

Gender of the Respondents			Age of the Respondents			Respondents' Occupation			Key Informants' Working Experience		
Response	N	%	Response	N	%	Response	N	%	Response	N	%
Male 60.0	120		18-24 Yrs	148	74.0	Studying	81	40.5	0-5 yrs	20	66.67
			25-29 Yrs	26	13.0	Employed	66	33.0	5-10yrs	8	26.67
Female 40.0	80		30-34 Yrs	20	10.0	Self-Employed	53	26.5	10+ yrs	2	6.67
			35+Yrs	6	3.0						
Total	**200**	**100**	**Total**	**200**	**100**	**Total**	**200**	**100**	**Total**	**30**	**100**

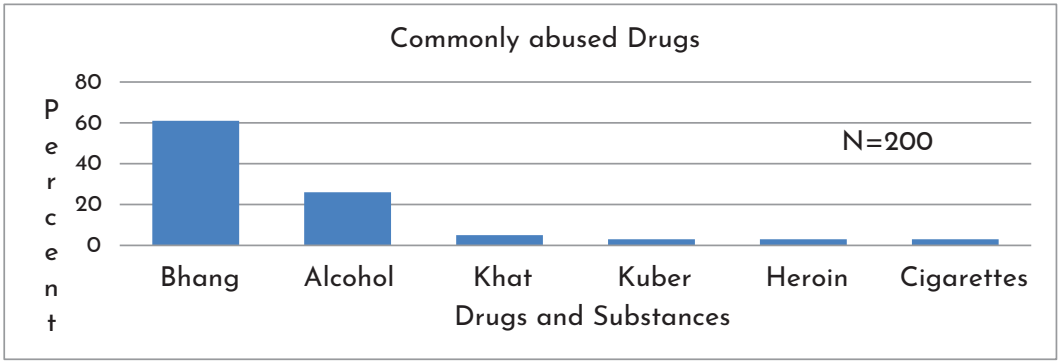
Source: Researcher, 2019

From Table 1, the male were 120 (60%) and the female 80(40%).The youth aged 18 to 24 years have the highest levels of drug abuse rates at 74% and majority of the respondents, 81(40.5%), were students. Most key informants have less than 5 years work experience as indicated by 20 (66.67%) of them.

The Nature and extent of Drug and Substance abuse in selected Informal Settlements in Nairobi County

The study considered the nature and extent of Drug and Substance abuse in the selected informal settlements in Nairobi county, made analysis and presented the findings as follows. Abuse of drugs is high in Mukuru kwa Njenga slums. This was corroborated by both the Assistant Chief and the Chief in Mukuru kwa Njenga Sub-location and location respectively. They placed the percentage at 55%.Concerning the commonly abused drug among the youths in the selected informal settlements; the study analyzed the data and presented the findings as shown in Figure 2.

Figure 2 Drugs commonly abused among the youth in Informal Settlements in Nairobi County, Kenya



***Source:* Researcher, 2019**

Bhang (Marijuana) was consumed more than any other drug as indicated by 120 (60%) of the respondents. This was followed by Alcohol as indicated by 53 (26.5%) of the respondents. Khat was also consumed at 12 (6%). This is majorly attributed to the fact that it is easier to conceal Marijuana than it is for alcohol. Other drugs abused in informal settlements include Kuber at 6(3%), Heroine at 6 (3%) and also Cigarettes at 6 (3%). The findings also revealed that youth were the most affected by the drug abuse as evidenced by 146(73%) of the respondents. The aged were the least affected as indicated by only 14(7%) of the respondents.

Benefits of using Social Media in prevention of Drug and Substance abuse in selected Informal Settlements in Nairobi County

Within this section, benefits accruing from interactions in social media platforms among the youth and its contribution in prevention of Drug and Substance abuse are presented. The findings indicated that all the respondents 200(100%) agreed that drug abuse among youth can best be handled through the social media. 67% strongly agreed and simply 33% agreed. The study deemed it necessary to inquire about the frequency with which the youth in the locality use social media in campaigning against drug and substance abuse. The results show that social media was frequently used in campaigns against drug abuse as 53% of the respondents affirmed. . However, the rest of the respondents which constitute 47 % indicated that social media was not frequently used in campaigns against drug abuse.

Challenges of Using Social Media to Prevent Drug and Substance abuse in selected Informal Settlements in Nairobi County

The study identified ownership of the problem of drug and substance abuse by youths as a possible remedy to manage it. The findings in Table 2 below showed that 52(26.0%) of the respondents strongly agreed and 109 (54.5%) agreed that acceptance of existence of the problem among the youth is vital in addressing the menace by the youth themselves.

Table 2 Ownership of the problem of Drug and Substance abuse by youth in the selected Informal Settlements in Nairobi County, Kenya

Response	Frequency	Percent
Strongly Agree	52	26.0
Agree	109	54.5
Un Decided	13	6.5
Disagree	13	6.5
Strongly Disagree	13	6.5
Total	**200**	**100.0**

Source: Researcher, 2019

Cumulatively, 161(80.5%) of the respondents indicated that ownership of the problem of drugs and substance abuse by youth is a possible remedy to managing the problem. It was however noted elsewhere in the study

that a significant number of respondents which constitute 94 (47 %) indicated that social media was not frequently used in campaigns against drug abuse among the youth in Nairobi's selected informal settlements.

The results in table 3 show that youth and youth leader's strategy had a negative effect on the prevention of drug and substance abuse. A unit change in the youth strategy results to a negative change in the prevention of drugs and substance abuse by 0.891. A unit change in the youth leaders' strategy results to a change in mitigating abuse of drugs and substances by -0.556.

Table 3 Multiple Regression Analysis showing the relationship between the various strategies in Prevention of Drug and Substance Abuse among the youth in informal settlements in Nairobi County, Kenya

Model B		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		Std. Error	Beta			
	(Constant)	2.646	.285		9.283	.000
	Youth leaders Strategies Mean	-.556	.145	-.305	-3.823	.000
	Youth strategies mean	-.891	.193	-.615	-4.608	.000
	Government strategies mean	1.157	.165	1.058	7.019	.000

Source: Researcher, 2019

However, on the government prevention strategy, there is a positive change of 1.157 in the prevention strategy resulting from a unit change in the prevention strategy otherwise categorized as a strong positive effect. The R-Square value of 0.232 with a standard error of 0.534 lie between 0.21 and 0.50 in Cohen's d Coefficient of Correlation, which implies a modest link. It thus shows lack of relationship between strategies adopted by different stakeholders in the use of social media to manage drug and substance abuse among the youth in the informal settlements of Nairobi County.

DISCUSSION OF THE KEY FINDINGS

Most researches suggests that early (12–14 years old) to late (15–17 years old) adolescence is a critical risk period for the initiation of substance use and that substance use may peak among young people aged 18–25 years(UNODC,2018) which is also the case in this study. Irrespective of the number of years one has worked, the key informants have at least noted existence of the problem of Drug and Substance abuse especially in the selected Informal Settlements of Nairobi County.

Cannabis is gaining preference over other drugs among the young people as indicated in World Drug Report 2018. This is attributed to the availability coupled with perceptions of a low risk of harm (UNODC, 2018). From the researcher's own observation, drinking of alcohol was evident among adults in Mukuru kwa Njenga informal settlement. This could be attributed to its availability and proximity of households to alcohol joints which are also quite numerous.

The rise in the number of youth connecting through social media could be attributed to the fact that most of the youths access the social media platforms and the instantaneousness of the connection allows users to stay in touch through instant messaging programs. Smartphones and similar technology have made it easier to disseminate the messages on prevention of Drug and Substance Abuse in the selected informal settlements in Nairobi County.

The positive impact in government strategies corroborate with revelations on the effects of interactive media usage and organizational campaign performance by Tundu (2017). According to the findings, 83.8% of the respondents unanimously reported that social media usage has had a positive impact on NACADA's organizational campaign performance. Social media platforms are deemed appropriate as messages can be conveyed far and wide while at the same time shielding the identity of participants in such groups sensitive topics on Drugs and Substance abuse in informal settlements can be discussed comfortably as opposed to what would happen in a face to face interactions amongst the youth and other players (Okello, 2016). As noted by a discussant who works as a computer instructor at SIDAREC ICT center that is adjacent to Mukuru kwa Njenga slums, said:"The youth may not be willing to freely talk about drugs in a social media forum because if already abusing the drugs without the knowledge of the parents or guardians, it could easily betray them"-Wednesday, 14th August 2019, computer instructor at SIDAREC ICT center.

The ineffectiveness of the youth and youth leaders' strategy is due to suspicion and fear from the youth on existence of social media platforms that handles use of Drug and Substance abuse among the youth in informal settlements. Two presenters from Ghetto F.M reiterated that use of social media in addressing issues of psychoactive substances among the youth is minimal. They intimated that Drug and Substance Abuse is a taboo topic and most of them do not want to be associated with platforms addressing issues of drugs.

Though all the respondents were of the view that social media can handle the problem of drug abuse among the youth, a significant percentage (47%) of those interviewed in Mukuru kwa Njenga do not identify with the problem of Drug and Substance as indicated in their interactions in social media platforms. A media personality hosting a talk show on Drug and Substance Abuse at Ghetto F.M located at the heart of Mukuru kwa Njenga slums had this to say: Use of Social Media in addressing issues of Drug and Substance abuse among the youth

is minimal. It can only be possible if the communication is done by an expert or institutions and not Individuals-Wednesday, 14th August 2019, Media Personality, Ghetto F.M

The general believe here is that suspicion and apprehension are common amongst individuals and given the correlation between drugs and crime, friends and peers may shy away from formulating a social media platform in which they can interact and discuss pertinent issues involving drug and substance abuse. Discussions in platforms created by public institutions such as NACADA are more acceptable as the youth freely ventilate issues of drug and substance abuse in the informal settlements through discussion fora or blogging

Conclusion

The study revealed that most of the youth in the informal settlements do not tag organizations or groups that discuss issues of Drug and Substance abuse, thereby; their involvement in managing of drug and substance abuse is minimal. NACADA should link up with community organizations such as Internet Society Foundation, Kenya chapter and Tunapanda Net initiative that is in the forefront in connecting informal settlements of Mathare and Kibera respectively to internet at a low cost (Miliza, 2018). With such programs, more youth will be connected; get a forum to discuss and blog on issues of Drug and Substance abuse and learn to cushion themselves from its effects in their localities.

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Effects of Environment and Parenting Practices on Alcohol Use among Primary School Pupils in Kenya

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Abstract

Alcohol remains one of the most widely used substances among early and late-adolescent youth. Underage drinking and its associated problems have profound negative consequences for underage drinkers themselves, their families, their communities, and society as a whole. Studies have shown that exposure to alcohol in adolescence can have detrimental effects on brain development and intellectual capabilities, and increases the likelihood for later alcohol dependence. The study aimed to determine the effects of environment and parenting practices on alcohol use among primary school pupils in Kenya. The study used a cross-sectional design covering primary schools from all the eight regions of Kenya. The study employed purposive, proportionate and random sampling methods. A total of 3,307 primary school pupils from 177 primary schools nationally were interviewed representing a response rate of 82.7%. According to the findings, 51.8% of the pupils interviewed were male while 48.2% were female. Data showed that 7.2% of primary school pupils were lifetime users of alcohol. Findings revealed that home environment, school environment and parenting were significant correlates of lifetime alcohol use. The study therefore concluded that prevention programs targeting primary school going children in Kenya require a multi-pronged approach. The study underscores the importance of integrating prevention programs with targeted interventions with focus on the home environment, school environment and positive parenting practices in order to achieve delayed onset or abstinence to alcohol use.

Key words: *Lifetime Alcohol Use, Environment, Parenting Practices and Primary School Pupils.*

Introduction

Alcohol remains one of the most widely used substances among early and late-adolescent youth (Komro et al., 2007; Jonhson et al, 2006; Hibell et al., 2004). Underage drinking and its associated problems have profound negative consequences for underage drinkers themselves, their families, their communities, and society as a whole (Harding et al, 2016). The challenge of underage drinking in Kenya is on the increase. A study targeting secondary schools in Kenya showed that 23.4% of students were lifetime users of alcohol (Kamenderi et al., 2019).

Onset age for alcohol consumption is one of the major factors predicting a later long-term negative outcome (Haan and Boljevac, 2009). Studies have shown that exposure to alcohol in adolescence can have detrimental effects on brain development

and intellectual capabilities, and increases the likelihood for later alcohol dependence (Brown et al, 2000; Monti, Miranda and Nixon, 2005).

The family structure plays an important role in learning, encouraging, and establishing adolescent health behavior-related values and norms (Šumskas and Zaborskis, 2017). Family may become the origin of a variety of developmental problems, including high-risk behavior or, conversely, become a strong protective factor (Cox et al., 2018; Becoña et al., 2012; Hoda čová et al., 2017; Villareal et al., 2010). According to social learning theory (Bandura, 2007), parents influence child outcomes directly by modeling behaviors that are then internalized and repeated by their children. Under-age alcohol use may be a socially learned behaviour that results from the interplay of a variety of social factors (such as modelling and imitation) which influence personal factors (such as beliefs, attitudes, and pro-alcohol cognitions) (Botvin, 2000).

The school environment may be another important setting for nurturing positive childhood behavior. School-based alcohol interventions are designed to reduce risk factors for early alcohol use primarily at the individual level (e.g., by enhancing student's knowledge and skills), although the most successful school-based programs address social and environmental risk factors (Stingler, Neusel and Perry, 2011). Therefore, reducing of risk factors and enhancing protective factors in the school environment can reduce adolescent alcohol use (Toumbourou et al., 2013).

Parenting practices have also been shown to influence youth alcohol involvement. Characteristics such as parental control, monitoring, support, nurturance and discipline practices are associated with adolescents' alcohol use (Barnes et al., 2000; Barnes and Farrell, 1992; Engels and van der Vorst, 2003; Stice and Barrerra, 1995; Wood et al., 2004). Parental influence has been shown to be a risk factor in the development of adolescent drinking behaviour with studies establishing that many youth imitate the alcohol consumption of their parents (Beal, Ausello and Perrinn, 2001; Ennett and Bauman, 1991; Yu, 2003; Zhang, Welte and Wieczorek, 1999). Young adolescents consume alcohol not just because of intrapersonal factors, such as personality type or social skills; they drink alcohol because it is part of their daily lives in their communities and, for many youth, in their homes (Komro and Toomey, 2002; Wagenaar and Perry, 1994). Studies have shown that good and supportive family relationships with parental monitoring and communication have been linked to reduction of substance use among adolescents (Peterson, Buser and Wesburg, 2010; Bohnert, Anthony and Breslau, 2012; Center for Disease Prevention and Control, 2016).

Despite the growing attention towards prevention programs targeting primary school pupils, literature on alcohol use behaviour among this target group especially in resource constrained settings is limited. Further, there is paucity of data on the nexus between parenting practices influence underage alcohol use in an African and Kenyan context where alcohol has a deep-rooted historical and cultural significance. Finally, there is limited data on the effect of home and school environment on underage drinking. Therefore, this study aims to determine the effects of environment and parenting practices on alcohol use among primary school pupils in Kenya. The findings will provide useful data to bolster drugs and substance abuse prevention intervention programs targeting primary school pupils.

Methodology

The study used a cross-sectional design employing a mixed methods approach combining both qualitative and quantitative techniques. The study covered primary schools from all the eight regions of Kenya.

Sampling methods

A national sample of schools was selected from a sampling frame obtained from the Ministry of Education, Science and Technology (MoEST). The study targeted primary school pupils from classes five (5) to eight (8) aged between 11-14 years.

The desired sample for the study was 4,000 primary school pupils distributed across 200 randomly selected schools in the eight regions of Kenya. The eight regions were stratified into a purposive sample of 29 counties based on geographic, socio-economic and rural – urban differences. The number of schools visited in each county was based on the proportion of schools' pupil enrolment in the county. The first step was to allocate the 4,000 pupils to be interviewed across the selected counties based on the total county enrolment levels. The number of pupils interviewed in a selected county was derived as follows:

Number of pupils interviewed =

(Number of pupils in class 5 to 8 in a county)/ x 4,000

(Total number of all pupils in classes 5 to 8 in the

29 sampled counties)

Thus, each pupil had an equal chance of selection. The number of pupils interviewed was determined by the number of primary schools selected. The target schools from each county were selected randomly and were on average equal to the number of sampled pupils divided by 20 (where 20 was the average number of pupils in each of the 200 targeted schools). The 200 randomly selected schools were sampled from a sampling frame of all primary schools in the country. In each of the sampled schools, the number of pupils interviewed in each of the classes (5 to 8) was proportional to the enrolment in each of the classes. The number of interviewees per class was computed as follows:

Number of pupils per class = (No. of pupils in grade) x No. of pupils selected for school
(No. of pupils in class 5 to 8)

Data collection

Data was collected through structured self-administered questionnaires. The first set of questionnaires targeted primary school pupils covering questions on knowledge, attitudes and individual drug use behaviour as well parenting practices.

The school questionnaire targeted school heads/ deputies and covered questions on school environment characteristics, interventions on awareness and control of drugs and substance abuse. The teacher questionnaire targeted the class teachers and covered questions on observed forms of drugs and substances of abuse in schools and interventions on awareness and control measures.

The questionnaire targeting primary school pupils was translated to Kiswahili and was administered in schools where English language was a challenge. The questionnaires were administered by trained research assistants. The pupils were taken through each question by the research assistants before they could respond to make sure that they understood what was required. This interviewer led process of data collection was used through the entire questionnaire. Data collection was

conducted over a three weeks period in the month of June 2018. Permission to undertake the study was also sought and granted by the Ministry of Education Science and Technology. A total of 3,307 primary school pupils from 177 primary schools were interviewed. This represented a response rate of 82.7%.

Estimating the prevalence of lifetime alcohol use

Lifetime alcohol use referred to the proportion of the sampled pupils who had ever used alcohol at least once in the past. Prevalence of lifetime use was computed as the number of pupils in the sample who had ever used alcohol at least once in the past (lifetime use) divided by the total number of pupils in the sample as indicated in equation below:

Prevalence = (Number of pupils in sample who were lifetime users of alcohol)/ (Total number of pupils sampled)

Data analysis

An interviewer screen was developed for data entry to minimize errors. Quantitative data was coded, sorted, entered and analysed using SPSS. Descriptive statistics were used to describe, organize and summarize collected data. Multivariate logistic regression was used to identify the correlates of lifetime alcohol use among the primary school pupils. The variables of consideration were gender; religion; type of school; class of study; home environment; school environment; and parenting practices.

Results

Background characteristics

According to the findings, 51.8% of the interviewed pupils were male while 48.2% were female. In terms of class level, 28.8% were in class five (5), 22.9% were in class six (6), 22.5% were in class seven (7) and 22.8% were in class eight (8). Data also showed that 7.2% of primary school pupils were lifetime users of alcohol.

Correlates of lifetime alcohol use

Table 1 presents findings from multivariate logistic regression analysis with lifetime alcohol use being the dependent variable.

Table 1: Correlates of lifetime alcohol use

Variable	P - value	Odds Ratio	95% Confidence Interval	
			Lower	Upper
Demographic characteristics				
Gender	0.004	1.561	1.149	2.121
Religion	0.801	1.095	0.542	2.213
Type of school	0.0001	0.176	0.098	0.318
Class of study	0.001	0.795	0.691	0.915
Home environment				

Family member who lives with the pupil at home	0.026	0.874	0.776	0.984
Parent or guardian uses alcohol	0.0001	2.321	1.660	3.244
Parent or guardian keeps alcohol at home	0.033	1.716	1.044	2.819
Accompany parents to events where alcohol is served	0.174	1.498	0.836	2.685
Active member of a church/mosque/ temple	0.014	1.633	1.106	2.413
School environment				
Knowledge of schoolmates or friends who use alcohol	0.697	1.060	0.790	1.423
Often inspected for drugs and substances of abuse in school	0.814	0.959	0.678	1.357
Ever seen a teacher coming to school drunk	0.599	0.891	0.579	1.371
Ever attended an awareness talk on the dangers of alcohol and drugs abuse in school	0.008	1.554	1.119	2.158
An active member of any sport, club or study group	0.417	0.863	0.605	1.231
Parenting practices				
A. Parenting skills				
Parent or guardian is available to discuss with you any issues affecting you	0.440	1.058	0.917	1.220
Parent or guardian usually talks to you about the dangers of drugs and substance abuse	0.791	1.020	0.879	1.184
Parent or guardian discusses with you about the kind of friends you keep	0.533	1.051	0.898	1.231
Parent or guardian takes time to discuss with your teachers about your character and performance in school	0.012	0.823	0.707	0.959
Parent or guardian has an open communication with you about your academic and social life	0.754	0.977	0.842	1.132
Parent or guardian shows you affection e.g. through hugging, providing presents	0.172	1.097	0.961	1.253
Parent or guardian cares about you e.g. by providing you with the basic needs	0.020	0.804	0.669	0.966
Parent or guardian spends time with you in the evenings or school holidays	0.638	1.041	0.882	1.228

Parent or guardian praises you after some achievement	0.004	1.265	1.077	1.485
Parent or guardian reprimands you when you make mistakes	0.755	1.026	0.872	1.207
Parent or guardian gives you advice and guidance	0.170	0.884	0.741	1.054
B. Parental disrespect of individual worth				
Parent or guardian ridicules you or puts you down (for example, say you were stupid or useless)	0.306	0.934	0.819	1.065
Parent or guardian expects too much of you in school	0.004	0.854	0.767	0.951
Parent or guardian embarrasses you in public or in front of your friends	0.716	0.977	0.861	1.108
Parent or guardian unfairly compares you to someone else (such as to your brother or sister or to themselves)	0.238	1.076	0.953	1.215
Parent or guardian ignores you (for example, walk away from you or not pay attention to you)	0.374	1.057	0.935	1.195
C. Parental monitoring				
Parent or guardian usually tries to know who your friends are	0.387	1.064	0.925	1.223
Parent or guardian usually tries to know how you spent money in your possession	0.895	1.008	0.890	1.143
Parent or guardian usually tries to know where you were most evenings after school	0.557	1.046	0.901	1.215
Parent or guardian usually tries to know what you did with your free time	0.138	1.111	0.966	1.278
Parent or guardian asks you to assist with household chores	0.494	0.954	0.832	1.093
Parents or guardian looks through your books or homework	0.009	1.191	1.045	1.357

Source: Survey data, 2018

Demographic factors

Results showed that gender (AOR = 1.561, 95% CI 1.149 – 2.121, p=0.04); type of school (AOR = 0.176, 95% CI 0.098 – 0.318, p=0.0001); and class of study (AOR = 0.795, 95% CI 0.691 – 0.915, p=0.001) were significant correlates of lifetime alcohol use among primary school pupils.

Analysis on gender showed that pupils who were male had a higher likelihood of lifetime alcohol use compared to those who were female. Findings on the type of school showed that pupils from "mixed boys and girls day" and "boys day" schools had a higher likelihood of lifetime alcohol use compared to pupils from boys boarding; boys day and boarding; girls boarding; girls day; girls day and boarding; and mixed boys and girls boarding schools. The findings also showed that pupils in class eight had a higher likelihood of lifetime alcohol use compared to pupils in class five, six or seven.

Home environment

Results on home environment showed that parent's or guardian's alcohol use (AOR = 2.321, 95% CI 1.660 – 3.244, p=0.0001); type of family member who lives with the pupil at home (AOR = 0.874, 95% CI 0.776 – 0.984, p=0.026); parent's or guardian's alcohol use (AOR = 2.321, 95% CI 1.660 – 3.244, p=0.0001); parent or guardian keeping alcohol at home (AOR = 1.716, 95% CI 1.044 – 2.685, p=0.033); and not being an active member of a church/ mosque or temple (AOR = 1.633, 95% CI 1.106 – 2.413, p=0.014) were significant correlates of lifetime alcohol use among primary school pupils.

Findings showed that pupils who either lived with a "guardian" or "father only" at home had a higher likelihood of lifetime alcohol use compared to pupils living with both mother and father; mother only; or grandparents. Results also showed that pupils with parents or guardians who use alcohol had a higher likelihood of lifetime alcohol use. In addition, pupils with parents or guardians who keep alcohol at home had a higher likelihood of lifetime alcohol use. Finally, findings also showed that pupils who were not active members of a church, mosque, temple had a higher likelihood of lifetime alcohol use.

School environment

Results showed that lack of exposure to an awareness talk on the dangers of alcohol and drug abuse in school (AOR = 1.554, 95% CI 1.119 – 2.158, p=0.008) was a significant correlate of lifetime alcohol use among primary school pupils. Analysis showed that pupils who had not been exposed to sensitization and awareness talks on the dangers of alcohol and drug abuse in school had a higher likelihood of lifetime alcohol use.

Parenting practices

Results showed that parents or guardians who did not take time to discuss with teachers about a pupil's character and performance in school (AOR = 0.823, 95% CI 0.707 – 0.959, p=0.012); parents or guardians without caring attitudes for the pupil (AOR = 0.804, 95% CI 0.669 – 0.966, p=0.020); parents or guardians who did not praise the pupil after some achievement (AOR = 1.265, 95% CI 1.077 – 1.485, p=0.004); parents or guardians expecting too much from the pupil in school (AOR = 0.854, 95% CI 0.767 – 0.951, p=0.004); and parents or guardians who were not actively monitoring their children e.g. looking through a pupil's homework (AOR = 1.191, 95% CI 1.045 – 1.357, p=0.009) were significant corelates of lifetime alcohol use among primary school pupils.

Findings showed that pupils whose parents or guardians did not find time to discuss with teachers about their character and performance in school had a higher likelihood of lifetime alcohol use. In addition, pupils with parents or guardians without caring attitudes had a higher likelihood of lifetime alcohol use. Analysis also showed that pupils with parents or guardians who

did not praise them after some achievement had a higher likelihood of lifetime alcohol use. Further, the pupils whose parents or guardians expected too much from them in school had a higher likelihood of lifetime alcohol use. Finally, pupils with parents or guardians who were not actively monitoring their children e.g. looking through their homework had a higher likelihood of lifetime alcohol use.

Discussion

The study showed that 7.2% of primary school pupils in Kenya were lifetime users of alcohol. The findings revealed that primary schools in Kenya were not drug free environments. In another study from Trinidad and Tobago, 31.6% of primary school pupils were lifetime users of alcohol (Agu et al., 2018). Another study in Kenya targeting secondary schools showed that 23.4% of students were lifetime users of alcohol (Kamenderi et al., 2019). These studies underpin the importance of undertaking mitigation measures targeting the basic institutions of learning to delay early onset to alcohol use. Literature shows that alcohol remains one of the most widely used substances among early and late-adolescent youth (Komro et al., 2007; Jonhson et al, 2006; Hibell et al., 2004). Underage drinking and its associated problems have profound negative consequences for underage drinkers themselves, their families, their communities, and society as a whole (Harding et al, 2016). Age of onset of alcohol consumption is one of the major factors predicting a later long-term negative outcome (Haan and Boljevac, 2009). Studies have shown that exposure to alcohol in adolescence can have detrimental effects on brain development and intellectual capabilities, and increases the likelihood for later alcohol dependence (Brown et al, 2000; Monti, Miranda and Nixon, 2005).

Demographic factors

Examining demographic factors helps to explain local differences in drinking patterns and understanding of alcohol problems (Marsiglia et al., 2004; Stewart and Connors, 2007; Stewart and Power, 2003; White and Jackson, 2005). In this study, findings on gender showed that pupils who were male had a higher likelihood of lifetime alcohol use compared to those who were female. Pupils who were males were disproportionately more exposed to lifetime alcohol use compared to female pupils. The findings were consistent with another study targeting secondary school students in Kenya where being male was a risk factor for drugs and substance abuse (Kamenderi et al., 2019). A Spanish study conducted among school going children established that males had a higher likelihood of alcohol consumption (Moñino-García et al., 2018). Similar findings were reported in Trinidad and Tobago where the male gender was associated with increased likelihood of lifetime alcohol use among primary school pupils (Agu et al., 2018). The study emphasizes the importance of focusing on the "boy child" in light of the on-going national debate on protecting this vulnerable target group through positive parenting practices, parental role modeling and other boy-centered prevention programs.

Analysis of the type of school showed that pupils from "mixed boys and girls day" and "boys day" schools had a higher likelihood of lifetime alcohol use. The results showed that boarding schools were protective against exposure to lifetime alcohol use with greater risk being associated with day primary schools. The findings also revealed that pupils in class eight had a higher likelihood of lifetime alcohol use compared to pupils in class five, six or seven. The results showed that the risk of exposure to lifetime alcohol

use increases with the number of years a pupil was in school. This finding is consistent with another study targeting secondary school students in Kenya where risk of drugs and substance use was dependent on the number of schooling years (Kamenderi et al., 2019). Disruption of this vulnerability curve of exposure is achievable through implementation of targeted prevention programs focusing on the infant years of a child's development in order to delay early onset or attain abstinence to underage alcohol use.

Home environment

Understanding the risks associated with the home environment in relation to exposure of early onset of alcohol use is the basis for developing targeted prevention interventions. The study showed that pupils who either lived with a "guardian" or "father only" at home had a higher likelihood of lifetime alcohol use compared to pupils living with both mother and father; mother only; or grandparents. This finding lay emphasis on the importance of understanding the family structure in relation to exposure of children to the risk of under-age alcohol use. Literature shows that alcohol consumption in teenagers is influenced by family structure (Fraga et al., 2011; Griffin and Botvin, 2000). The family structure plays an important role in learning, encouraging, and establishing adolescent health behavior-related values and norms (Šumskas and Zaborskis, 2017). Family may become the origin of a variety of developmental problems, including high-risk behavior or, conversely, become a strong protective factor (Becoña et al., 2012; Hoda čová et al., 2017; Villareal et al., 2010).

Findings also showed that pupils with parents or guardians who use alcohol had a higher likelihood of lifetime alcohol use. Parental role modelling comes to focus in shaping behaviour in the different developmental stages of children. According to social learning theory (Bandura, 2007), parents influence child outcomes directly by modeling behaviors that are then internalized and repeated by their children (Cox et al., 2007). Under-age alcohol use may be a socially learned behaviour that results from the interplay of a variety of social factors (such as modelling and imitation) which influence personal factors (such as beliefs, attitudes, and pro-alcohol cognitions) (Cox et al., 2018; Botvin, 2000). Witnessing parents drink alcohol may lead adolescents to drink and/or adopt norms permissive of alcohol use (Cox et al., 2018; Duncan, Duncan and Strycker, 2006; van der Vorst et al., 2009; White, Johnson and Buyske, 2000). Evidence suggests that adolescents whose parents drink regularly are at increased risk for using alcohol (Cox et al, 2018; Alati et al., 2014; Ary et al., 1993).

Parents or guardians may be enablers of under-age alcohol use through storing or stocking alcohol within homes. The study showed that pupils with parents or guardians who keep alcohol at home had a higher likelihood of lifetime alcohol use. Similar observations have been reported where parental provision of alcohol and home alcohol availability; parental report of providing alcohol to their child; and the accessibility of alcohol in the home were associated with significant increases in the trajectories of young adolescent alcohol use and intentions (Komro et al., 2007). Student report of receiving alcohol from their parent or taking it from home during their last drinking occasion were the most robust predictors of increases in alcohol use and intentions over time (Komro et al., 2007).

Religion is a critical pillar in a child's early life for molding character and values which may be protective against negative behaviour including underage alcohol use. The study showed that pupils who were not

active members of a church, mosque, temple or any other religious affiliation had a higher likelihood of lifetime alcohol use. Studies have shown that high levels of religiosity are predictive of young adults' abstention from high risk behaviour (Koenig and Heath, 2011; Langer, Warheit and McDonald, 2001; Sauer-Zavala, Burris, and Carlson, 2012). In another study, high religiosity was associated with lifetime alcohol abstention and was found to be protective against hazardous drinking (Drabble, Trocki and Klinger, 2016). Religiosity's protective properties for alcohol use have been particularly robust and demonstrated across age, gender and socioeconomic status (Wills et al., 2003). Although studies have demonstrated the protective effects of religion, Brechting et al., (2010) established that individuals must exhibit highly religious behaviors in addition to highly religious beliefs in order to benefit from religiosity's protective effect.

The study therefore lays emphasis on reducing of risk factors and enhancing protective factors in the family environment in order to reduce underage alcohol use and a range of health and social problems (Toumbourou et al., 2013).

School environment

The school environment provides an important opportunity for implementing prevention programs to delay early onset of alcohol use. The study showed that pupils who had not been exposed to sensitization and awareness talks on the dangers of alcohol and drug abuse in school had a higher likelihood of lifetime alcohol use. School-based alcohol interventions are designed to reduce risk factors for early alcohol use primarily at the individual level (e.g., by enhancing student's knowledge and skills), although the most successful school-based programs address social and environmental risk factors (Stingler, Neusel and Perry, 2011). Teaching general personal and social skills in the absence of other components of the social influence approach such as drink refusal skills training and normative education has only been found to have a minimal impact on alcohol use (Caplan et al., 1992).

Parenting practices

Parenting styles and practices have raised concerns over the years in Kenya due to the changing lifestyles, urbanization and challenges associated with work-life balance leading to deprivation of the quality time needed to raise children with the desired values. Parents play a critical role in the socialization of children, serving as their primary source of influence throughout childhood. Although peers become increasingly important during adolescence, parents continue to be instrumental in the socialization process throughout adolescent development (Wood et al., 2004).

The study endeavored to understand how parenting practices influence lifetime alcohol use among primary school pupils. Findings showed that pupils whose parents or guardians did not find time to discuss with teachers about their character and performance in school had a higher likelihood of lifetime alcohol use. In addition, pupils with parents or guardians without caring attitudes had a higher likelihood of lifetime alcohol use. Parental love and care towards children impart self-confidence and self-worth of a child thereby reinforcing positive behaviour. Studies have also linked parental hostility, rejection, and harsh, inconsistent discipline to childhood drinking and alcohol-related problems (Chartier, Hesselbrock and Hesselbrock, 2010).

Recognition of simple achievements by parents or guardians was protective against lifetime alcohol use by primary school pupils. Analysis showed that pupils with

parents or guardians who did not praise them after some achievement had a higher likelihood of lifetime alcohol use. Further, the study showed that pupils whose parents or guardians expected too much from them had a higher likelihood of lifetime alcohol use. The findings show that enforcing unrealistic targets to a child may lead to stressful experiences resulting to under-age alcohol use as a coping mechanism.

Consistent monitoring of a child by a parent or guardian reduces the risks of negative behaviour because the child is aware that they are being followed closely. Findings showed that pupils with parents or guardians who were not actively monitoring their children through simple activities like looking through their homework had a higher likelihood of lifetime alcohol use. Because of increasing demands on their time and attention, parents are spending less time with their children (Kumpfer, 2000). Studies have shown that high quality parent-child communication (Carver et al., 2017), including the communication of strict alcohol specific rules (Mattick et al., 2017; Schinke, 2004), and parent's monitoring of adolescent's activities and whereabouts (Kelly, Becker and Spirito, 2017; Van Ryzin, Fosco and Dishion, 2012) are associated with reduced levels of alcohol consumption among adolescents. It has also been shown that alcohol consumption in teenagers is influenced by parental monitoring (Abar and Turrisi, 2008; Duffy, 2014; Kelly, Becker and Spirito, 2017). Evidence shows that positive parenting practices remains as a key pillar in any prevention efforts on underage drinking targeting primary school pupils in Kenya.

Conclusion

The study depicts parents or guardians as enablers of underage alcohol use among primary school pupils in Kenya. Exposure of children to alcohol through storage and drinking at home was a major risk factor. This was despite the existence of a law regulating access to underage children especially in areas where alcohol is stored or consumed (GoK, 2010). Evidence also showed that negative role modelling was a dominant influence to early exposure to underage alcohol use especially among alcohol using parents or guardians.

The school environment was another notable setting for implementation of prevention programs including sensitization and awareness programs on the effects of alcohol and other drugs; and life skills training which imparts young children with drug refusal skills, communication skills, problem solving skills and anger management skills.

Further, negative parenting practices was shown to increase the risk of exposure to underage alcohol use among primary school pupils. Positive parenting practices including parenting skills, parental monitoring and embracing parent - child relationships may be promising protective interventions for school going children.

The study therefore concluded that prevention programs targeting primary school going children in Kenya requires a multi-pronged approach. The study underscores the importance of integrating prevention programs with targeted interventions with focus on the home environment, school environment and positive parenting practices in order to achieve delayed onset or abstinence to alcohol use.

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Policy Brief on National Survey on Alcohol and Drug Abuse among Secondary School Students in Kenya

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Executive Summary

This survey on alcohol and substance abuse in Kenyan secondary schools contributes to the growing body of knowledge on the impact of alcohol and drug abuse in the country as a whole and the education sector. The school environment is a critical point of interaction between the students and society. The survey showed that the age of onset to alcohol and drug use marks the period of transition from primary school to secondary schools. The age between 13 to 15 years presents the most critical period for the students in secondary schools to initiate alcohol and drug use. The students are likely to initiate prescription drugs and inhalants at the age of 13 years; 14 years are likely to be initiated to alcohol, khat/ miraa, tobacco and heroin; and 14.5 years to 15 years initiation of cocaine and bhang respectively. The National Campaign Against Drug Abuse Authority (NACADA Authority) is mandated to undertake quality research on alcohol and drugs use to guide policy and programming in the country.

Introduction

The Government of Kenya recognizes the threat of alcohol and drug abuse to all sectors of the economy. The types of drugs available in the market have increased overtime while channels of communication and distribution have expanded giving drug merchants an ever-increased access to a wider market. In response, it has enacted a legal and institutional framework within which the problem of alcohol dependency and drugs abuse can be addressed.

The negative impact of alcohol and substance abuse is reflected in the immediate and long-term effects that individuals, families, and society suffer. These effects include death, as has been documented by the Kenyan media, and psychological instability. Alcohol and drugs use also leads to poor academic outcomes on the part of students. As a result of these, the Authority undertook a national survey on Alcohol and Drug use among students in secondary schools to brings out the current trends of alcohol and drug abuse among students in secondary schools. The objectives of the survey were to: determine the perceptions of students on alcohol and drug abuse; determine the prevalence of alcohol and drug abuse among secondary school students in Kenya; document the risk factors associated with initiation and continuation of ADA among students in secondary schools; document the protective factors for ADA among students in secondary schools; document the current strategies put in place to address ADA in secondary schools; determine the role, gaps

and opportunities for using guidance and counselling teachers in ADA prevention, control and management; and recommend effective strategies of ADA prevention, control and management in secondary schools.

The survey will contribute to the on-going debate regarding student perceptions, attitudes, prevalence and risk factors in relation to use alcohol and other substances. It also presents information on the school environment in which alcohol and drugs use behaviours occur. The findings will support the Authority to design effective evidence-based strategies to reach out to this key target population.

Findings

The following is the summary of the findings of the study:

- Secondary schools in Kenya are not drug free environments;
- Environments around schools were reported to be a major source for drugs being used in schools e.g. alcohol selling outlets (bars) and local brew dens near schools;
- The home environment is a major risk for initiation of drugs by students;
- The age between 13 and 15 years present the most critical period for the students in secondary schools to initiate substance abuse. This age marks the period of transition from primary school to secondary schools;
- The guidance and counselling teachers are not equipped to deal with alcohol and drug abuse issues during their training. This is further complicated by the issue work overload as a result of teaching other subjects in schools;
- There is a higher likelihood of using drugs and substances of abuse in schools attended by male only students e.g. boys boarding or boys day;
- There is a higher likelihood of using drugs and substances of abuse among students in Form 3 or Form 4; and
- There is a higher likelihood of using drugs and substances of abuse among schools in Lower.

Lifetime/ ever use of drugs and substances of abuse

Students were asked if they have used drugs and substance abuse in a lifetime. The responses were as follows:

- 23.4% (508,132) of secondary school students have ever used alcohol in their lifetime;
- 17.0% (369,155) of secondary school students have ever used khat/ miraa in their lifetime;
- 16.1% (349,613) of secondary school students have ever used prescription drugs in their lifetime;
- 14.5% (314,869) of secondary school students have ever used tobacco in their lifetime;
- 7.5% (162,863) of secondary school students have ever used bhang/ cannabis in their lifetime;

- 2.3% (49,945) of secondary school students have ever used inhalants e.g. glue and petrol in their lifetime;
- 1.2% (26,058) of secondary school students have ever used heroin in their lifetime; and
- 1.1% (23,887) of secondary school students have ever used cocaine in their lifetime.

Current use of drugs and substances of abuse

Students were asked if they currently use drugs and substance of abuse. The responses were as follows:

- 3.8% (82,517) of secondary school students are currently using alcohol in their lifetime;
- 3.6% (78,175) of secondary school students are currently using khat/ miraa in their lifetime;
- 2.6% (56,459) of secondary school students are currently using prescription drugs in their lifetime;
- 2.5% (54,288) of secondary school students are currently using tobacco in their lifetime;
- 1.8% (39,087) of secondary school students are currently using bhang/ cannabis in their lifetime;
- 0.6% (13,029) of secondary school students are currently using inhalants e.g. glue and petrol in their lifetime;
- 0.2% (4,343) of secondary school students are currently using heroin in their lifetime; and
- 0.2% (4,343) of secondary school students are currently using cocaine in their lifetime.

Policy Recommendations

Based on the survey findings, the following policy recommendations are made:

- The Authority in collaboration with other stakeholders should develop a curriculum on drugs and substances use that also encompasses the other aspects of life skills training;
- The Authority in collaboration with the Ministry of Education, Science and Technology should support in the provision of the relevant training to guidance and counselling teachers to empower them to deal with the emerging challenges of alcohol and drug abuse;
- The Ministry of Education, Science and Technology, Teachers Services Commission (TSC) and KICD should address the issue of overloading guidance and counselling teachers in order to improve the quality of the services that they provide;
- Strict controls and enforcement of legislations on access to prescription drugs by the Pharmacy and Poisons Board should be enhanced;
- The Authority in collaboration with other stakeholders should support secondary schools to come up with school-based drugs and substances of abuse policies that holistically address the aspects of promoting free drug environments within the school; early identification of students with drugs and substances

of abuse problems; focus on extra-curricular activities; and evidence based preventive strategies of dealing with cases of drugs and substance abuse in schools.

Communication and Addiction

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Abstract

Communication is key to many problem-solving situations especially in relating with and supporting the persons with addiction through their recovery. Learning the skills of effective communication is imperative not only for the caregivers of the person with addiction but for the recovering person with addiction her/himself. This article examined the relationship between communication and addiction. It concluded that the importance of effective communication in the understanding and treatment of addiction as well as in interacting with the person with addiction cannot be overlooked. Also, that, treating addiction will involve the person with addiction learning to communicate effectively and the addiction professionals and family members doing the same.

Keywords: *Communication, Addiction, Neural Communication, Intra and Inter Communication, Addiction Treatment, Communication Skills.*

Introduction

Addiction has been viewed from different perspectives that have offered different explanations such as brain disease, result of moral decadence, lack of will, maladaptive behavior, spiritual possession, and so on. The complexity in the understanding of the nature of addiction also exists in how addiction plays out in the communication patterns between family and friends, and the person suffering with addiction. A person with addiction finds it difficult to communicate intra as well as to have an effective communication inter. We are social beings, and everyone has some sort of desire to engage in social interaction, hence, meaningful conversation or interaction can only exist through utilization of effective communication skills. As important as communication is, one of the problems of a person with addiction to alcohol and drugs is the reduced ability to communicate effectively. The person with addiction may feel withdrawn, isolated or ashamed, leaving members of the family and caring friends also confused, disturbed, and helplessly powerless to reach out or help out their loved one. It might, therefore, become problematic if persons with addiction cannot effectively communicate their physical and emotional needs to their significant others.

The interaction between communication and addiction is also found with the excessive use of the Internet by many individuals who suffer from Internet Addiction Disorder (IAD). This situation where people communicate with or through technology has made some experts to propose a syndrome called Communication Addiction Disorder (Psych Central, 2018) or Internet-communication disorder (ICD) which

exists in the growing amount of individuals suffering diminished control over their use of online communication applications; leading to diverse negative consequences in offline life (Wegmann, & Brand, 2016).

The purpose of this study is to examine the relationship between effective communication and addiction. In doing so, the concept of addiction will be examined from neurological perspective, how addiction affects neural communication pathways, and how communication pattern of family and addiction professionals can either be helpful or discouraging in the process of addiction treatment.

What is Addiction?

Addiction is often misunderstood or confused with the use, misuse, or abuse of alcohol and other drugs (AOD). One can be addicted to anything including gambling, shopping, internet, phone, food, sex, spirituality, or any "healthy" activity, such as eating or sex. However, there are certain criteria that must be met before one can be diagnosed as being addicted. The 2013 Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) gave some criteria for addiction to alcohol and drugs which are termed substance use disorders based on decades of research and clinical knowledge. The criteria are:

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts you in danger.
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

However, when it concerns behavioral addiction, it can be said that the person with addiction exhibits:

1. Inability to consistently abstain from a certain behavior.
2. Impairment in behavioral control.
3. Craving, strong urges, or increased "hunger" for the behavior.
4. Diminished recognition of significant problems with one's behaviors and interpersonal relationships; and
5. A dysfunctional Emotional response.

Although, these five characteristics are not "diagnostic criteria" of addiction, they are

widely present in most cases of addiction.

Addiction is a serious difficult disorder that touches every aspect of one's life: physical, mental, social, and spiritual. Addiction takeovers the brain functioning, causes 'fake' euphoric feelings, destroys relationship with self, others, and makes one lose the sense of meaning and purpose in life. According to the American Society of Addiction Medicine (ASAM, 2019), "addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors."

Addiction and Neural Communication

There is a connection between behavior and nervous system. In generating complex patterns of behavior, the nervous systems have evolved extraordinary abilities to process information and evolution has made use of the rich molecular repertoire, versatility, and adaptability of cells (Laughlin & Sejnowski, 2003). Neurons are able receive and deliver signals at up to 105 synapses and able to combine and process synaptic inputs, both linearly and nonlinearly, to implement a rich repertoire of operations that process information (Koch, 1999). So, within the understanding of the brain's electro-chemical communication system, it is understood that information is sent through a vast network of interconnecting neurons. With time, the brain develops a preferred or standard pathway to send signals between neurons. This process is known as neural pathway. These neurons are constantly adapting to changing circumstances like brain damage or altered brain chemical activities through drug use. The ability of the brain to change and adapt to new information is known as brain or neural plasticity while the change that occurs at the synapses, the junctions between neurons that allow them to communicate is called synaptic plasticity (Tyagarajan & Fritschy, 2010); The University of Queensland, 2018).

When someone drinks alcohol or uses drugs or engages in certain behavior like gambling or playing video game, the pleasure or euphoric feeling one experiences is due to the stimulation of the brain chemicals such as dopamine, serotonin or GABA. These chemicals, known as neurotransmitters, through normal neural communication, are responsible for the way we feel. The drugs or behaviors that are addictive either mimic, excite or inhibit the neurotransmitters and so alter the neural communication. In this case, new neural pathways are formed as addiction develops. In other words, addiction chemically altered the brain's communication system (NIDA, N.D.). When one stops drinking alcohol or using drugs, the brain again forms new neural pathways. This shows how communication intra can be affected by altering thought process which informs behavior.

Addiction and Inter-Communication

There is a strong connection between addiction and communication as both interact in a two-way traffic relationship. In the first place, those who suffer or experience psychological distress due to communication disorder can find themselves abusing drugs to alleviate their feelings of anxiety or depression. This is by the way of using alcohol and drugs as coping mechanism to temporarily increase confidence and sociability while potentially minimizing their communication difficulties. People with such communication (emotional) disorders who use addictive drugs to self-medicate suffer

two disorders. Self-medication in this case is to escape from emotional pain caused by the communication disorders. In other words, this is a coexistence of both a mental health and a substance use disorder known as co-occurring disorders or dual diagnosis according to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2020).

Just like people with communication disorder, people who abuse or are addicted to alcohol and other drugs or any other behavioral addiction can isolate themselves from others or exhibit communication problems. In other words, drug or behavioral addiction can cause communication disorder. This can be in form of slurring words, comprehension problems, and utterances of nonsensical sentences depending on the types of active drug used. Chronic or heavy use of alcohol and other drugs can make communication difficulties permanent as it may affect brain functioning, creating serious distress that in turn pushes one deeper into addiction. According to Dr. Marvin Seppala as quoted by Bebinger (2020), addiction is a disease of isolation.

Obstacles to Effective Communication in Addiction

In view of these relationship between communication and addiction, one of the focus of addiction treatment is to improve communication skills. People with addictive disorders who are currently in recovery do exhibit low self-esteem (Institute of Behavioral Research, 2019). It is also possible that these individuals have, over time, developed, unhealthy or immature communication skills as a result of things they have done in their addiction, hurting family and friends, maltreating their loved ones, mistreating themselves, engaging in maladaptive behaviors, allowing their health to decline, and so on. These are very difficult things to come to terms with and to accept. While helping them to overcome their low self-esteem, there is also the need to learn effective communication skills, a way of mastering new language. This process can be challenged not only by the feeling of low self-esteem but also by the following as expressed by Staff (2018) as obstacles to positive communication:

Perfectionism – people who are recovering from addiction are usually too hard or they put pressure on themselves to be perfect. They want to say the right thing every time and create a perfect image of themselves in the minds of others. In doing so, they forget that authentic relationships do not consist in showing off, rather, in honesty and acceptance of self and others.

Shame – Most people with addiction feel a great deal of shame, particularly in early recovery when they begin to face the consequences of their past behavior. If this is not resolved, shame can be paralyzing. Shame directs the person's focus inward, preventing them from listening attentively, being honest with themselves, and from spontaneous and full engagement in conversation.

Dishonesty – Being dishonest is a way people with addiction protect themselves from being disturbed by their loved ones. By lying and manipulating others, they can continue in their compulsive drug use or engage in their compulsive addictive behavior. In recovery, dishonesty becomes the enemy of effective communication, and of recovery itself. Developing genuine intimate relationship requires honesty.

Lack of Boundaries – People with addiction have difficulty establishing healthy boundaries. They may say yes when

they mean no; and they often trample on the rights of others. It is not uncommon for people to divulge too much information too soon and trust others without discernment in early recovery.

Aggression/Passivity – People with addiction can either be passive or aggressive in presenting their case as a form of defense mechanism. They sometimes find it difficult to maintain balance between saying something overly harsh and not saying anything at all. They may be overly passive, bottling up feelings or giving undue weight to other people's needs; overly aggressive, trampling on people's rights and trying to "win" at all costs; or passive-aggressive, conforming or trying to accommodate others on the outside but acting aggressively in subtle ways, for example saying yes but meaning no.

Effective Communication skills in addiction.

It is overtly important that dealing with addiction include improving communication skills to help repair broken or soiled relationships, building of new ones, and maintaining sobriety or staying in recovery process. Some of the communication skills necessary to maintain recovery are:

Assertiveness – This is having the ability to express positive and negative ideas and feelings in an open, honest and direct way. It involves exercising one's right without ignoring or disrespecting the rights and freedom of others. It is standing one's ground without falling on the ground.

Empathy – This is showing the other person that s/he is listened to and that their inner universe - thoughts, emotions, attitudes, values, etc. - is being understood because one can put him/herself in shoes of others to experience how it feels in the abstract sense. In this case, the person recovering from addiction can feel how others feel about them and so respond accordingly.

Self-talk – This is an internal monologue, a person's inner voice which provides a running verbal monologue of thoughts in the state of consciousness, leading to a person's sense of self. Self-talk comes naturally throughout waking hours. This is a powerful tool the person recovering from addiction can use to increasing self-confidence, self-motivation, and productive lifestyle to curb negative emotions.

Listening – It is easier to hear than to listen. Ability to listen to oneself in communication intra, can help to listen to others in communication inter. In fact, it is the key to all effective communication, and without which messages are easily misunderstood. A person with addiction may find it difficult to listen to others for the presumption that they are judgmental thereby ending up being judgmental him/herself. Learning and exploring this powerful effective communication skill can facilitate appropriate behavioral or attitudinal change which is important in recovery.

Respect – This is showing respect for other people's different opinions, talents, and abilities while effectively asserting one's views. It involves fully listening to the views of others while not becoming adamant to one's view on the same subject matter. A person with addiction can sometimes be opiniated about some people, a situation that can block communication process. Showing respect in this regard gives room to learning and change through due acceptance of people in their own uniqueness.

Reading social cues – Effective communication does not consist in just verbal communication; it also has non-

verbal components. Unspoken words which are expressed through body language, facial expressions and tone of voice are necessary in the true understanding of the information being shared. If one wants to be understood as to understand others, this aspect needs to be taken into consideration by someone in recovery.

Not too personal - Conversation with the person either actively in addiction or in recovery can sometimes be very challenging and in most cases ending up the way it is never intended with a lot of displayed anger on the parts of both parties. Therefore, it is important for the person in recovery to learn to step back and take a look at the bigger picture without taking what is said too personally. Address the issue at hand and not get caught up in the conversational drama.

Communicating with the Person with Addictive Behavior

No-one automatically knows how to talk to someone living with an addiction, according to Hartney (2019). When communicating with the person with addiction, families and friends or loved ones would likely want to say, "We acknowledge your addiction", "Our anger is directed towards your disease not you", "We are willing to support your recovery", "We care about you", "We love you", etc. (Staff, N.D.). Meaning that, as Hartney (2019) noted, it is possible that people who have lived and worked with people with addictions may have discovered effective ways to communicate. The truth is that, communication with the person with addiction is usually difficult because there are confusions created by addiction in the person with the addiction, and in those around them.

The focus and the thought of the loved ones are that they can make the person with addiction stop drinking, using drugs or stop gambling. But honestly, family and friends cannot "make" their loved ones stop drinking alcohol or use drugs or stop addictive behaviors. This is not, however, to say that no one can play a critical or significant role in addiction recovery, because family and friends do. The problem is that, in the process of making the person with addiction stop using or engaging in addictive behavior, many end up enabling them to continue in their addictive behavior, while the person with addiction continue to play the game of denial and lying. Worst still, the parent, spouse or children of the person with addiction may become co-dependent in the attempt of rescuing their loved one from addiction. The co-dependent in turn becomes 'addicted', not to destructive substance, but to destructive pattern of relating to other people (Li, 2006; Egunjobi, 2015).

To facilitate effective communication with the person with addictive behavior, certain factors are imperative. These are:

Time - What has time got to do with communication, one may ask. There is the right time and wrong time in communication, most especially in engaging in conversation with the person with addiction. Family members or concern friends should be mindful of this. Communicating or engaging in conversation with a person with addiction especially those with substance related addiction, is not to be done when the person is intoxicated. Communication cannot be effective at this time as the person with alcohol or drug addiction may not be in the right state of mind due to inappropriate neural communication which makes one susceptible to misunderstanding, misrepresentation, misconception, misinterpretation, and some sort of temporal insanity. The most suitable time to communicate

meaningfully and effectively with someone in addiction is when the person is sober or detox from alcohol and drugs or inactive from gambling or playing video game or using the internet.

Respect – communication is effective when there is respect for the person one is communicating with. It is not impossible for family members and friends to have lost respect of the person with addiction and so tend to shout, force, or feel in control of the life the person with addiction. This can really be a blockage to effective communication. Respecting and acceptance of the person with addiction help a long way. The person of the person with addiction has to be separated from drug or behavior of addiction. For addiction itself is a disease, a bug, and a possession. Remember, if you cannot respect me, I cannot have conversation with you, is the attitude of many people with addiction.

Assertiveness – There is the tendency that observing the power flow in communication which exists between the father and the son or husband and wife for example, can lead to aggression (over-assertiveness) or passivity (non-assertiveness) thereby daunting communication process. Family members and friends need to be assertive by being able to stand up for their rights in the relationship and also respecting the rights of the person with addiction in calm and positive ways, without being either aggressive, or passively accepting 'wrong' behavior (SkillsYouNeed, 2017). The family members need to get their points across without upsetting the person with addiction or becoming upset themselves. They need to take into consideration their own and other people's rights, wishes, wants, needs and desires. To be passive or non-assertive in responding to the demands or needs of the person with addiction means being in compliance with his/her wishes or undermining his/her rights and self-confidence. Being aggressive due to frustration is undermining the rights and self-esteem of the person with addiction.

Compassion – Communicating compassion or showing compassion is also known as Compassionate communication or nonviolent communication. This helps family members to remain empathetic with each other, even in situations fraught with anger or frustration as it teaches people to speak to others without blaming and to hear personal criticisms without withering (Dickinson, 2019). This also involves focusing on the other person with addiction, listen attentively, not rushing to respond, speaking well of him/her, not taking his/her responses or behavior too personal, and avoiding assumptions. Communicating compassion and offering compassionate response to the person with addiction on a deeper, more human level, address the deeper needs and greater chances of getting those needs for addiction treatment, self-care, or recovery met.

In addition to the above, the Recovery Center of America (2019) proposed 5 communication tools for alcohol addiction recovery, especially in relation to the stages that family members need to observe to communicate with the person with addiction. These I summarize as the 5-Ls which are specifically useful to communicate the necessity of treatment and recovery:

1. ***Learn.*** The first step in communicating effectively and helping a loved one to recover from addiction is learn all you can about addiction from series of sources such as books, reputable articles and websites that provide information about specific or different types of addiction. Focus should be on

the nature of the causes, effects, and treatment modalities.

2. ***Listen*** – One think that is very difficult is listening to the person with addiction. Listening involves hearing what the person with has to say as s/he explains the use of alcohol or her or his experience of addiction. Asking helpful questions to clarify and show proper understanding will be helpful as well as the willingness to support the person with addiction. For example, a concerned loved one may ask, "Is there anything I can do to make it easier for you to access treatment?" or "When our friends and family show up with alcohol, should I tell them to get rid of it?"

3. ***List.*** – From the learned and understood nature of addiction and understanding how this is affecting the person with addiction after listening, it becomes necessary to self-assess oneself to formulate how one will respond to the situation and identify one's expectations. This is done by writing a list of the addictive behaviors that one considers damaging to self, relationships, and the family. These behaviors may include for example, lying, manipulation, neglecting responsibilities, and demonstrating negative emotions. The expectations for behavioral change such as: do you expect your loved one to see an addiction counselor? Or meet with an addiction recovery center support group, are noted. The consequences that will be enacted if the person with addiction does not cooperate with the expectations are also listed.

4. ***Leave*** – This is the time to leave your guilt of feeling responsible for the addiction problem. You are not responsible for the decisions that your loved one has made, or for the behaviors over which they no longer have control. Also, leave situations that tempt you to join and participate in the addiction. Meaning that you also don't engage in addictive behaviors even if it is with moderation. Don't enable addiction by supporting the person with addiction financially to perpetual in her or his addiction.

5. ***Love*** – Love conquers all and it consists in acceptance, concern, and support. The person with addiction needs to be reassured of love and commitment to supporting her or him through addiction treatment and long-term recovery. For example, provide transportation or transport fare, attend meetings with them if acceptable, and participate in therapy, as part of your commitment to love and support.

Communication in Addiction Treatment

Communication is very vital to problem-solving situations especially when trying to solve the problem of addiction in individuals. As expressed by Choices Recovery (2018), when people stop communicating with other people due to their addiction, it becomes particularly challenging to effectively understand and express the causes of their addiction. It can also be challenging to try to get addiction help from medical or mental health professionals, or even have healthy relationships with family members and friends. These make recovery plans nearly impossible. Communicating effectively in recovery is a necessary part of the process. And the process starts from addiction specialists or mental health professionals in addiction treatment communicating genuineness, compassion, empathy, and unconditional regards to the persons with addiction.

Beginning from screening stage, to intake and, of course, assessment, the addiction counselor need to relate with the person with addiction in such a way that therapeutic communication is involved; and to the extent that the whole process enhances communication and provider-patient relationship, with client-centered interviewing producing the relevant biopsychosocial reality of each client at each visit (Smith, 2002; Egunjobi, 2016). In this case, the needs of the persons with addiction such as their interests, concerns, questions, ideas, and requests, are met.

The addiction counselor as a teacher and coach, develops a positive relationship with the person with addiction in order to promote behavioral change. This means that by promoting respect, dignity, and self-worth in the person with addiction, who already avoids confrontational communication (Elkins, 2018), the addiction counselor is able to create learning environment for the person with addiction communicate respect, dignity, and self-worth to her/himself and others.

It is imperative for the addiction counselors to exhibit and teach people in recovery from addiction strategies and skills for improving communication and the living environment. This tasks also extends to creating an environment to teach the concerned family members and friends or their caregivers problem-solving skills, communication techniques and other tools for promoting recovery of their loved ones (Elkins, 2018).

Conclusion

Addiction affects every aspect of person's personal and relational life. Getting in touch with oneself and others become very challenging. Understanding addiction from the integrated biopsychosocial-spiritual factors and exploring the same factors in dealing with the persons with addiction within the family setting and in treatment or recovery during the intake and assessment will lead to considerable effective communication leading to appropriate treatment plans and intervention which focus on the holistic treatment of the total person (Egunjobi, 2016)

The importance of effective communication in the understanding and treatment of addiction as well as in interacting with the person with addiction cannot be overlooked. In fact, addiction can be explained from the understanding of effective communication as addiction can be caused and can impact on intra and inter communication. It may not be wrong to define addiction as inadequacies caused by alcohol and drugs in neural communication (communication intra) resulting in defective and ineffective communication inter patterns through isolation, manipulation, and denial. Treating addiction will involve learning to communicate effectively and the addiction professionals and family members doing the same.

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Hierarchy of Help Model in Addiction

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Abstract

People suffering from addiction are usually conceived as living in denial of their addiction and are not usually ready to be helped. In contrary, the Hierarchy of Help Model by Joyzy Pius Egunjobi shows that persons with addiction do make effort to help themselves before seeking the help of others. The Hierarchy of Help Model is presented with the four hierarchical stages and in relations the Transtheoretical Model or Stages of Change Model of James O. Prochaska and Carlo DiClemente. The two models are integrated to foster better understanding of help seeking and stages of change in addiction treatment. This work concluded that the people with addiction ask for help not because they have not tried to help themselves. They ask for help because they are aware that they cannot do this on their own. Blaming, nagging, and scolding are not what they need supports and encouragements.

Keywords: *Addiction, Help Seeking, Self-help, Hierarchy of Help, Stages of change*

Introduction

People with addiction are generally thought of as living in denial, careless, and carefree. They are perceived to be in denial of the problem of addiction and in denial that they have resources to help themselves. Hence, a person with addiction rarely seeks help because s/he is seen as not knowing s/he have a problem. Far from this perception, persons with adddiction, be it, alcohol, drugs, or behavioral (sex, gambling, work, etc.) do make efforts to quit the alcohol, substance of abuse and addiction, or stop the addictive behavior. They do desire to be clean and sober; but the hold of addiction may be too strong that they can't just let loose of themselves. The truth is that, addiction is an obsessive, compulsive, possession. It takes over the total person's biopsychosociotechno-spiritual life; making the person feel helpless. The feeling of helplessness can make the person with addiction sink more into her/his addiction. Yet, help is available, but it is not automatic. Help for a person with addiction is in stages of hierarchical nature. It is the help that is likely to begin with the "self", that is, with the person with addiction and ends with surrendering to fate.

This study exposes the Hierarchy of Help Model (HHM) as developed by Joyzy Pius Egunjobi (2014a), compares it, in an integrative manner, with the Transtheoretical Model (TTM) developed by Prochaska and DiClemente (1977), and relates the integrative model to help seeking and stages of change in addiction treatment.

Purpose

The purpose of this review is to present the key idea of the Hierarchy of Help Model (HHM), to bring into awareness that the person with addiction do recognize that

they have problems and do need help, and relates the Hierarchy of Help Model with the Transtheoretical Model in an integrative manner.

Background

Addiction is seen from different perspectives and as such has many definitions. American Society of Addiction Medicine (ASAM, 2019) defines addiction as a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. It is a chronically relapsing disorder characterized by: (a) compulsion to seek and take the drug, (b) loss of control in limiting intake, and (c) emergence of a negative emotional state (e.g., dysphoria, anxiety, irritability) when access to the drug is prevented (Koob & Simon, 2009).

As a brain disease, it has physical, mental/emotional, moral/criminal, and sinful effects or consequences. This means that the consequences can be biopsychosociotechno-spiritual in nature such as causing medical condition, psychological disorders, disconnection in human relationship and loss of job, obsession with technological devices, and loss of meaning and purpose in life.

No one wants to get addicted to anything or anyone. Addiction is a progressive brain disorder. Although everyone's path to addiction (Alcohol and other drugs -AOD or behavioral) is different, all AOD and behavioral addictions has to do with stunning increased levels of brain chemical called dopamine (Sheikh, 2017). Dopamine associated with the reinforcing effects of drugs of abuse, for example, and that the faster the increases in dopamine to cause the feeling of pleasure, the more intense the reinforcing effects (Volkow et al., 2007).

However, addiction is only the brain disease, it can be genetically and environmentally factored. For example, twin and family studies have been found to show that there are critical genetic and environmental components in the inheritance of substance use disorders, and modern genetics studies have identified specific variants that may predispose an individual to these disorders (Meyers & Dick, 2010). Due to the multifaceted components of addiction, treatment can be complex as the kind of treatment that works for one person with addiction may not work with another even when they are addicted to the same substance or behavior. These also account for what may some people to easily seek help and others find it difficult to seek help.

Help Seeking

Help seeking can be defined as efforts made to maximize wellness or to ameliorate, mitigate, or eliminate distress (Saint Arnault, 2009). It can also be conceptualized as steps taken to purposefully find solution or correct certain behaviors such as maladaptive or addictive behaviors. Viewing addiction as a chronically relapsing brain disease (NIDA, 2020) presupposes the possibility that no matter how well the person with addiction has tried, there will most likely be an episode of lapse or relapse. This means that the person with addiction may have engaged in self-help or have been helped to maintain abstinence by others. Whatever the help, the person with addiction is particularly important in the helping process. No doubt, we all will experience tough times in our lives at one time or the other and going through difficult life situations alone can be stressful, confusing, and exhausting. Although, one may be able to solve some personal problems, sometimes the problems may require other's assistance. Seeking assistance from family, friends and or others can really be supportive to achieving the goal of help seeking.

To help a loved one who is struggling with AOD or behavioral addiction is often a long and heartbreaking journey. This can sometimes be so overwhelming that ignoring the situation may seem like an easier solution (Bockisch, 2020). Helping the person with addiction isn't easy, that there's no magical formula that will get him/her to treatment. According to Ackermann (2020), addiction is a condition that the individual person with addiction must learn to manage as no one can take the fight on for the person with addiction. It is important that the person first recognize that has an addictive disorder, be ready and willing to address the addiction before recovery can even begin. In a nutshell, change is possible.

Stages of Change

In 1977, James O. Prochaska and Carlo DiClemente developed Stages of Change Model also known as the Transtheoretical Model (TTM) (Prochaska & DiClemente, 2005). This model is an integrative, biopsychosocial model to conceptualize the process of intentional behavior change. Stages of Change Model evolved through studies examining smokers who quit on their own and smokers requiring further treatment in order to understand why some people can quit smoking on their own and some others cannot. These were attempts to understand why some people are able to quit smoking on their own and some others not. It was found out that people quit smoking if they were ready to do so (LaMorte, 2019). In other words, changing a behavior is not an accident but a process with different people at different stages of change and readiness; moving through the five stages: precontemplation, contemplation, preparation, action, and maintenance (Prochaska & Diclemente, 1982). Thus, the 1983 version of the model was later modified to include Termination stage in the 1992 version of the model. This made the sixth stage.

Precontemplation – The person with addiction at this stage do not intend to take action to change either now or in the next six months. S/he may be uninformed or under informed about the consequences of her/his addictive behavior which makes the person to remain in the Precontemplation stage. This person may have made multiple unsuccessful attempts to change leading to feeling of hopelessness or discouragement her/his addiction. This person can sometimes be described as resistant, unprepared, unenthusiastic for help.

Contemplation – The person with addiction at this stage is aware of the damages or consequences of his addictive behaviors as the benefit of change. Hence, s/he intends to change in the next six months. However, this person may remain in this stage for a long time if s/he becomes ambivalent due to persistent consideration of the consequences and benefits of changing. Procrastination is common

Preparation – At this stage, the person with addiction plans to action in the within the next month. S/he has a plan of action, such as finding resources or consulting family members, friends, or professionals on the best option to treatment.

Action – This stage is evident when the person with addiction has made specific blatant behavioral adjustments within the past six months. S/he is making a conscious effort to stay clean and sober with observable acceptable lifestyle.

Maintenance – This stage continues from the action stage beginning from six months of successful stable action stage where the person with addiction has become confident and less threatened by relapse. Although s/he may be less tempted to relapse and grow increasingly more confident that they can

continue their changes, some research show that maintenance lasts from six months to about five years.

Termination – The person with addiction has no temptation to relapse has s/he is self-aware and possesses healthy coping skills to disallow returning to the old unhealthy addictive behavior.

The Transtheoretical Model was based on the assumptions that (Prochaska, Redding, & Evers, 2008):

1. No single theory can account for all complexities of behavior change. A more comprehensive model is most likely to emerge from integration across major theories.

2. Behavior change is a process that unfolds over time through a sequence of stages.

3. Stages are both stable and open to change, just as chronic behavioral risk factors are stable and open to change.

4. The majority of at-risk populations are not prepared for action and will not be served effectively by traditional action-oriented behavior change programs.

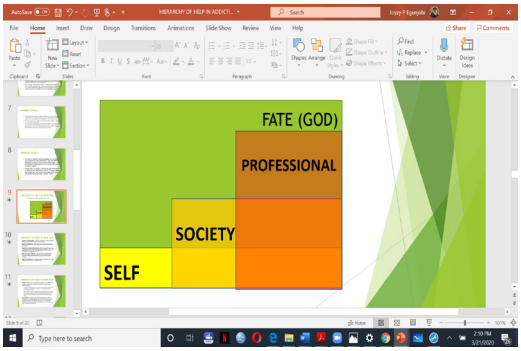
5. Specific processes and principles of change should be emphasized at specific stages to maximize efficacy.

Transtheoretical Model recognizes that the individual with addiction or any other problem needs to be self-aware and be ready to take action in order to navigate the stages of change. Of course, these stages revolve around the person who needed help and not the helpers. This same idea was projected by Ginsburg (2014) in his educational Hierarchy of Help in which he stated that students need to work independently first, using all available resources before consulting or collaborating with group members if necessary, and finally, summoning the teacher when all members of the group have exhausted their resources and are still stuck. It all boils to the face that an individual is important in helping her/himself as well as having inner resources to facilitate her/his own help. When s/he has tried and unable to self-help, s/he can now seek external resources which are also ranked in the other of their resourcefulness and expertise.

The Hierarchy of Help Model

The Hierarchy of Help Model was developed from a Relapse Prevention class presentation by Egunjobi (2014a) at the California State University, East Bay, Hayward, CA, USA where he opined that people struggling with addiction do make efforts to self-help. Human experiences show that the persons with addiction can sometimes be too weak trying to do things by themselves. When there is a problem, they often look beyond of themselves to find solution; yet, the solution is right within them. The truth is that helping someone without the person's willingness or cooperation can be difficult. In other words, no one can help you without you. That is why in Figure 1, the SELF is present and involved in all the involvement of others: Society/Community, Professional, and Fate (Transcendence/God), in helping one.

Figure 1 Hierarchy of Help Model



Source: Egunjobi (2014a)

Help-seeking can be categorized into four hierarchical stages: Self-help; Relational Help; Professional Help and Transcendental Help.

Self Help [Self] - Before someone seeks help, one tries to help him/herself. In solving problems, an individual is an expert about his or her own life; for everyone has the inner resources to resolve issues concerning him/herself, and or finding solution to his/her problem (Egunjobi, 2014b). Moreover, Carl Rogers, as cited by Hopper (2018), is believed to hold that, it is the client who knows where it hurts, what directions to go, what problems are crucial, and what experiences have been deeply buried. For no one understands a person better than him/herself. Furthermore, "the client who sees his problem as involving his relationships, and who feels that he contributes to this problem and wants to change it, is likely to be successful" (Rogers, 1957, p. 101). Notwithstanding, there may be some personal issues that one lacks the understanding of, or confused about, that may require assistance. Hence, the expert client is found in therapy seeking clarity of another expert. One helps himself brushing the mouth, yet it takes others to perceive the smelling mouth, not the self. Yet, there is nothing to perceive if the person does not make the mouth available.

Relational Help [Society] – Often times, when someone is unable to solve his/her problems, there is the possible move to consult with a trusted person who may be a member of one's family, a friend or a colleague. In other words, one seeks help of another/others – father, mother, brother or sister, friends, peer etc. However, it is not easy to seek help; seeking help requires incredible courage and strength. It requires humility, openness, and honesty to oneself. The trusted person may help one to understand and resolve what seems problematic. The trusted person is sometimes considered as more knowledgeable or wiser. Notwithstanding, this person may equally be incapable of solving the problem. Referral to a more knowledgeable may be necessary. Also, the person needing help may jump the scale from seeking the help of a significant other to the expert in the area of the problem, when he or she finds him/herself incapable of solving the problem.

Professional Help [Professional] – When family and friends find themselves inadequate or incapable of alleviating the problem of the help-seeker, professional assistance may be sought in the related area of the problem. According to Mental Health America (n.d), the process of finding professional help includes:

a. Obtain names of mental health professionals from your doctor, friends, clergy or local Mental Health America affiliate, and from workplace employee assistance program (if available).

b. Interview more than one professional before choosing the one who one feels comfortable with.

c. You can see a psychologist, psychiatrist, social worker, pastoral

counselor or other type of mental health professional. Of these, only a psychiatrist can prescribe medication.

In other words, a physician in the medical related problems, psychiatrist, psychologist, or counselor in mental health related challenges, a community elder in the socio-cultural related issues, an engineer in the technological related problem, and a clergy or guru in the concerns relating to individual religion/spirituality. In some instances, the professional may also be unable to understand the situation or resolve whatever the situation is. Depending on the type of problem, intervention may be unproductive without the openness, sincerity and cooperation of the person seeking help.

Transcendental Help [Fate/God] -When an individual is unable to self-help, family and friends have no skill and expertise to help, and the expert fails, the situation is left to fate. Fate, according to Merriam Webster Dictionary, is "the will or principle or determining cause by which things in general are believed to come to be as they are or events to happen as they do" Fate involves finding meaning and purpose in the situation outside one's control yet not outside of one's reach. This is when the solution rests between oneself and his/her fate (faith). Miracle which depends on the person's belief happens at this stage. Hence, one can say, I am the master of my fate and the captain of my destiny (Bloom, 2014). Fate stage can also be the moment of finding a sustained answer to the question or solution to the problem and breaking the chain of hopelessness.

Although, these stages are in hierarchical order, they are not linear. A stage or two can be skipped as well as two or more stages can co-occur. This means that it is possible for the one who seeks help, after trying by him/herself to no avail to skip the relational help and proceed directly to seeking professional help. Also, while the person is making personal effort to overcome the ordeal, she or he may at the same time be seeking relational and professional help while not excluding leaving everything to fate.

Transtheoretical Model and The Hierarchy of Help Model

Understanding the Transtheoretical Model (Prochaska et. al., 1994) can shed more light in the understanding of the Hierarchy of Help Model, as the stages of change focuses on the decision-making of the individual struggling to get help. In the transtheoretical model, change is considered a process involving progress through a series of stages (Prochaska & Velicer, 1997). These six stages of TTM are integrated with the four hierarchical stages of help.

Stage One: Pre-contemplation – Persons with addiction do not think seriously about changing and may not be interested in anyone's intervention or any kind of help. In the hierarchy of help, this stage is a zero level of no personal need for help and of no desire to do so.

Stage Two: Contemplation – At this stage persons with addiction tend to be aware of the personal consequences of their addictive behavior and they spend time thinking about their problem. This stage occurs within the 'self-help' as characterized by internal struggle to change. Help here is within.

Stage Three: Preparation/Determination – At this change, people with addiction have made a commitment to self to make a change. Their motivation for changing is reflected by statements such as: "I've got to do something about this", "This is serious", "Something must change", "What can I do?" In the hierarchy of help, the person with addiction goes beyond self-exploration

and self-help to seeking the guidance and assistance of family members and friends. Other available resources in the community are sought, and inquiries about available treatment modalities are also made.

Stage Four: Action/Willpower - This is the stage where people believe they can change their addictive behavior and are actively involved in taking steps to change by utilizing a variety of treatment modalities. This stage, from hierarchy of help model perspective, is characterized by reception of professional assistance either in form of personal therapy, using medication to target withdrawal symptoms in order to stay clean and sober, or undergoing treatment in the rehabilitation facility. The person with addiction willfully and consciously undergoes treatment and is in full cooperation with the treatment program employed.

Stage Five: Maintenance – This stage occurs after completing treatment and it involves being able to avoid any temptations to return to the addictive behavior. The maintenance stage from the hierarchy of help understanding, combines the professional stage and fate stage where the person with addiction partakes in support group and in community activities. S/he lives to discover more and more the purpose for her/his existence, and being mindful of her/his thoughts, feelings, and behaviors; avoiding every occasion that triggers and results in relapse.

Stage Six: Termination – At this stage, the person with addiction displays minimal to zero tolerance for compulsion and are almost very sure they will not return to their old unhealthy addictive habit. Although, life experiences show that this stage is difficult to predict as someone who has been sober for 30 or more years can relapse. This is the Fate (God) stage in the hierarchy of help. Being in this stage also does not mean that one cannot relapse. The reality here is that, relapse is not failure; for if one does not know what it is to lapse, s/he may not know what it is to recover. The fall, lapse, or relapse is a signal and a pointer to stand better erect in avoiding the triggers. The Fate stage can constitute both positive and negative experiences. Positive if one experiences transcendency where fall is impossible. Negative if one experiences several relapses with the hope for divine intervention.

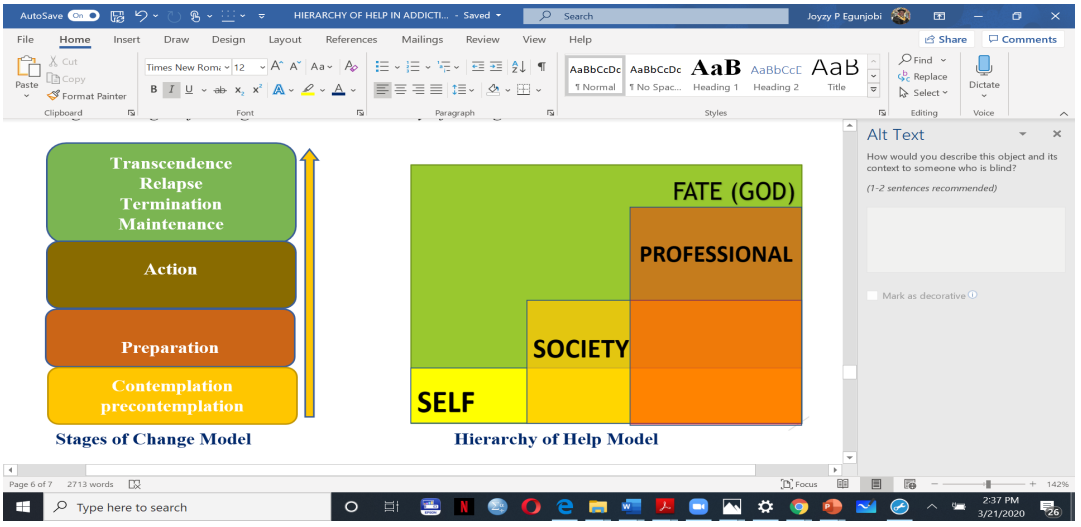
Although, there are six stages in the TTM as developed by Prochaska and DiClemente (1977), Relapse, and Transcendence were later added.

Relapse: - This stage was conceptualized by researchers as a recycling stage when a recovering person with addiction returns from either Action or Maintenance stage to an earlier stage (Prochaska & Velicer, 1997). Relapse is often accompanied by feelings of discouragement and seeing oneself as a failure. Mostly driven with lack of biopsychosocial-spiritual integration, it occurs when a person who has gone through treatment and has been in recovery goes back to drinking alcohol or using drugs. Modern addiction science, however, do not see this as a failure. Relapse is seen by some as part of recovery, or better viewed as an unfortunate part of the lifelong recovery process (O'Leary, 2016). Relapse is not a single event of the person with addiction going back to drinking or using, rather a setback along the road to recovery. In the hierarchy of help, relapse puts the professional, society, and the self, in the state of helplessness. Not necessarily a failure but a reality of the nature of addiction which reveals itself as an obsessive, compulsive, possession. Only the divine in the transcendence stage, can help.

Transcendence – This stage is not part of the Prochaska-DiClemente Stages of Change model. It is a stage known as maintaining maintenance. Kern (2008) added transcendence to Prochaska-DiClemente States of Change Model to explain the stage when the people with addiction reach a point where they are able to work with their thoughts and emotions, and understand their behaviors and view it in a new light. It is a transcendence to a new life; a period of biopsychosocial-spiritual healing. The persons with addiction have developed a sense of purpose and meaning and are connected and in touch with themselves, their families, friends, and treatment communities, as well as with their God. This is when they are totally free. This is the highest point of recovery where the person with addiction has truly recovered by becoming truly one with the treatment.

The relationship between Stages of Change Model and Hierarchy of change model is expressed in Figure 2. Of course, while stages of change focuses on the process by which people overcome addiction, the hierarchy of help claims that the person with addiction do make steps to seeking help beginning from personal effort, to either the supports of family, friends, and professionals, or/and finally handing everything to fate in struggles and freedom. Notwithstanding, both Stages of Change Model and Hierarchy of Help Model are focused on how people with addiction move on the ladder of change.

Figure 2 Stages of Change Model and Hierarchy of Help Model



Source: Researcher (2014)

Discussion

Change is possible for those who seek help and that change also begins from self. Helping a person with addiction requires the person's willingness, cooperation and collaboration. Addiction is a complex biopsychosocio-spiritual disease which requires a holistic approach to treatment. The assumption is that the severity or seriousness of addiction makes it difficult to treat. Hence the person with addiction who is in recovery is (somehow) expected to relapse. The belief that has made some people to see addiction as not curable

rather, treatable. Of course, from disease model of addiction, it may be considered incurable. Hence, a statement such as "an addict is always an addict". What this means is that means that once a person has been addicted to a substance s/he will always be at risk of further addiction or at risk of relapse. Yet, the National Alcohol Longitudinal Epidemiologic Survey in 1992 show that 16% of people with alcoholism recovered without any treatment (Dawson, 1996). A study also reveal that drinkers were able to walk away from alcoholism out of their own volition through the use of their willpower coupled with developing a physical aversion to alcohol after bottoming out, and experiencing some kind of life-changing experience (American Addiction Centers, 2020).

If the family and friends do not understand the nature of addiction and are unable to separate the addiction from the nature of the person, they may not be able to offer effective support. In the first place, they will not be able to recognize the inner strength of the person with addiction. This is the reason many family members, friends, and colleagues get frustrated with the person with addiction. The frustration comes from trying to help someone who they perceived as not willing or seeking help; trying to help without involving the person with addiction. The frustration experienced do make family and friends feel helpless to require expert's intervention not only for the person with addiction but also for themselves.

On expert or professional level, the person with addiction is offered treatment. A reasonable treatment should begin by assessing the willingness of the person with addiction. Although, this may be a difficult task as many persons with addiction are in denial of their addiction. Even those who return to treatment after a period of abstinence or sobriety, may not be willing to be in treatment as they may believe that the family and friends are rather nagging instead of supporting and encouraging them. Professionals may use Medical Assisted Treatment (MAT), Talk Therapy (Psychotherapy/Counseling), Rehabilitation, or the combination of the three in the treatment. The success of the treatment is not necessarily on the treatment modality, or the expertise of the professional, rather, on the cooperation of the person with addiction. Although, different types of addiction as well as the object of addiction have different influences on the treatment success rates. Success rate, however, is not necessarily determined by treatment program completion. Rather, success rate is determined by the lifestyle of the person with addiction after treatment. For there are those who relapse on the very day of treatment program completion, some within a few weeks of treatment completion, and some other, months or years after.

The self is as present as the Fate (Figure 1), that whatever step is taken to seeking help, it is within Fate. Fate is only influential on the Self because the Self is in cooperation. Hence it is said, the gods will not do for man what man cannot do for himself (The Odyssey Quotes, n.d.); and the gods are only able to help the man only when man is helpless. Again, the Fate and the Self are present and without whom help may be difficult. However, while the self is limited to self, and only available to the society and the professional, Fate is over and covers all.

Conclusion

People with addiction may be in denial, but this does not mean that they do not recognize that they have problem which requires change. The fact that they are still drinking alcohol, using drugs, or still engaging in the same addictive behavior does not mean that they are not trying to

take care of the problem themselves. Self-help is usually the beginning before seeking the help of a close member of the family, friend or a professional. When, they ask for help, it is because they have not tried. They ask for help because they are aware that they cannot do this on their own. Blaming, nagging, and scolding are not what they need rather, support and encouragement. They are to be seen as human being before their addiction. Hence, being referred to as people with addiction rather than the addicts. Addiction is not an easily treated disease, as such, gaining the trust and confidence of the person with addiction is very important. Addiction is not about the alcohol, the heroine, the internet, then pornography, the shopping, the prayer etc., addiction is all about the relationship that the person with addiction formed with the object of addiction. To support the persons with the addiction, forming healthy relationship with them without enabling the addictive spirit is all that matters. No one can help you without you; even God needs you to help you. This is the point the Hierarchy of Help Model expresses.

Recommendations

1. Addiction Counselors should focus on acknowledging and bringing out the inner strength/resources of the person with addiction in treatment
2. Families, friends, and caregivers should acknowledge the efforts of the person with addiction rather than blaming, nagging, and discouraging.
3. Empirical studies are required to investigate the parts played by the person with addiction in her/his recovery
4. Empirical studies are needed to investigate the hierarchical relationships between the stages of the Hierarch of Help Model

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