Thesis

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Drug addiction and social rehabilitation: a case study of Lagos, Nigeria

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DRUG ADDICTION AND SOCIAL REHABILITATION: A CASE STUDY OF LAGOS, NIGERIA.

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A THESIS IN THE DEPARTMENT OF SOCIOLOGY SUBMITTED TO THE FACULTY OF THE SOCIAL SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY OF THE UNIVERSITY OF IBADAN.

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DEDICATION.

This thesis is dedicated to NKIRU.

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CERTIFICATION

I certify that Emeka Emmanuel Obioha carried out this Project in the Department of Sociology University of Ibadan.

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ABSTRACT

Existing literature shows that drug addiction is one of the contemporary social problems in the Nigerian society. There is persistent increase in the number of drug addicts who need rehabilitation, and those who have undergone rehabilitation without much success in our society. This indicates that much ground is yet to be covered in drug addiction studies in Nigeria. The scenario further suggests that there is little understanding of the factors related to the problem of drug addiction and successful rehabilitation. Most of the existing literature lack information on the interface between drug addiction and sustainable care and support programmes in Nigeria, especially from sociological and anthropological perspective. Against this background, the main objectives of this study are to describe the patterns of drug addiction, to describe the initiation processes, and to identify the social background factors influencing patterns of drug addiction. The study also examines the existing rehabilitation opportunities and their effectiveness, the response of the drug addicts under rehabilitation, and the obstacles hindering the rehabilitation processes.

This study focuses on drug addicts who seek care in psychiatric, social welfare, and faith-based rehabilitation centres in Lagos. The study makes use of a

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sample size of 430 subjects proportionately selected from some chosen centres. The questionnaire schedule, in-depth interview guide, key informant interview guide, and observations are the instruments of data collection. The study adopts the Discriminant Analysis, Independent Samples Test (T-Test) One Way Analysis of Variance (ANOVA), Chi-square test, and Logistic Regression for comparative and inferential purposes in the quantitative data analyses, and content analysis for the qualitative data sorting.

The major findings of this study using the Discriminant model are first, that there are two patterns of drug addiction, namely "Progressive addiction" and "Stable hard addiction". The first connote a process starting from the use of soft drugs to the hard drug, while the latter involves initiation into drug use with hard drug without a shift in later usage. Second, drug addiction mainly begins with soft drugs and ends up with the hard drugs. This confirms the stepping stone theory of drug addiction. Involvement in drug use starts at a mean age of 16years, while average ages of 16 and 24 are for the progressive and stable hard addiction respectively. The study also found that peer group is the major source of introduction to drug use followed by self-experimentation. The discriminant model also reveals that family discipline, family stability, location of residence,

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criminality, family size, parental social status, parental supervision and family affection are significant social background factors influencing pattern of drug addiction. Economic and social life problems, especially breakdown on work and familial relationship are found to be prominent in the period of drug addiction. The study further reveals the importance of family members as the major sources of referral to the rehabilitation. However, the chi-square test of difference shows that faith-based rehabilitation approach is the most effective system of rehabilitating the drug addicts over the social welfare, and psychiatric centres. In addition, a significant relationship is found between category of addiction and adjustment pattern. Comparatively the progressive addiction is found to be more difficult to manage than the stable hard addiction. Using the Logistic Regression Model in assessing the contribution of selected socio-demographic, drug history, and rehabilitation variables, only method of rehabilitation and category of addiction have impact on clients' adjustment pattern in the drug rehabilitation centres. Sex, age, age at first drug use, rehabilitation residence status, among others do not have any significant impact in the model.

These results have implications for sustainable, care and support programmes for drug addicts in Nigeria. These further show the influence of drug

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history and social background contexts on drug addiction, which is an important clue for designing a successful rehabilitation Programme. Programmes should therefore be designed to accommodate these individual and group differences. The study also suggests a comprehensive social rehabilitation approach that will involve the integration of the faith-based, social welfare, and psychiatric approaches in one process. Finally, civil society organizations should be encouraged through enabling legislation in participating in worthwhile effort.

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CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 INTRODUCTION

"Drug" has been a subject of multidisciplinary study by various scholars in the field of sociology, and other related areas in the social sciences, medicine and law. The substance "drug" has no single definition. It is any substance that modifies one or more chemical functions in the body of a living organism when introduced to it. Implicitly, by its chemical nature drug can affect the structure and functions of a living organism (WHO 1969; Nwolis, 1982). Conceptually, substances referred to as drugs have some useful and medicinal purposes when processed. Originally they are non-medicinal and are consumed by man in various parts of the world not for the medicinal purpose but for the sensation, which they produce. They have psychoactive properties, which produce stimulation or depression of the central nervous system, by altering the mood, thought and behaviour that usually lead persons to a state of dependency or invalidity. The dependent potency of these substances makes them dangerous to human consumption in the society (Domenighim and Bellusi, 1991). The United Nations Convention of 1961 and 1971

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prohibits the substances classified as dangerous. Those so categorized are marijuana, cocaine, heroin, and opium, among others. There are other socially accepted ones such as alcohol and tobacco that are not prohibited, but are controlled by laws and conventions. The former and the later are referred to as hard and soft drugs respectively.

Drugs are used for various useful purposes in different societies. These include relief of pains, spiritual incantations and religious practices (Gossop, 1991). It is hard to trace for certainty when the use of drugs started in human society. But some historical and archaeological evidences have provided insight in this regard. The use of stimulants and sedatives dates back to human history with fermentation being one of the earliest discoveries predating the fashioning of metal. This was revealed in the archeological discovery in one of the pre-historic sites in China, where strands for marijuana plants embedded in Chinese pottery dated over ten thousand years were excavated (Abel, 1980).

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In spite of this evidence, when man started using stimulants and sedatives to alter his consciousness, reduce stress and combat anxiety is not yet certain. What is known is the fact that ingestion of mind-altering substances is a human, universal and practical phenomenon (Kuper and Kuper, 1996). Human beings have

discovered several intoxicants in several ancient societies, for instance, the Incas of Peru used Coca as part of troop ration because of its lightweight and capacity to deaden the effects of hunger and fatigue. Also, the Indians of south west of United States have used Peyote kites, a form of tea to induce religious trance (Olaniyan, 1991). However, drugs are naturally beneficial to mankind when administered properly. Drugs in themselves are not something evil rather it is their abuse that is evil and dangerous to societies.

Abuse of drugs is conceived among human societies as a deviance, a social problem and a teleological force in social disorganization in some societies since earliest times in history. Because of this dysfunction, no society and culture had been permissive of excessive use or misuse of drugs. The illicit use of substances of psychoactive properties entails a violation of morals, norms and values prescribed by various cultures as in the traditional societies and breakage of laws and decrees in the modern societies. For instance, it is criminal and an offence punishable by imprisonment in Nigeria to use dangerous drugs as stipulated in Indian Hemp Act of 1966 and Decree No. 20, 1984. The imprisonment ranges from six months to life duration in the legal framework and provisions of Decree 48, 1989, (Olaniyan 1991, and Odejide, 1998).

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Through recorded history, the phenomenon of abuse of social drugs manifesting in behavioural disorder can be traced to the earliest times in the history of man in connection with the "ordinary drug use", which makes it an early universal and sociological problem. The Holy Bible in Genesis 9: 20 – 21 demonstrated the antiquity of drug addiction problem by indicating the production and misuse of intoxicant by Noah, which resulted in some far-reaching behavioural dysfunction.

In recent decades, precisely over twenty years now, the abuse of drugs has spread at an unprecedented rate and has reached every part of the world. The problem has taken a different dimension, perhaps towards an epidemic proportion (Hochman 1972, Mazzitelli 1996). Most drug abusers are young, poor or both. No nation is immuned from the devastating consequences of drug abuse and illicit trafficking; an upsurge in crime, violence and corruption; the draining of human, financial and other resources that might otherwise be used for social and economic development (Ghali, in Drug Abuse 1992:1). Drug abuse is tearing apart human societies, spawning crime, spreading diseases such as AIDS, and killing the youth and the future. There are estimated 190 million drug users around the world (Annan Kofi: United Nations Secretary General cited in Awake 1999:3), which is one way

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in, which the malaise of a confused and disordered society is expressed. It is also very often intricately interlinked with various other manifestations of suffering or failure to adapt, suicide, delinquency, violence and rejection of all integration into schools or working life among the youths (UNESCO, 1987:13).

The whole society pays for the misfortune of drug problem among a minority set of its people. The drug users make streets unsafe for others. Through the influence of drugs, accidents become very frequent, and the neighbourhood perceived as unsafe for peaceful habitation due to crime and violence. This is because drug users often resort to crime or prostitution to finance their habit, while rival gangs fight and kill to maintain control over drug distribution and trade (Awake, 1999: 5). The concern for the increasing incidence of drug abuse in Nigerian cities, which is similar to the scenario in other nations of the world, and the need to formulate solutions in this regard, largely motivate this study.

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1.2 OVERVIEW OF DRUG ABUSE PROBLEM IN NIGERIA

The literature on drug abuse in Nigeria includes policy statements by government officials which by and large follow the line set by international organizations created to design counter measures to drug consumption. Much attention has also

been on psychiatric issues in drug abuse. At this present stage, the debate should revolve largely around sociological and anthropological dimensions of drug abuse, the effectiveness of different preventive strategies, control programmes, and the performance evaluation of care agencies. Scholars should also bewail the perversion of moral values in Nigeria, which is a result of drug abuse among other factors, and pay substantial attention to the popular culture in which the drugs are used. This could be done by proffering factors that could lead to such situation and possible solutions. The above observations have been given theoretical explanation from sociological point of view by few Nigerian scholars among whom the work of Oloruntimehin, (1990) is very outstanding, and viable.

The abuse of drugs in its entirety is not alien to the Nigerian culture. Intoxicating substances (alcohols) have been in production and use in the country before the colonial times. The use of stimulants such as palm-wine and kola nuts are well established part of everyday life in Southern Nigeria which definitely predated external contacts (Klein, 1994). The existence of this hedonistic value in alcohol in Nigeria created an already made market found for distilled spirits and later tobacco brought by European merchants trading on the Atlantic West coast during the era of legitimate trade. From then on started the heavy internal consumption of both

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foreign and locally made spirits and tobacco. The presence of hard drugs was not yet felt then as the ones already in use were regarded as "soft" or "socially accepted". It was not until the end of the World War II that the consumption and cultivation of Indian hemp was introduced in Nigeria (Borrofka, 1966).

The effective use of hard drugs in Nigeria may well be identified with the years immediately after the termination of the Second World War. Nigerians who served with the British forces in Asia during the world war brought back Indian hemp into the country on their return. The substance was then cultivated on small scale, which induced local consumption that was descriptively negligible in the population (Olaniyan, 1992). In the 1960's as the cultivation of the Indian hemp intensified after independence, the local consumption rate also rose drastically among youths. Some of the excess products from the local farms were exported to Great Britain. Within a short span of years, particularly from the period of the Nigerian civil war and the petroleum oil boom period, there had been a witnessed galloping increase in the use of marijuana (Ndika, 1986).

The Nigerian population was not yet well introduced to the use of other hard drugs until 1980's when the country was caught up in the web of international drug triangle. Since then, Nigeria has become a major importer of cocaine and heroin,

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including by-products of the refinement process. Until recently, conventional wisdom had it that Nigeria merely serves as a transit point for the dangerous cargoes from where the drugs are re-exported to other parts of the world (Chukkol, 1990). The assumption had been that the internal consumption of the substance is close to non-existence as there was lack of evidence of any refinement capacity, and no history of coca or other narcotic cultivation in the country.

However, the use of cocaine, which is in epidemic phase, would have spread to Nigeria by the[1] *Beentos* or [2]*Lebanese* merchants. There is evidence that some Nigerians first acquired the habit of taking hard drugs during periods of their study or their vacations abroad. Through the networks of friends and circles of followers these habits soon spread to other sections of the urban community where it retained nimbus of sophistication (Klein, 1994). Although this viewpoint is one of the strongest hypotheses on the introduction of hard drugs into Nigeria, the position of Nigeria as a transit point in the international drug trade and the involvement of Nigerian businessmen in the trade cannot be underestimated. While it remains true that most cocaine/heroine arriving in Nigeria is smuggled onwards to the lucrative

[1] Beentos are Nigerians that were in overseas countries for their studies or business.
[2] Lebanees are natives of Lebanon, but Nigerians sometimes use the name in identifying Arabians and natives of Indian sub continent.

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markets of Western Europe, the United States, and elsewhere, a considerable amount is consumed by a rapidly growing number of local drug users. Such developments have parallels in other producer countries with history of internal consumption, including those with centre for the refinement process (Gillis, 1990; Odejide, 1998).

Drug use in Nigeria is like that of any other nation with such problem, especially with drug trade. Though a latent demand preceded availability, these drugs spread with surprising rapidity across the entire social spectrum once brought to market (Klein, 1994). Evidence abounds on the rate of spread of illicit drug consumption in Nigeria, especially in the urban areas (Raza, 2000). Estimated populations of 3–5 million Nigerians have used marijuana at least once, (Kalunta in Olabiran, 1990). Other previous studies showed that drug abuse problem spares no community, no social class, age, sex, and ethnic leaning in Nigeria (ICAA 1989; NDLEA, 1992; Obot 1993; and Odejide, et al. 1993; 1996). These studies present a previously unknown phenomenon at least, so far as its dimension is concerned. For instance, the NDLEA's study showed the preponderance of adolescents and young adults involvement in the illicit behaviour. Information with regard to high rate of

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substance abuse among prisoners, motor-park touts, and [3]*area boys and girls* in Lagos metropolis and other urban centres in Nigeria have been cited by Chiemeka (1991), Olaniyan (1991), NDLEA, (1992), Ekpo *et.al.* (1995) and Raza (2000). They gave the prevailing rates of up to 44.5% and 89% for prisoners and "area boys and girls" respectively.

With particular reference to neighbourhoods, various[4] *joints* are well established for the perpetration of this illegal business of addiction. Joints have become a permanent feature in the cityscape of states like Lagos. Both the high and low-density areas are consumed in the process. With the narrow all-ways in the most congested areas, such as the former Maroko, and Ajegunle, the drug-dens operate in greater security and flourishing. The population is predominantly male with few women among the clientele, including market sellers and prostitutes, but also educated beentos who have picked up the habit while overseas (Klein, 1994), and youths in the schools, both secondary and tertiary institutions in Nigeria (Nevadomsky, 1981, 1982 and Uche, 1990). The spread of substance abuse is most

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[3] Area boys and Girls are the youths who are hooked in drug addiction especially in Lagos Island, who also involved in other criminal activities and prostitution in order to finance their addiction business.

[4] Joints are makeshift buildings and tents, even open places where illicit drugs are procured and/ used.

remarkable on the so-called "soft drugs", alcohol and tobacco. Among the illicit or "hard drugs", marijuana is far greater than any other substance in use, although the use of cocaine, and heroine is now very popular among diverse population in Nigeria (NDLEA, 1996, 1997).

1.3 THE STATE AND CIVIL SOCIETY RESPONSE TOWARDS ABUSE OF DRUGS IN NIGERIA

In the light of the drug consumption epidemic in Nigeria, the government has taken several initiatives in form of regulations, laws, decrees, enforcement, public education and drug addicts' rehabilitation to combat the social problem of drug addiction. Legislation prohibiting trafficking and use of psychotropic substances in Nigeria dates back to the colonial era. The first important law on dangerous drugs was the ordinance enacted in 1920. The uses of opium and coca leaves were included in the list of prohibited substances in the reformulation of the law to the Dangerous Drugs Regulations of 1934. It was extended by the Drugs Ordinance, promulgated the following year, directed against the cultivation and consumption of cannabis (Iyamabo, 1990). Subsequently, with the widespread consumption of marijuana in the country after independence, there were Decrees in 1966 and 1975

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prescribing penalties for its cultivation, sale, possession and use. The penalties during this period ranged from six months to ten years imprisonment, (Olaniyan, 1991). A variety of stimulants and barbiturates including amphetamines were prohibited under the food and Drug Act, 1974.

Little attention was paid to the consumption of more sophisticated hard drugs during the earlier periods as they were assumed to be non-existent due to lack of evidence of refining apparatuses and the high level of poverty level until in the 1980's. When cocaine and heroine came into the drug scene in the early 1980s, stringent laws were introduced to stem the tide. Decree No. 20 was promulgated in 1984 under the Buhari/ Idiagbon military regime. Section 3 (2) of this Decree provides that any person without lawful authority, who deals in, buys, sells, smokes or inhale the substance known as cocaine or other similar drug shall be guilty of an offence and liable on conviction to suffer death by firing squad (Olaniyan, 1991). Due to the public criticisms of this decree, it was reviewed and replaced by Decree No. 22 which removed the death penalty and replaced it with imprisonment terms ranging from two months to life jail. These laws and regulations were made at different periods when each of the illicit drugs started constituting a problem, and as a result of this there was hardly a co-coordinating channel for these government

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effort (see appendix V for the list of various laws as compiled in Odejide 1998). Unfortunately it has been observed that these laws were mere draconian and unrealistic in practice (Alemika, 1998) because of some inherent characteristics in Nigeria society, among which is corruption that rendered these legislations unworkable (Rotimi, 1998).

Responding to the above pointed loophole in the system, and with report of increasing consumption and demand for the illicit drugs, the Federal Military Government promulgated Decree No. 48 in 1989 establishing the National Drug Law Enforcement Agency (NDLEA). The Decree No. 48 of 1989 was subsequently modified in 1990, 1992, 1993, and lately by the money laundering decree under Gen. Abacha with more emphasis laid on internal consumption control, which had over the years been relatively relegated as a non-serious objective.

Within the new legal framework for the control of illicit use of drug in Nigeria, the NDLEA also embarked on Drug Demand Reduction Programmes. These programmes are geared towards primary, secondary, and tertiary prevention of drug problems. Such programmes include public education and enlightenment, treatment of addicts, and the rehabilitation and aftercare of the drug addicts (Odejide, 1998).

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The government in collaboration with the intra-governmental bodies and the community has also been carrying out primary, and secondary prevention strategies, which involve early education, drug supply control and prosecution of offenders without paying much attention to the drug addicts in the proper sense. Thus Klein (1994) commented that the emphasis of the legislations are mostly on trafficking of drugs with little attention paid to the issues arising from their consumption in Nigeria, particularly the situation of consumers/addicts who need rehabilitation. As the growing need for the correction of the already affected individuals became apparent, the United Nations Drug Control Programme in Nigeria provided three psychiatric based and one exclusive drug addicts rehabilitation centres in the country. This move was actually in complement to drug addicts' treatment that was an exclusive function of the already established psychiatric hospitals in Nigeria under the Federal Ministry of Health (Odejide, 1998).

Initially, committing a drug-dependent relative to a mental or psychiatric institution was the standard response of families, but as time went on the need to look out for other treatment and socializing avenues became important. Today, non-governmental organizations, including the religious and secular ones are fully involved in the process of rehabilitating addicts (Odejide, 1998; Partnership for

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Drug Free Nigeria, 1999). The involvement of the community in rehabilitating drug addicts and the seemingly high patronage by clients may not be unconnected with the relatively high cost of maintaining clients in the psychiatric hospitals and with the fact that non-governmental organizations charge little or nothing in addicts rehabilitation. In some cases, the non-governmental organizations procure funding from interested donor agencies for implementing their charitable programmes, which influences their non-profit making status. Quite different from the government's initial intervention through the psychiatric/medical approaches, the involvement of the government in the drug social welfare rehabilitation programmes has increasingly received public recognition. Typical examples of this case are the People's Bank of Nigeria's Drug Addicts Rehabilitation Project in Lagos Island in 1993, and most currently, the Good Boys and Girls Rehabilitation Project in [5]*Isheri* Lagos under the Col. Buba Marwa administration.

In spite of all these programmes and measures embarked upon by the government, non-government agencies, and the community to correct and socialize drug addicts in the population, not much has been achieved. There are authentic indications that the use of illicit drug and the attendant serious damage to the social

[5] Isheri is a suburb of Lagos Cosmo polis.

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fabric of the country are on the increase. Scientific sources make it certain that the number of people involved in substance abuse and the substances being abused are increasing daily rather than declining (Odejide and Ohaeri, 1993).

1.4 STATEMENT OF THE PROBLEM

This study examines drug related social antecedents of drug-addicts, and their consequent rehabilitation processes and adjustment in Nigeria. The study is hinged on the observation of the gruesome problems which drug addiction poses to the individuals, groups and the entire society. It has been observed that drug abuse is a social problem that has spread and increased rapidly in recent decades across diverse segments of Nigeria, constituting a threat to the effective functioning and survival of the society. Many lives are being lost through drug dependence and activities of the addicts, including road accidents, violent crimes, cultism, and prostitution among others, which are traceable to the influence of drugs. Attributive use of drugs further leads to breakdown of relationships and places further stress on already heavily burdened families in Nigeria, (Odejide, 1993; Ijeomah 1997; and Iheonye, 1998).

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As mentioned earlier there are evidences of the increasing number of drug dependent persons who need to be remobilized into the values and norms of the Nigeria society. Admission of drug related cases in psychiatric centers in the country rose from about 8,234 in 1994 to 70,316 in 1989 (The Guardian, 7/7/91). A group known as the Partnership for Drug Free Nigeria has substantiated this need. According to this group,

> "Well over 2 million Nigerians mostly between the ages of 12 – 35 years got into the deep trouble with alcohol, tobacco and other drugs. 70% of the serious road accidents involving death are traced to drunk driving and other substance abuses. 90% of persons involved in homicide and other violent crimes parade a history of substance abuse. Over 90% of our street children (area boys and girls) and the homeless need treatment for substance abuse, which presently they are not getting. Even when they are receiving the corrective measures we do not know how far the whole process is sinking into their inner selves. Knowledge of this is important so as to intervene and prevent poor adjustments, which eventually may be a risk factor for recidivism.
>
> (Partnership For A Drug Free Nigeria 1998: 37)

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In response to this observed need, the government and the civil society, aimed at both treating and remobilizing the affected individuals through series of rehabilitation programmes. It seems however that in spite of the efforts, the addiction problem maintains an uninterrupted increase. What is observed is a

[6]*"revolving door syndrome"* (e.g. Peoples Bank Trial Project, 1993), which is contrary to the conventional wisdom, and ideals of rehabilitation.

The persistent increase in the number of people hooked in use of drugs and the presence of those undergoing social rehabilitation without success however reflect that much ground is yet to be covered in this direction. The scenario further suggests that there is little understanding of the early life experience of the drug-addicts as related to their drug history before embarking on their rehabilitation exercise. Thus there is a need to take a retrospective view of the drug-addicts' life experience including their drug history, and the rehabilitation opportunities available to them at present in order to provide a holistic dimension of the interactive processes to drug-addiction and sustainable social rehabilitation. This would serve as a contribution to knowledge in sustainable care and support programme for drug addicts in Nigeria, which have not been well examined as main focus in the previous and recent research scenario in Nigeria such as those of Oviasu, 1976; Ekpo et al. 1995; and NDLEA 1996 and 1997. These present works are obsessed on the psychiatric health plethora, leaving out sociological and anthropological questions that are very important in the whole problem. Some of

[6]Revolving door syndrome implies where there is persistence in the illicit use of drugs even after attempts of rehabilitation

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these studies also dwell on rudimentary aspects of drug addiction research, such as the "traditional" street, general public, and school based non in-depth surveys of the predisposing factors to drug addiction. This leaves out the more in-depth intra drug addicts' population focused questions and analyses in relation to their drug history, the predisposing factors, and rehabilitation opportunities, which are supposed to be the research issues at present.

These include knowing what the processes involved in becoming a drug-addict is, the patterns of drug addiction and social background features considered significant in determining this pattern. They also include knowing the major problems of living with drug addiction; the pathways to seeking health care and rehabilitation; and how the drug addicts' are being helped out of their problem, and how effective are the various methods employed; As well as how far the various categories of drug-addicts are recuperating under rehabilitation. Providing clues to these issues will provide an insight in sorting out the margin line between relapse possibilities and complete staying off drugs by showing the characteristics of vulnerable population and the diverse needs, which are pointers towards improved rehabilitation of addicts in Nigeria.

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1.5 JUSTIFICATION FOR THE STUDY

This study intends to complement the on-going research on drug abuse in Nigeria, with particular reference to understanding the social circumstances surrounding drug addiction from both the emic[7] and the etic[8] perspectives. This involves knowing the processes to drug-addiction, the patterns, the adverse effects on individual social life and the response of the society and community in managing the addicts. Previous studies in Nigeria on drug abuse have dealt mostly on the problem as it manifests in different populations in the country and the effects on the individuals health conditions. There exists a gap in knowing how drug addiction begins and the consequent developing pattern, the processes involved in rehabilitating the affected individuals, and how effective these efforts have been so far on the target group.

Although, information about the predisposing factors to drug addiction in Nigeria exists in the literature, these are isolated and inadequate works that have not explored the interface between these predisposing factors and the developing

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[7] Emic perspective is an anthropological terminology that emphasizes investigation of a social or cultural phenomenon from the viewpoint of the insiders or constituent members of the social or culture group that the investigator is interested in studying.

[8] Etic perspective is the methodological opposite of the emic perspective. The two approaches are usually complementary.

patterns of drug addiction. The existing literature also lacks information on the care and support system for drug addicts' in Nigeria (Odejide, 1998) and its interface with drug history and social background contexts, which is a vital area of research. This area is particularly an emerging concern in social research as the number of organizational involvement in the process increases vis-à-vis the increasing number of unsuccessful attempts to rehabilitate the addicts.

Due to the scanty information in this direction, this study hopes to fill the existing gap in research and literature for future academic purposes. The study consequently will attempt to provide information and recommendation to policy makers involved in formulating and implementing the intervention programme designs on drug-addiction prevention, care and support services in Nigeria, and in determining how best the drug addicts could be managed.

1.6 OBJECTIVES OF THE STUDY

The major objective of this study is to discern the pathways[9] to drug addiction and social rehabilitation process in Nigeria. This is in order to provide important clues

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[9] Pathway connotes the course or ways in which the social problem follows, from inception to eventual cessation.

for improved and sustainable "clients[10]" need care and support/intervention programme for drug addicts in Nigeria.

In order to achieve this major objective, the specific objectives include:

1) To investigate, and describe how drug addiction begins. This includes understanding the major initiation patterns into use of drugs (sources, venue, and age of initiation).
2) Identify and describe the pattern of drug-addiction found among the subjects, based on an analysis of their drug use development and how it relates to the initiation pattern.
3) Identify the social background factors influencing this pattern of drug addiction.
4) Examine the drug-addicts' continuity and problems in the process of addiction, and pathways to healthcare and social rehabilitation programme.
5) Examine drug addicts' social rehabilitation in the various caring agencies in Nigeria, and their adjustment pattern with a view to determining the most effective method of rehabilitation for them, and response rate of specific social categories.

[10] Drug addicts who seek help from the rehabilitation centers.

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6). And, also identify the major obstacles militating against their rehabilitation in Nigeria and ways of alleviating such problems.

1.7 RESEARCH QUESTIONS

Following the research problems, objectives and the theoretical underpinnings of this study, the following questions are formulated to guide the research. The questions seek clarifications in the following direction.

- First, how do people become drug addicts? In order to clarify this, the specific questions to be investigated include; what are the major sources of initiation or who led our subjects to drug addiction? Which places are remarkable for the process of initiation? What age or stage in life is most prominent to drug initiation?
- Second, what are the patterns of drug addiction? How does it relate to the pattern of initiation? What are the social backgrounds factors influencing pattern of drug addiction?
- Third, what are the features of continuity with drug use, and the prominent problems encountered by people living with drug addiction?

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- Fourth, how can the drug addicts be helped out of the problem or corrected? This requires answering the following questions: How are the drug-addicts being managed presently, and how effective are the methods employed, in view of discovering what methods are most effective among others to be recommended for drug addicts' management and rehabilitation in Nigeria.
- Finally, how are the various categories of drug addicts adjusting under the rehabilitation process? The specific questions are: Does pattern of drug addiction influence adjustment pattern? Do the socio-demographic variables (sex, age) influence level of adjustment? Do the drug history variable (age of initiation) and rehabilitation variable (residential status) significantly influence adjustment pattern of the clients? These are with a view of knowing the problematic categories to be recommended for more intensified management.

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1.8 SCOPE OF THE STUDY

This study examines the processes of drug-addiction and social rehabilitation in Nigeria, using what obtains in Lagos as a case study. This includes the initiation process, precisely the stage in life and major sources of introduction to the habit, the patterns, and the social background conditions influencing it, and efforts in rehabilitating the addicts. The analyses in this work are based on information gathered from two medical, a social welfare, and two faith-based rehabilitation centres in Lagos. The traditional medical care and Islamic religious faith systems do not form part of this study because at the time of this study there was no clear evidence of their contribution in the study area as a whole, even though their contributions might be present in some parts of the country. Information gathered here in respect of drug addicts is strictly for those that are under control or remobilizing system, excluding those on the streets, even though the drug history aspect could be applicable to those on the streets. Information from this study could also be applicable to drug addicts in the whole country irrespective of where they live because of the cosmopolitan nature of Lagos where the centres of this study are located. Lastly, the concept of drugs here implies the social drugs, or those

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substances that are consumed without medical prescription, and which uses are controlled or restricted by legislation.

1.9 THESIS OUTLINE

This thesis is subdivided into six chapters. Chapter one deals with the background to the study. In chapter two the literature review and theoretical framework of the study are presented, which provides the theoretical background to the study. The methodology of the research is presented in chapter three, while chapters four, five, and six are devoted to the presentation of research findings (results of the study), discussion and conclusions. While chapters four and five have the processes of drug-addiction and the social rehabilitation as their main focus, chapter six dwells on the summary and conclusions of the major findings of the study.

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CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 INTRODUCTION

This chapter deals with the literature review and theoretical framework, which are germane to this study. Among the literature reviewed here are some old studies that were carried out at the peak of drug problem both in Nigeria and other parts of the world, mostly in the 1960s and early 1980s. The literature review and issues highlighted in the discussion are limited to some of the key issues of this study.

2.1 LITERATURE REVIEW

2.1.1 Origin and Functions of Drug Use in Historical Perspective

The origin and use of psychoactive drug substances have been traced to times before the birth of Christ. Moria (1991) wrote that use of drugs in order to alter state of consciousness is behaviour, which has been in existence throughout history. According to him, the first known brewery operated in Egypt around 3700 B.C. Evidences abound about people using alcohol, (Gomez, 1991; Kuper and Kuper, 1996), which was made from the fermentation of almost any carbohydrate containing material as far back as the prehistoric time of the Stone Age.

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Furthermore, the Holy Bible in Genesis 9: 20-21, records that drug use was in existence during the time of Noah. McGrath and Scarpitti (1970) also reported the use of opium across continents amidst vast species of drugs. Following their work, Samarians, Assyrians, Egyptians and Greeks left written evidence that the opium poppy was known and used long before the birth of Christ. They can actually be historically traced back to the time of Herodotus, Hippocrates and Aristotle to Vigil and Pliny the elder. Abel (1980) earlier on demonstrated the antiquity of marijuana drug use. He evinced that strands of marijuana plants embedded in China pottery have been found by archaeologists in sites estimated to date back to ten millennia.

The functions and reasons for the use of these drugs in different societies are areas of interest, which have attracted a fair scholarly patronage. Psychoactive drugs have been used for social, religious and other purposes. Opium and cannabis have been taken for social purposes for thousands of years in the Far East Asia, African, and South American societies, and coca leaves chewed for stimulating the mind (Forston (1988).

Olaniyan (1991) argued that man had used various substances of psychoactive properties with the ultimate aim of reducing physical pains and to also alter the state of consciousness. According to him, several ancient societies like the

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Incas of Peru used coca as part of troop-ration because of its light weight and ability to deaden the effects of hunger and fatigue during long marches and farming in the forests. Relatively, hemp (cannabis) was used medically for curative purposes as far back as 2700 B.C. in China sub-continent, which is still being used extensively in the Middle East (Gomez, 1991).

In relation to religion, Forston (1988), Olaniyan (1991) and Gomez (1991) also evinced the use of drugs for religious purposes. For Forston, the ancient Greeks and Aztecs used hallucinogenic herbs and plants in some of their religious ceremonies to create mystical effects, and the Egyptians compound many mind-altering positions with drugs. Similarly, Olaniyan cited that the Indians of South-West of the United States used peyote kites (a derivate of opium) to induce religious trance, and the Holy Bible has it in Genesis that Noah used wine for social as well as religious purpose such as libation instrument in the temples.

The uses of these substances in societies is not only a historic process but a present phenomenon; with different types of drugs dominant in certain cultures and regions of the world. Moria (1991) noted that coca leaves are known in South America, opium in the India sub-continent, alcohol in the West and opiate fairly

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common in China. The culture of drug use has therefore developed through time in history with evidences of cultural inclinations.

2.1.2 Cultural Milieu and Drug Use

Perhaps in attempting to understand more of the drug use phenomenon, the broad cultural factors that influence the ways in which a people use or abuse drugs are important. This includes the society's cultural approval and perception, which are related to drug use as a cultural phenomenon.

Against this background, Gossop (1984) in a detailed description of alcohol use among diverse nations and race, showed differences and perceptions of various nations on the nature and types of drug use. For him alcohol plays an important role in every day life among Frenchmen and women in France. He is of the view that alcohol consumption is generally encouraged, with few proscriptive norms restricting its usage that makes intoxication appear to be socially acceptable among the French, which is opposite of what obtains in the Arab sub continent. Gossop's position was supported and corroborated with survey of public opinion in France on the quantity of alcohol to be taken daily, and the prevalence of alcohol related problems, which is extremely high in France. Subsequent similar studies of Gomez,

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(1991), Bachman (1991) and (1993), and Albrecht *et al*. (1996) are consistent with the above view.

Even though, drug usage existed in various human societies as has been noted above, it is also important to consider the fact that even within the societies that tolerate use of drugs there are some members of such society that are regarded as deviant drug users. They organize themselves within the confines of drug use habit, with various structures as a defined sub culture.

2.1.3 Drug Use Sub-Culture and Social Differentiation

At this juncture let us start by understanding what a sub-culture means from some scholars' developmental perspective. For Cohen and Short (1957), and Bordua (1961), a sub-culture presumably develops when people effectively interact with one another to resolve common problem of adjustment. According to them, in the process of interaction a certain stable pattern of behaviours is developed, which are indeed unique to the group as its identity, thereby differentiating it from the larger society. Linking this concept of sub-cultural development to drug use, it is important to note that the knowledge of the organization of the drug use sub-cultural phenomenon has been an area of scholarly interest, and controversies in recent time.

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In describing the social types and categories of the drug use sub-culture, Suther (1969) distinguished and described three major social types, as the mellow dude, the Pothead and the Player. Suther provided insight into what he called the social categorization and stratification in the drug use sub-culture. Within the system as Suther described, people are differentiated at major turning points, from where they enter into different social worlds and fall into different kind of associations; take on the features of different social types; come to occupy different positions and roles, and have different runs of experience which orient them along different career lines. Unlike the personality approach adopted by Suther, Hochman (1972) devised a more comprehensive categorization of drug users in America into six classes, according to the types of drugs used.

From the foregoing position, it is appropriate to say that the drug use sub-culture like any other human grouping is not a homogenous social arrangement in the strict sense rather there are variations. It is a dynamic one, which entails a continuous process of selection within the cultural system. After getting involved in the sub-culture, individuals are bound to observe and learn the stratification, social categories and relations that exist therein.

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Having known the nature and classifications of drug sub culture it is also important to have a brief look at the workings and mechanisms for the sustenance of the sub culture amidst society's reproach.

2.1.4 Maintenance of Social Equilibrium and Survival of Drug-Use Sub-Culture

The illegal drug use sub-cultural system survives and is maintained through its common sub-cultural norms, values and motives which bind the individuals together among other factors that may be external to the sub-group. King (1953), Eldridge (1962), Lindersmith (1965), Schur (1965), and Smith (1966) studied the influence of public policy and societal reaction as important factors in the development of drug use sub-culture. In their view, the public policy and societal reactance further strengthen the system through a process of resistance by the sub-culture to the public policy, which significantly influences the behaviour of illegal drug users. Schur (1965), Fiddle (1962), Becker (1963), Margolis (1969), Hochman (1972), Stimson (1973), Ground,(1993) and, Power *et al.* (1995), observed that the addict sub culture evolved to deal with the common problems of adjusting to criminal status, stereotypes and stigma as "dope fiends" and to the illegal market on the streets, against the prescription of the law of the society. These are made in order to

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differentiates members of the sub-culture from the rest of the society. Besides, there is what Fiddle also termed a "neighbourhood warning system" which operates to protect addicts from the raiding of the law enforcement agents.

On stressing the importance of these defensive structures, relationships and networks, Power *et al.* argued that they exist to maintain drug supplies. According to Power and his colleagues, short-term friendships would develop, which are based on high level of reciprocation. They steal together, and do other things together. Summarily, their strong social network system is characterized by functionality, reciprocation, trust and "fluid friendship" in the drug-use social network system. Within the drug use subculture, individuals and groups are brought into the system through various processes, and developed further into using different drugs at various stages in their life.

2.1.5 Involvement and Development Process in Drug-Use

Even though drug usage existed in various human societies as highlighted above, and having developed as distinct sub culture, it is important to consider the obvious process of getting involved in drug use in first instance and how it develops.

Getting involved in drug use is usually a process that is characterized by different descriptions and stages, depending on individual routes into the habit.

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Cloward and Ohlin (1960) advanced a "double failure" paradox in initiation to drug use. Their hypothesis entails that some adolescents, who are unable to find a place in a violent gang sub-culture, a criminal sub-culture or a conventional non-deviant youth sub-culture face status dilemma. As a result of this status dilemma resulting from repeated failure in aspiring for success, adolescents select or fall back to retreatist role adaptation through the use of drugs as an escape formula. Cloward and Ohlin's position is what is also referred to generally as the "safety valve" hypothesis, which is further facilitated by a strong "escapist euphoria" in the drug use habit.

Contrary to the safety valve position or retreatist role adaptation of the drug use involvement, Suther (1966), and Hochman (1972), later proposed a deliberate self-conscious attempt in regard to drug use. In their view, the process of getting into drug use is a deliberate, self-conscious attempt, rather than a life paradox. Suther for instance is of the opinion that adolescents are being shown the way in through being turned on by significant others or through an experience with drug using peers. According to him, the entrance into the drug use is a developing experience and a highly selective process that depends on access to drugs, acceptance of drug using associates, kinds of images which youngsters form of drug

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use, and the runs of experience, which affect their interpretation of the drug effects. The continuity or discontinuity of the habit depends on some major factors, which Hochman identified to include the general anxiety experienced by the individual and the social pressures imposed upon him by the society.

Developmental stages in drug abuse are not strictly static. Scholars believed that there are stages or ladder through which drug addicts climb in their drug use career. There is the common consensus on the "stepping stone" hypothesis which stipulates that drug use habit develops from beer and wine (alcohol), to hard liquor, to marijuana, then to other harder drugs (Kandel, 1975; O'Donnel and Clayton's 1982). O'Donnel and Clayton's (1982) survey study of youths between the age of 20 – 30 in United States of America showed a positive relationship between heavy drug use of marijuana and increase in the likelihood of using other illegal drugs. From the study, 73% and 35% of those who have used marijuana on daily basis later tried cocaine and heroine respectively, in contrast to less than 1% of non-marijuana smokers who later used harder drugs.

Contrary to the "stepping stone" hypothesis, Kandel *et al.* (1986) enunciated that the use of a particular drug does not invariably lead to others in sequence of strength classification. From their study, they discovered that only about 25% of the

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students who drank hard liquor progressed to and only 25% of the marijuana users went on to try other drugs including heroine. The researchers also found that the students progressed from beer or wine to illegal drugs without drinking hard liquor first, and very few students progressed from liquor to hard drugs without trying marijuana.

Involvement in and use of drugs also occur within some social environmental specifics. Without knowing these specifics, the information in regard with drug use may be incomplete; therefore knowing these socio environmental contexts is germane in this discussion.

2.1.6 Social Environment and Drug Use

Earlier scholars have studied the social background factors or the predisposing factors determining or associated with substance abuse. With particular reference to social environment and micro milieu of individuals, Robins *et al.* (1980), Lazzari (1991) pictured the relationship between close contact and availability of drugs as a risk factor to the use of drugs itself. In other words, people can be put at risk because of their proximity and close contact with drugs and drinks. Robins *et al.* demonstrated a positive relationship between war tensed environment and use of drugs from their study of the American soldiers in Vietnam.

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Their study showed that all kinds of drug use were widespread among the American soldiers with the majority of them being addicted to some of the drugs on return to the United States. Follow up study of these soldiers in the United States revealed that more than 90% of the persons who were addicted to opiates in Vietnam never became addicted again because of change of environment. Robins and his group also collected similar data in their study of brewery workers in Austria, and suggested it for some professionals who are also vulnerable to drug abuse, namely, barmen, merchants, seamen, and members of the armed forces, journalists and musicians. Their studies further show that the exposure to stimulants can be the most important determining factor in the development of drug addiction and that controlled use veers towards compulsive use when the drug is more widely available and doses are consequently increased.

Residence and neighbourhood structure have also been studied in relation to drug abuse and consequent addiction and sustenance. Chein, Gerrad, Lee and Rosenfeld (1964) evinced a prevalence of drug addiction among socially disadvantaged groups as being very high in the U.S.A. where Blacks, Puerto Ricans, and other ethnic minorities from deprived inner city are over represented among the addict population. According to their research, more precise social conditions

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associated with drug addiction in the study include areas with high concentration of underprivileged minority groups, poverty and low economic status, low educational attainment, disrupted family, crowded housing conditions and high proportion of teenage males. Later works of Halim (1991), and Albrecht *et al*, (1996) showed no residential difference for blacks as against whites even though there is a significant difference of higher drug usage patterns among the urbanites than the rural dwellers in terms of alcohol and marijuana. The study categorically and statistically showed that approximately 10% of urban high school students claim to have used marijuana compared to less than 6% of their rural counterparts.

Contrary to the above views, Westerman (1970), Gossop (1979), discovered that there is little evidence showing a positive relationship between poverty or social disadvantage and drug use. They argued that drug users come from every social category and socio-economic status. According to their views, the general notions that people from lower socio-economic status are more involved in drug use are not statistically valid in their study. Westerman particularly pointed out that people from the lower socio-economic levels get caught more frequently in all categories of law breaking, and that the number of people dependent on drugs who are able to hide their problem increases as one proceeds up the socio-economic ladder.

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Put differently, UNESCO (1987) posited that socio-economic background merely determines and influences the course of drug users development in terms of types of drugs used rather than the commonly held view of scholars that drug users are mostly from less privileged, and socially deprived homes. UNESCO's work showed that certain types of drug dependence are more widespread in certain easily identified, more or less marginal social groups, whether economically privileged or underprivileged. For instance, young, poor people sniff solvents, while cocaine is used by many affluent and privileged youths in the society.

Apart from contact with drug using environment, contact with drug using friends brings out a more serious case for concern. As Becker (1970) pointed out, an involvement in marijuana culture might be expected as a result of individual's participation in groups which marijuana use is commonplace.

2.1.7 Peer Factor and Drug Use

The influence of peers as a major factor determining drug use habit cannot be underestimated. The peer factor comes in connection with other conditions such as environment, personality and cultural milieu when one considers that there must be a group through which every learning process goes. Becker (1970), Gossop (1984), and Lo (1996) argued that peer pressure has a powerful influence on the

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development of problem drinking among adolescent drug users, who report considerable difficulty in abstaining from drugs when they are in certain social setting where drugs are used. The peer group reinforces the drug use habit through an inbuilt sub cultural support system apart from pace for the initiation, which they aid in establishing.

Two social mechanisms have been advanced to explain this peer influence on individual substance use, namely, modeling and normative influence as Bank *et al* (1985) indicated. In modeling Bank *et al* explained, that individuals might see their friends both as symbols to imitate and as sources of norms in normative orientation. Through association with friends, Bank and his associates believed that attitudes of individuals might change to more closely reflect the social norm shared by their group friends. One of the backdrops of this hypothesis is that the social mechanism however does not necessarily operate identically for both genders. While some scholars like Printice and Miller (1993) showed that males conform more readily to their perception of their group norms than females, Berkowtz and Pekins (1987) reached the opposite conclusion that females are affected more than males by drinking styles of peers, because of their sensitivity to environmental factors. This

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point indeed has created a puzzle and an issue of controversy that needs to be confirmed empirically.

2.1.8 Gender and Drug Use

Scholars have studied gender roles and social perspectives, which are patterned by definite cultural prescriptions and aspirations. For Gossop (1984), men have traditionally been more likely to use drugs than women in most cultures due to sex perceptions. From a more conventional point of view the work of Albrecht *et al.* (1996), demonstrated a greater possibility of use of drugs among young men than women, although with exception of tobacco, which shows no significant difference. From their research on gender differences, boys are 50% more likely to use alcohol and twice as likely to smoke marijuana than are girls. While in hard drugs, there is only a slight sex difference showing 2.9% of girls and 3.9% of boys in the ratio of hard drug use.

In explaining the reasons for these sex differences, a number of studies have pointed out the variation between men and women patterns of leisure involvement as an important factor (Petrie and Miton 1983; Bailey 1985; McKay 1986; Biddle and Henderson 1986; Lensky, 1988; Lock 1993; Anderson, 1994,and Lo 1995). They showed that women have lower levels of participation in physical or sport

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activities than men, but are generally more involved in activities centred on the home, and attending the religious functions, which do not expose them to negative influences of peers unlike the males.

Furthermore, Lo explored the social mechanisms for the gender difference. His study compared the drinking behaviour of and the social mechanisms leading to alcohol use in the two gender groups. The result showed males as being more likely than females to drink up to intoxication as a result of three main reasons, namely, the more likelihood of males than females to be associated with others who present problem drinking norms and drinking models. Secondly, females are more likely to be influenced by their parents, and in association with parents' more restrictive norms, which results in less favourable alcoholic use definitions among females, and in turn a lower level of alcoholic use. Thirdly, Lo advanced that peer-drinking norms, which are more permissive exert a stronger impact on male definitions of alcohol use and level of intoxication than on female definition. In this case, Lo is implying that association with parents and peers can also explain gender differences, if the differences are shown to exist. He maintained that it is not unlikely that the same forces influence gender groups differently, since males and females are treated differently in various ways by their societies. This position lends credence to the

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traditional protective influence of cultural values on women against drugs and alcohol use in the society, v*is-à-vis* the male population.

But the unfolding changes in the few decades are having tremendous influence on this basic and culturally defined notions and behaviour in most patriarchic societies. There has been a steady rise in the number of women who are running into alcohol difficulties (Royal College of Psychiatrists Study (RCP) 1979; Engs and Hanson 1985; Berkowitz and Perkins 1987). From these reports, equal rate of alcoholism between sexes is one of the prices to be paid for a more equal place for women in the society. Similar explanation had also been made about the incidence of smoking among men and women and the respective rates of lung cancer and respiratory diseases. In spite of all the above positions, the influence of gender in drug use is still a controversial issue in drug studies.

2.1.9 Genetic and Physiology factors, and Drug use

Research studies using twin and adoption have demonstrated genetic influences on alcohol and other drug use. Gomez (1991) explained genetic influence in relation to race and diverse human species. He enunciated that the Koreans, Chinese and the Japanese are more liable to circulatory upset than the Caucasians when they drink because they look more flushed and are less able to clear their system of

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acetaldehyde. He further pointed out that the Eskimos and certain American Indian groups are particularly slow to sober up after an alcoholic, which lends credence to relationship between body, genetic make up and alcoholism.

From a biological perspective rather than the racial explanation for alcohol use, Corrigan (1985), McGrady (1988) found that male drinking of larger quantities of alcohol than females may be attributed in part to the unequal physical size and advantage of males over females. However, the relationship between physiology, genetics and drug use cannot be isolated from the social context. But what the scholars are saying is that drug use motivation may be inspired by inheritance and the sustenance achieved through physical and biological tolerance of the body system.

2.1.10 Personality Characteristics and Drug Use

Personality traits as they affect human behaviours and performances in general can influence negatively or positively the use and non-use of psychoactive substances. Scholars have positively correlated some personality traits to be significant factors in substance abuse behaviour. Previous work of Marcovitz and Meyers (1944) and Becker (1970), and later Wood *et al.* (1995), showed that the personality traits associated with the illicit behaviour include sensation seeking, curiosity and

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experimentation, need for fantasy and escape from psychological and real life situations the individual feels he cannot face.

For Becker, the first step in the sequence of events that must occur if a person is to become a user is to experiment on the use of proper smoking techniques so that his use of the drugs will provide desired effects near to his preconception. Becker further noted that these techniques involve a process of long observation and imitation. According to him, the novice will ordinarily have faith, which is developed from his observation of users who do get high. In order for the drugs to produce some new experience, he will continue to experiment on it. It is only when the novice becomes able to get high in this sense that he will continue to use marijuana for pleasure seeking. Consequently, in every case, in which use continued, the user must have acquired the necessary concept with which to express to himself the fact that he has satisfied his curiosity and was experiencing new sensation caused by the drug. Becker further noted that the environment in which the learning process takes place would influence the rate at which the drug use takes off and is sustained. Their study allows an explicit test of sensation seeking to help account for substance abuse among selected youths in high schools. Their finding provides strong support for considering sensation-seeking variables like thrill,

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immediate gratification and impulsivity in substance abuse. In the result for each of the five substances examined, sensation seeking factors generated statistically significant influence.

In stressing some other personality characteristics of drug users, Westerman (1970) Smith (1986), UNESCO (1987), Marcott *et al.* (1988) Marlatt, Donavan and Kivlahan (1988), and Olaniyan (1991) pictured and identified addiction to drugs as being positively related to antecedents and individual experiences. Their works show that drug users are generally vulnerable people who have presented numerous behavioural and personality disorders as children. UNESCO buttressed this in form of life histories marked almost inevitably by desertion, broken relationships or excessive emotional attachments. Teenage drug users particularly are mostly those who do not conform to the traditional values of their societies. People who score high in various test of social conformity, that is seeing themselves as conforming to the traditional values of their societies are less likely to abuse drugs than those who score low on such test. Conformity or non-conformity to traditional values among drug addicts would hardly be explained without correlating the issue to the family sub system.

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2.1.11 Family Subsystem and Drug Use

Scholars have previously contributed towards a better understanding of the relationship between family factors and drug use or the family contexts that predispose adolescents or young adults towards drug use, (Westerman, 1970; Smart *et al.*, 1972; Davidson *et al.*, 1980; UNESCO, 1987). For Davidson and his associates, their several studies and surveys conducted in Western countries show that subjects who later became addicted to drugs usually come from family in which use of drugs is far more frequent than in ordinary population. Earlier, Smart *et al.* (1972) observed that the type of drugs used by father or mother is often the same as that to which son or daughter becomes addicted. This study showed a positive relationship and interdependence between genetic factors and social interaction in the family on one hand, and predisposition to substance use and abuse on the other. The works of Roebuck (1962), Chein (1964) Eastman (1965), and Mason (1965), were a bit different from the usual position of others above. Their position centres and revolves on the personality of the youthful drug use as fallout of family functioning and experience. For them, if the youth receives too much love or inadequate love, or if the mother is overwhelming in some ways, then the child has the tendency of developing inadequately. Attitudes of mothers who are variously

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controlling, overpowering, guilt ridden, hostile, aggressive and seductive in their child upbringing leads adolescents to drug abuse. Implicitly, what the scholars are saying is that a child with the above background is unlikely to withstand future pain and discomfort let alone coping with a complex world of reality.

Arguing also on family upbringing, Cohen (1955), Hochman (1972), observed that the simple willingness to experiment with an illegal drug is evidence of rebelliousness and defiance of authority due to permissive child rearing and raising. They attributed involvement of lower class boys in delinquencies as a result of inadequate upbringing, which makes it difficult for them to compete favourably and successfully for high status through the conventional means. Cohen for instance was of the view that these boys may more likely not be trained as much as the middle class children to forgo immediate gratification; taught the value of rationality; and control of aggression. Carter (1954) Morris (1958) Zanne and Sasao (1992), attributed most delinquency to some manifestations of social disorganization which include "problem families" with inadequate social control over their children, low standard of child care and absence of emotional stability at home which provides the young adults freedom to get involved with the delinquent others.

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Contrary to the regular position of scholars that presence of cultural expectations and family organizations create good behaviour, Loo (1991), and Hunt *et al.* (1995) made claims that family ties, loyalties, cultural expectations and beliefs manifest as significant sources of stress which contribute to defiance as individuals try to develop a sense of autonomy in an extended multi-generational household

Parental attitude towards drinking can influence adolescents' drug use behaviour. Individuals, especially adolescents and young adults, are affected by their parents' attitudes towards drinking, from where they may also model directly the alcohol using behaviour demonstrated by parents (Barnes *et al,* 1986). Mausner and Platt (1971) in their survey of 1,500 adolescents in United States found that the use of tobacco by parents, siblings, and peers was very strong influence in initiation. A total of 32% of their sample population was children of mothers who smoked, compared with 23% who had non-smoking mothers. Mausner and Platt believed among scholars that having a father who smoked was a significant factor in teenage smoking. Relatively the influence of an elder brother or sister who smoked was even greater. It was also observed through the empirical investigation that only 20% of teenagers whose siblings did not smoke were involved in tobacco use, whereas 43%

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of the teenagers whose elder siblings smoked were also involved in tobacco use (Bank *et al.* 1978; Spielberger *et al.* 1983).

Thompson and Wilsnack (1987) and Wilks *et al.* (1989) provided an insight on the relative influence of each gender parent (mother and father). For Thompson and Wilsnack, children are more likely to be influenced by the same gender parent, for instance father/son, mother/daughter. But generally Wilks *et al.* argued that fathers have a stronger impact than mothers have on both son and daughter's drug behaviour.

Nurco (1996) studied the influence of family structure and functioning on vulnerability to narcotic addiction. The study was a retrospective case control study of male narcotic addicts aimed at determining whether family structure and functioning factors as occurring during early teenage are associated with subsequent addiction. The result of the study showed a statistically negative association at a significant level between intact family structure (defined as residence in a household consisting both natural parents) and drug addiction. Furthermore, other family functioning factors negatively associated with later addiction independent of family structure include strong attachment to father or father figure; positive home atmosphere; strong parental adherence to traditional norms; expected parental

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disapproval of misbehaviours, and attachment to mother or mother figure. More elaborately, Nurco showed that intact households with both natural parents were clearly the most common feature. Among non-intact households, single parent households with the parent in almost all instances the natural mother were common, and the next were the household in which the natural mother lived with a surrogate father (step father). Another common feature was one or two grand parents but have no parents or other parental figures; only siblings or other adults unrelated to the immediate family residing in the household.

Nurco (1996), also in measuring quality of parenting with frequency of parents at home, found it significantly higher for non-addicts than for addicts between both the father and mother figures alike in comparing the quality of parenting between addicts and non-addicts. Also focusing on home atmosphere as a characteristic of family functioning, the recollections by non-addicts were significantly more positive than recollections by addicts. Thus, from the study there is a significant positive relationship between positive home atmosphere and later status of non-addiction.

With reference to the parents' disapproval of subjects' misbehaviour, most subjects (both the addicts and non-addicts) believed that their parents would have

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disapproved strongly. However, the strong disapproval by parents of non-addicts was on average significantly higher than disapproval of addicts' parents. Thus, higher degree of parental disapproval was significantly associated with later non-addiction. Finally, attachment to both parents was strong, but as expected, attachment to mother or mother figures was recalled as much stronger than attachment to father or father figures.

Reporting on parental supervision, discipline and attitude towards their children and the influence of each variable on the children's drug use behaviour, some scholars (MacCord, 1979; Loeber and Stouthamer-Loeber, 1986; Shoulder and Block, 1990; Adejumobi, 1992; Utting *et al,* 1993), found poor parental supervision or monitoring, erratic or harsh parental discipline, parental disharmony, parental rejection of child's activities, as well as antisocial parents, and large family size were found as important predictors of offending.

2.1.12 Religion and Drug Use

On the issue of religion and religiosity, studies have shown the relative strength and influence of religion on substance use disposition. A low level of religiosity as usually measured by participation in religious activities is positively correlated to substance addiction (Robin, 1980; Jessor *et al.* 1980; Gersick *et al.* 1981; Kandel,

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1982; and Cochran, 1991; Adejumobi, 1992)). More recently, Albrecht *et al.* (1996) argued that individuals who never attended religious services are significantly more likely to use drugs than those who attend religious services at least once a week. Their study showed that among those who never attend services, 25% smoke, 37% drink, 13% use marijuana, and nearly 60% claim to have used hard drugs. On the other hand, regular church attendants are among the least likely to use any substance. In the sample studied, only 9.5% smoke marijuana and slightly more than 2% have used hard drugs.

Having considered some of the social contexts associated with drug use, it is also important to know some of the consequences of abusing drugs on the individual and the society, as reported in literature.

2.1.13 Consequences of Drug Abuse

Scholars have investigated the effects of drug addiction on the individual and society levels. On health, Gossop (1984), and Fazey (1991) commented that heavy use of drugs causes gastro-intestinal bleeding, stomach ulcers, kidney damages, and cirrhosis of the liver, which are the commonest causes of accidental deaths. Other health implications include neurological disorders of the nervous system, showing symptoms such as epileptiform fits, ataxia, muscular weakness, amnesia, psychotic

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confusion and dementia. Drug use is also connected to the spread of HIV/AIDS through sharing of contaminated needles (Schutter, 1992), which is a challenge to human society.

Various scholars have considered abuse of drugs of psychoactive properties as being capable of inducing family stress. Gomez (1991) stressed that alcoholism and addiction lead to social isolation in the family of the victim through the shame and embarrassment associated with it. Gomez buttressed further that financial hardship, lying; quarrels, infidelity and violence are also possible outcomes of drug addiction at home. In most cases, the victim may not be able to take on his basic responsibilities at home. Family stress and loss of responsibilities could also result from drug use due to a condition involving a combination of shortage of money drained away on drinks or drugs, and inefficient management which leads to debt, stealing and not investing money in other needs of the family.

Smith (1989), Ethone (1992), Inciardi *et al* (1993) and Joe (1995), reported very high incidence of family violence among female substance users as a result of parental alcohol and drug abuse. In Joe (1996), for instance, 84% of the women in the sample indicated use of drugs or alcohol by one or both of their parents. Nearly half of the parents used marijuana, and over 33% of them cocaine. Joe's study

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showed that alcohol and other drug use was typically connected with family violence in the families of the respondents who described their home life as violent. People most immediately affected by someone becoming a problem drug user are their family members. The families of users of illegal drugs often suffer in many ways from having cash stolen, having goods taken and sold for cash, to introducing siblings to drug (Fazzey 1991).

On Work and Labour effects, Gomez (1991) saw a relationship between drug abuse and inability to perform well at work places. According to him, alcohol consumption impairs human motor and sensory organs, making coordinating of duties difficult. The alcoholic man in Gomez's view is difficult to work with. He is often late or absent from work, and engages only about 25% of his time in the work and labour, which affects productivity with consequent unsatisfactory work records.

There are contentions among scholars on the direction of relationship between alcohol and criminal behaviour. Some scholars believe that alcohol disposes persons to criminality and heavy drinking as sometimes a lead to crime, but more usually one amongst several factors of causal importance that are coincidental (Glatt 1952; West 1963; Shafer Report 1973; Guze 1976; Edwards, Hensman and

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Peto 1977; Fazey 1991; Rosenberg 1994)), others like James (1969) and Gordon (1973) believe the opposite.

Prins (1980), classified three major categories crimes likely to be associated with drug use viz:

1) Offences against various act and control, which include unlawful possession, distribution and consumption of drugs.

2) Offences committed in order to obtain drugs such as burglary, stealing and prostitution; and

3) Offences due to ingestion of drugs, such as traffic/motoring offences, public order crime, assault, and cases of serious violence or damage to property.

Prins' classification did not consider crime against individual as more important than crime against property as Rubington (1969) argued. From his study in America, Robington evinced that alcoholics were more likely to be involved in crimes against individual than against property and their crimes were more likely to be impulsive than planned.

From the foregoing discussions, drug addicts are deviants in the society, who present a problem of adjusting to the norms and values of their society. They therefore require a re-orientation exercise to enhance their re-integration into the

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society. Scholars have documented their views in literature about this rehabilitation process, including the underlining principles.

2.1.14 Principles of Rehabilitation

The drug addicts' rehabilitation process is integrated into the whole conceptualization of rehabilitation. The addicts are in themselves deviants because they violated the laws and conventions of their society by indulging in the abuse of drugs. Cressey (1961), proposed two principles of rehabilitation namely, the "groups-relations principle" and "clinical principle". They are in effect related to theories of rehabilitation of deviants. Group-relations principle for rehabilitating deviants is based on the interrelationship between personality and culture. And on the general criminological theory that maintains in essence that deviance is a behaviour, which a person in question has appropriated from the social relationships in which he has been participating. The main thrust of this criminological leaning is that deviance like other behaviours, attitudes, belief and values is the property of groups not of individuals (Staton and Schwatz, 1954). Deviance is therefore not just the product of an individual's contact with certain groups, but in its real sense a behaviour that is "owned" by groups rather than by the individuals.

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Taking the above assumption into consideration, Group relations' principle holds then that attempts to change the deviant behaviour of a person must be directed at modification of the groups owning the behaviour. Therefore if the behaviour of a man is an intrinsic part of the groups to which he belongs, then attempt to change that behaviour will succeed only if the groups are somehow modified. In this principle, individuals and group psychotherapy are rapidly becoming the rehabilitation devices. In individual psychotherapy, the psychological needs of individual deviants are of primary consideration, and the usual assumption here is that correction of any psychological disorder or problem the individual may have will change his criminality. It is also the position of the group relations' protagonists that individual psychotherapy is effective in changing criminality to the extent that it serves as a stimulant or inducement to changes in social relationships. The group relation principle also implies that for rehabilitating criminals there must be more than just group therapy. In addition, there must be opportunities for integration into groups that own abundant anti-criminal values and behaviour patterns. Therefore interaction in a clinical group might be effective as a rehabilitation technique to the extent that it gives the criminal participant experience in the role of a law-abiding person, and to the extent that these

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experiences carry over to affect the degree of group relations the participant experiences later.

Quite different from the group-relations principle, the clinical principle of rehabilitating deviants is also consistent with the criminological thinking that criminality is a personal trait or characteristic of a person exhibiting the behaviour. An extreme position is that criminality is a biological phenomenon. This view however tallies with much more popular theoretical position that criminality is a psychological and physiological defect or disorder, or a symptom of both. Here criminality is considered as the property of the individual rather than the group. The clinical principle implies that individual disorders producing criminality are psychological and are therefore to be corrected though psychological attention. The implication of this statement is that criminality is analogous to an infectious disease and should be corrected or treated clinically in the clinic without reference to the conditions under which it is acquired. Cressey further believed that the clinical principle is predicated on the view that because criminality is an expression of individual psychological disorders, it should be corrected by eliminating the disorders. Hence, because the disorders in turn spring from the restrictions societies have placed on "free" individuals, correction of them must be in the form of

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modifying the impact of the restrictions on the individuals. This include giving them relief from restrictions in form of "ventilation", "catharsis", "acting out" and other devices for removing tensions, aggression, unconscious tendencies and wishes, among other individual disorders. These rehabilitation principles, whether of the group relation or the clinical must be designed specifically to meet some expectations and objectives.

2.1.15 Objectives and Problems of Drug Addicts Treatment

Identifying and treating drug addicts by the use of different methods are not the ends of the processes in themselves. Rather it is important to understand the major objectives behind their treatment as already posited by previous scholars. For instance, Clausen (1961: 208) identified the major objectives of treating drug addiction as follows,

> "The treatment of drug addiction entails two major objectives. Firstly, terminating physiological dependence through the withdrawal of drugs with a minimum of suffering. Secondly, providing appropriate forms of therapy and training to increase the addicts personal resources so that he will subsequently not relapse or retreat to drug use".

However, these objectives may not be achieved smoothly without some anticipated problems during the confinement in the rehabilitation centre. Wilker (1955: 567)

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characterized the problem of rehabilitating the drug addict within the centre by believing that the most generally applicable statement that can be made is that by continuous use of certain drugs, the addict develops a *modus vivendi*, which is of value to him, however undesirable it may be from the standpoint of others. Consequently, re-education in drug-free environment appears to be essential if the probability of relapse is to be reduced. Furthermore, no controlled environment can duplicate the everyday life situations to which the client must return. Hence, the period of confinement in an institution should be limited ideally to that which affords sufficient time for available methods of re-education to be given a thorough trial. In the process of confinement within the rehabilitating centres, the drug addicts undergo an experience of living to accept or reject their change trials.

2.1.16 Adjustment and Social Influences

The concept of adjustment refers to the quality of adaptive

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the process of adjusting, the individual has to contend with physical factors in the environment to sustain life.

There are two major ways scholars have viewed adjustment. The first is the classic socio-cultural emphasis on the individual's adaptation to social demand. The second view is concerned with the individual's satisfaction in his relationships with the social environment, and or his growth and actualization. With reference to the latter, adjustment has been distinctively conceptualized by (Szasz, 1961), Homans (1967a) and Maslow (1970). For Szasz, adjustment can mean the process or desires such as motives, attitudes, and values to social requirements. In Szass's view, society is conceived as a force requiring an individual's compliance through socialization. From a different, though related point of view with Szasz's, Homans views adjustment in "ego-centric" terms as the satisfaction achieved by the individual through pleasing relationship with his environment. This view unlike Szass's focuses on the individual needs (rather than the conception of society as a force) and satisfactions in certain relationships or transactions with other people, within the social constraints of a culture. From Maslow's point of view, adjustment is sometimes presented in terms of an unfolding of the individual's potentialities

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through maturation and experience. It is a view that grew out of those theories of personality that emphasize self-actualization.

From the foregoing positions, though differing in emphasis, these views relate to the key theme of individuals functioning within the framework of social demands and requirements for social acceptance as Hollander (1971) argued. Therefore adjustment as a projected or internal behaviour may be due to a response to social influence or as a response to internalized frustration and conflict. In respect to the former, Hollander meant that the essential quality to adjustment is dynamism, that is prospect to change. Adjustment occurs whenever the individual encounters new experiences from the external factors that require response. But there are also internal motivations of the individual, which arising from past learning may operate to move the individual toward the achievement of social goals in the environment such as status, recognition, or power. Both the former and latter positions are anchored on the belief that adjustment is socio-culturally construed through social influences. The society and social order therefore present members with strong influences; which are highly pervasive; Ash (1959).

Sociologically, it is important to note that the group-based quality of human society is an inescapable fact of life. Hollander (1971) posited that social

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relationships pervade human experiences and carry demands in the form of expectations of others. These, according to Hollander are especially important where those others are significant to an individual's identity. Besides, the flow of social interaction progresses within the context of group norms and role demands.

Contrary to the above, Hollander also puts forward the idea that adjustment is a response to internalized frustration and conflict. This conception is derived originally from the view that individual motives, which cannot always be satisfied, lead to a state of frustration. This singular factor accounts for many theories of adjustment based on the egocentric definition offered. Satisfaction of one motive is sometimes inconsistent with the satisfaction of another equally impelling motive that leads to a state of internal conflict. In psychological perspective, frustration and conflict are conditions, which represent the essential bases of psychological adjustment. These can lead to expressive behaviour, as a relief from the tension produced by frustration, or to behaviours that could be instrumental in achieving the goal (Hollander, 1971).

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2.2 THEORETICAL FRAMEWORK

For the purpose of this study, some theoretical positions relating to social structure and deviance are utilized in explaining drug abuse behaviour. Sociologists and anthropologists usually conceive drug use as a social behaviour that could be explained by social theories, which fall under the general rubric of deviant and social problem. These include social disorganisation, control, social learning and Anomie theory, which are jointly applied through a synthesis. This idea arose from the perceived inadequacy of a single theory among these in explaining the problem of drug addiction, which is socially a procedural problem.

Social Learning Theory (SLT)

Bandura (1977) developed the social learning theory in explaining human behaviours and responses to social situations. The idea behind his theory was originally borrowed from B.F. Skinner's work in biological sciences and later developed and validated by Jessor and Jessor (1977), and Akers (1985; 1992; 1994). The social learning theorists assume dual directional relationships between deviance and conformity. To them conformity or deviance is influenced by the processes of modeling and reinforcement. In their major premise, the process of deviance development is akin to that of conformity, but the difference is the direction in

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which the processes operate, which makes individual behaviour a balance of social influences. It is an either all or nothing process. Human behaviours, which are either deviating or conforming to the norms usually, exhibit some stability overtime, although instability and change do occur with time or circumstances. Particularly, deviant behaviour is learnt through all of the mechanisms of learning process available to the individual. The theory assumed the principal mechanisms to include, differential association that involves direct and indirect interaction with others; differential reinforcement (instrumental learning through rewards and punishers); imitation (observational learning); and cognitive definitions (attitudes). These mechanisms present favourable or unfavourable contexts which function as discriminative (cue) stimuli for behaviour in any situation. The principal behavioural effects according to the theory come from interaction in or under the influence of those groups with whom one is in excessive association, which control sources and patterns of reinforcement, provide normative definitions and expose one to behavioural models and cognition. Non-conforming behaviour can be expected to the extent that it has been differentially reinforced over alternative behaviour, and is defined as desirable when the individual is in a situation discriminative for the behaviour (Akers, 1985), as Edwin Sutherland earlier enunciated in his sociological

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theory of differential association. Once an act has been performed, the actual consequences that act as social and non-social re-enforcers and punishers of the specific behaviour come into play to affect the chances that the behaviour in question will be continued or not, and at what level. The social learning theorists argued that initial acts might occur in the absence of definitions favourable to them, but they get applied retroactively to define the initial deviant acts. After a deviant activity has begun and the consequences accompanying it are experienced, the association patterns may consequently be altered so that further interaction with others is based, at least in part on whether they too are involved in the deviant activity and to what degree. This position is what Akers defined as sequencing and reciprocal relationship of feathering and flocking.

Social learning is a complex on going behavioural process, and the sequence of events is variable depending on the particular behavior and individual in question. Nevertheless, the typical process envisioned by the theory is that individuals interact and identify with different groups such as peers in which they are exposed to as behavioural models, norms and reinforcement patterns tending towards drug use or non-use. The balance of definitions favourable and unfavourable to use of drugs combined with imitation and anticipated balance of

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reinforcement produce the initial drug trials (Kaplan, 1996). In all instances of drug use, differential peer influence is not the only influence however, as common sense may deceive us. Parents, other family members, neighbours, church and religious groups, school teachers, physicians, authority figures and other individuals and groups in the community as well as the mass media and other remote sources of attitude and models have varying degrees of influence on drug use. It is important to note that when the differential sources act in harmony to move the individual in the direction toward either using or not using the drugs, the chances of behaving that way are maximized. While when these sources are in conflict, basically individual will most often behave similarly to close peers. It is usually believed that it is in peer groups that drugs typically are first made available and opportunity for use provided. After initiation into drug use, imitation becomes less important, although the facilitative effect of modeling may remain with great or no alternation. On the other hand, the effect of norms and definitions, which are heavily affected by the initial act of smoking or drug use, continue together with the reinforcement patterns. Whether an individual will continue or abstain from taking drugs depends on the past, present and anticipated future rewards and punishment perceived to be attached to each alternate decision. It will also depend on the attitudes, orientations,

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or evaluative knowledge, which are favourable or unfavourable to using drugs. These are cognitive and verbal behaviour, which can be directly reinforced. The more individuals view the behaviour of drug usage as good or at least justified, or excusable rather than holding to general beliefs or specific attitudes counter to drug use, the more likely the use of drugs, and consequently less likely to adjust well under rehabilitation. There is indeed an assumed relationship between drug use and the social learning variables of differential association, differential reinforcement, cognitive definitions and imitation. The drug addict is more likely to continue the use of drugs and responding negatively to social rehabilitation when he or she still associate with those who use drugs and hold attitudes favourable to smoking or drug use by craving for it. Hence War (1993) maintained that individuals are commonly introduced to delinquency by their friends and subsequently become selective in their choice of friends, referred to as the principles of "feathering and flocking" which are not mutually exclusive but may instead be part of a unified process of complex sequential context and feedback that affects the human learning process.

The social learning theory explained more details about particular individual behaviour of conformity and deviance as being influenced by the individual contexts. This theory does not put into much consideration the broad society and

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sociological contexts of behavioural occurrence. To this end, other social theories are applied to explain the problem of the study. These are social disorganization, control and anomie theory.

Social Disorganization Theory (SDT)

Unlike the SLT, the social disorganization theory (SDT) proposed by Shaw and McKay (1931) explains and predicts deviant behaviours as being influenced by basic social factors, such as differences in economic status, residential mobility and physical nature of neighbourhood in which heterogeneity manifests. Rather than the individual-based explanation of the social learning perspective, the theorists assumed that deviant behavioural manifestation are commonplace in large complex societies. They believed that as the societal structure and contexts progress from simple to complex nature, deviation and non-conformity to societal norms and values increase. These behaviours become stronger as the limits of social interaction extend from local, face-to-face to large human settlements of cities and urban life where the social consequences of various forms of personal conduct have become discernable. In this process of societal transformation, the extended family and close-knit neighbourhood relationship and interaction, which enhance conformity

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relatively, disappear. In its place individual's indifferent attitudes to actions that surround the urban life become pre-eminent.

The social disorganization theory lays the background to the idea that the closer individuals are bonding into an informal network of social relationship, the greater the degree of conformity. When individuals are in a heterogeneous environment where there is variance in economic and social status, there will be no value consensus due to non-conformity of social values, which creates conflict situation. This theory therefore predicts conditions where antisocial behaviours are most likely to thrive due to the opportunities and lapses created by structural heterogeneity of values and consequently disorganization. When there is cultural heterogeneity, conflict in values and rules, the social control mechanisms will also be in conflict, weak and minimally functional. Apparently, individuals will deviate from the norms because the rules in existence may either be too loose or too harsh in application.

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Control Theory (CT)

In complement to the above theories, Hirschi (1969) in his control theory believed that the quality and measures of control exercised on the individuals could be used as a predictive measure for their propensity towards antisocial behaviours. In his

proposition, presence of effective control system prevents individuals from engaging in antisocial behaviours. This effective control is embedded and sustained in the collective consciousness of the society that limits individual actions. Hirschi identified individual attachment to the significant others, commitment to the conventional values, involvement in conventional activities and belief in the validity of social rules and norms as adequate control measure like in the simple societies, which are not expressively punitive in any way. Durkheim and Tonnies originally proposed this idea in their analysis of social relationships that exist in the simple, traditional society referred to as mechanical solidarity and *geimeinschaft*[11] respectively. Hirschi attributes conformity to social values on one hand and deviance on the other hand as outcomes of strong and weak attachment to the society. Most deviants are characterized by lack of strong bond or attachment to the conventional society. This lack of strong attachment induces development and maintenance of excessive relationship and stronger ties with deviant social network over that of conventional others. Theoretically, the social deviants according to Hirschi (1969) do indeed lack strong social assurance, confidence, and interpersonal

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[11] Geimeinschaft is a German word in Ferdinand Tonnies Philosophy and typological explanation of human society, which could be equated with rural/informal setting in the present sociological studies.

skills to the points of social disablement. However, the theory further holds that commitment to values, aspirations of the society and to the route achieving those values make individuals less willing to jeopardize those values through deviance.

Anomie Theory

Furthermore, Durkheim's anomie theory, later developed by R.K. Merton provides another explanation for deviance in the society. This theory have been modified by scholars to account for the pathways to drug addiction problem in Nigeria, prominent among which include Oloruntimehin's contribution in the book titled, *Narcotics Law and Policy in Nigerian* [12], published by Federal Ministry of Justice. Durkheim advanced a grand social functionalist approach in explaining human behaviours. In his anomie theory, Durkheim believed that individuals indulge in deviance as a result of malfunctioning of the social structure. Durkheim who was interested in the question of social order, solidarity and morality in his society believed that there is collective consciousness, which transcends individuals, thereby exercising constraint on their actions and behaviours. Central to Durkheim's

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[12] The book, *Narcotics Law and Policy in Nigeria* edited by Kalu U. Uwa and Yemi Osibanjo (1990) contains contributions of scholars from diverse fields of study on drug abuse and trafficking. Other sociologically oriented contributions in the book include that of Dr Ahire, among others. There are also contributions on political economy, legal and psychiatric perspectives of drug abuse and trafficking.

thinking in his theoretical postulation is the importance of shared norms and values which are expressed in the collective consciousness that presents ideal patterns of behaviour expected to be common throughout the society. Durkhiem assumed that the dynamics of change and transformation of the society from the mechanical, traditional, face to face nature to organic and modernity is capable of sweeping away the moral consensus and solidarity spirit. This condition in part leaves people to feel unsure about morality in the state of loss of solidarity and communal spirit. For him, this state of loss of communal spirit may further create an anomic situation ensued by the state of normlessness, which is a combination of moral confusion and uncertainty. The anomic theory holds that deviance is likely to prevail in the society when the individuals are in conflict and frustrated with the rules and values of their society, like in the urbanized settlements. Besides, individuals are only likely to cope well in the society with the support of others, without which frustration, boredom, hopelessness and helplessness ensue. Therefore orderly functioning and conformity is a result of the mutual inter-dependence between the individual and the society.

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Synthesis

In explaining drug addiction and consequent adjustment patterns of drug addicts, it can be conceptualized from the sociological or society based theories of social disorganization, control and anomie that individual patterns may be determined by some variables. The onset, and continuity in drug addiction is likely to be determined directly by degree, level and nature of socialization process related to the individual. Implied in this case are level of discipline, supervision, expressed love and caring attitudes of significant others during the formative years. When these are negative then individuals will be exposed to the risk of drug addiction. The societal and family's nature and level of control, attachment to social values resulting to the definite level of social integration are important explanatory factors and variables that could also determine the degree of involvement in drug addiction. There is no doubt that negative attitudes and behaviours are unlikely to prevail in social conditions where there is strong social bond, effective control and integration. Lack of social attachment, control and integration, which result from heterogeneity, and conflict of values create leeways to drug addiction and related problem.

Negative or low level of responses of drug addicts towards rehabilitation may be theoretically linked up with the nature of their social and individual contexts and

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dispositions. The pressure of the predisposing conditions to drug addiction may as well be predictive measures for negative response and maladjustment toward rehabilitation. For instance, keeping the old drug using peers or returning to the old drug using neighbourhoods of clients may hinder their eventual positive adjustment. Even within the rehabilitation system, the value situations in the wider society may be applicable to drug addicts therein. There are different enclaves and groups where individual members or identifiers may be significantly influenced. Environment and place of rehabilitation may affect the drug addicts' adjustment levels considerably as advanced by rehabilitation theorists. In some places individuals may perceive the centres as being favourable and conducive to them, which in turn may significantly influence their disposition. These are described as dynamic variables (Beal, 1956), which are capable of influencing individual responses. Therefore the effectiveness of a rehabilitation centre or the level of adjustment or response of individual addicts towards their social rehabilitation may be determined by the degree, level and nature of re-socialization within the system (or type of system). The level of social attachment, integration, control and nature of value consensus and reinforcement, coupled with state of emotional fulfillment within the system may as well be influential in determining their adjustment and response patterns in the rehabilitating

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milieu. Other important variables that could influence pattern of adjustment in the rehabilitation process include, sex, age of initiation, and the pattern of addiction among others.

From the review of the previous studies and theoretical orientations, one would expect to find a number of characteristics and assumptions on uses, patterns of drug addiction, and its rehabilitation. Such will include the following statements.

- People who engage in drug addiction are initiated into the act mostly by peers or the significant others, than other potential sources.
- Most people who engage in drug addiction are initiated in an informal familiar environment such as homes, among others.
- Most people that are involved in drug addiction would have had their first drug as adolescents.
- The take off point in drug addiction differ among individuals in the developmental analysis, usually on the category of drugs at the initiation. More people are likely to begin with soft drugs.
- Pattern of drug addiction that develops after some time may differ as a result of difference in social, cultural and drug history background that

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are also dissimilar. Hence social background characteristics and life experiences influence pattern of drug addiction.

- As the number of years spent in use of drugs differ, continuity or discontinuity in drug use depends on the balance between the social reinforcement supporting the habit such as interaction with drug use sub culture *vis-à-vis* the punishers.
- Drug rehabilitates are most likely to adjust best towards staying off drugs in an environment (care center) that is participatory in approach.
- The way clients respond to the rehabilitation programme depends on the differences in category of addiction; socio-demographic characteristics; drug history and rehabilitation statuses.

These assumptions provided the basis for further examination of drug use and consequent rehabilitation processes as it were in this study.

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CHAPTER THREE

THE RESEARCH DESIGN AND METHODOLOGY

3.0 INTRODUCTION

This chapter presents the research design, which comprises of the description of the location of study, the centers of study and methodology. The methodology includes the description of the study population, the sampling procedure and how the information required for this study was procured from the respondents. The methods of analysis for the data collected are also presented.

3.1 LOCATION OF THE STUDY

Lagos State is chosen as the location for this study. The state was created in 1967. It has an area of 3,577sq Kilometers, and an estimated population of 5,685,781 people according to the 1991 census (FOS, 1996). Lagos state is the most densely populated, cosmopolitan, and heterogeneous centre in Nigeria and Africa south of Sahara. The city has a composite population of most Nigerian ethnic groups and other nationals. Apart from the above status, the state is unique and suitable for this study because it is the leading business nerve centre of Nigeria and West coast of Africa where various trades including those on illicit drugs take place. It harbours

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two out of three functioning seaports, and the major international airport in the country. The presence of these two features, the sea and the airports contributes immensely in active illicit drug trafficking in and out of Nigeria. The city of Lagos is noted in the literature as the " junction box'' of illicit drugs distribution and consumption within and outside the country, especially in the "triangular trade'' and the "golden crescent trade" between Asian crescent, Africa, and North America (Klein, 1994; Albright, 1997). The record of arrests of drug traffickers in Lagos can attest to this statement. The record is appreciably high and consistent, showing 102, 72, 62, and 63 arrested persons in 1990, 1991, 1992, and 1993 in that order. In the United Kingdom, Nigerians make up the largest number of foreign nationals in the prisons for illicit drug possession. Most of those arrested had their route through Lagos city (Green, 1991; Klein, 1994; and Home Office of Statistics, 1995).

The prominence of Lagos in the illicit drug trade created availability of drugs within the reach of the 'grassroots' people in the city (UNDCP Report on Nigeria and Kenya, 1994). Drug consumption is a notorious habit in the inner city areas of the metropolis where *joints* are found in all corners. These include the *bukas* and residential houses of the low-density areas of *Apapa,* the medium density areas of *Surulere* and the high-density area slums of *Ajegunle* and *Maroko* (Klein, 1994).

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There are drug addicts on and in the streets of Lagos known as *'area boys and girls'* whose drug consumption have turned them to social miscreants in the society (NDLEA, 1992; Ekpo *et al* 1995).

As the problem of drug abuse and area boys' phenomenon became prominent, the Lagos society responds in various ways in an attempt at rehabilitating these deviants. These include medically oriented psychiatric system, social welfare, and faith-based system. In this respect, Lagos state habours one of the foremost psychiatric wards for drug addicts' rehabilitation in Yaba (T. Asuni and A. Lambo wards) and a drug addict's treatment ward under the General psychiatric ward in the University teaching hospital Idi-Araba. There is also a recently developed social welfare rehabilitation centre for drug addicts in Isheri (Good Boys and Girls home) and other centres established by the voluntary agencies and nongovernmental organizations, mainly the religious organizations. These rehabilitation centres are established as non-profit making towards rehabilitating the addicts. An important aspect of recognizing these organizations is by understanding the various approaches, which they adopt in achieving their major objectives.

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3.2 STRUCTURES OF THE SELECTED REHABILITATION CENTERS

The centres chosen to represent the psychiatric method are the drug addicts' treatment wards in Yaba psychiatric hospital and the Lagos University Teaching hospital's psychiatric ward at Idi Araba. Apart from the major feature of medical orientation, they are considered as government designated centres. The 'Good Boys and Girls' home is chosen, also a government designated centre. Christ Against Drug Abuse Ministry (CADAM) located at Akute (ACME Parish Ikeja) established by the Redeemed Christian Church of God (RCCG), and The Finger of God's Ministry located at Ijaiye, Lagos are the centres chosen to represent the faith-based system. These centres differ from the government owned because their establishment and funding is non governmental based. The functions and operations of the above mentioned centres are derived from their names.

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3.2.1Yaba Psychiatric Hospital (Drug Addicts Treatment Ward)

The Yaba psychiatric Hospital was established purely for treatment of general psychiatric cases and illness in Nigeria. At the period the hospital was built, there were probably little or no severe cases of drug addiction. However, with the growing problem of drug-abuse and addiction, the World Health Organization and United Nation's Drug control Programme jointly established drug-addicts' treatments wards

in selected psychiatric hospitals in Nigeria. Among other hospitals that benefited from this project Yaba Psychiatric Hospital has the T. Asuni and A. Lambo Wards established purely for drug-addiction cases or cases that are clinically related to drug-addiction.

The major objective of the rehabilitation centre is to reduce the effect of hard drugs on clients through medical or drug therapy, and consequently reduce the cases of drug-addiction in the society. This objective is also carried out through the treatment of those that are already affected by drug addiction on one hand, and by enlightening the entire society on the dangers of use of prohibited and dangerous drugs on the other hand. In achieving its major objective, the centre had engaged the services of a good number of professionals and auxiliary workers since inception. On the average the Centre handles about 500 clients per year in different batches.

Presently, the centre has 104 clients comprising of resident and non-resident clients who are being managed by 33 trained professionals and auxiliary workers. These staff is engaged in various departments. In other words there is an organizational structure in place which has the Chief Medical Director of the Psychiatric Hospital as the General Overseer and Administrator. Under him is the industrial unit concerned with skill training, the medical and psychiatry unit who are

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in control of medical examination and administration of drugs to the clients. There is also the social work unit that is engaged in the counseling and psychotherapeutic works. Generally, all the staff is involved in the processes of managing the addicts. The funding of this project is purely by government and it is statutory based.

3.2.2 Lagos University Teaching Hospital (LUTH) Drug Addicts Treatment Unit under General Psychiatric Ward

The Lagos University Teaching hospital is located on Ishaga road in Idi Araba area of Lagos state. It is a teaching hospital with a general psychiatric ward established in 1977. The drug addicts' treatment process is undertaken in the general psychiatric ward. Drug addiction cases are separated and treated exclusively without mixing them up with other psychiatric cases. The centre's major objective is to treat and help in integrating the drug addicts into the society. The treatment process is carried out mainly through chemotherapy.

Since its inception, the centre has handled 1,400 clients. At present session, there are about 86 clients comprising resident and non-resident categories. The unit engages the services of more than 35 professionals who are engaged in one or more aspects of the project. The medical Director of LUTH is the head of all

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administration. However the social work and medical professionals who are involved in counseling and drug administration respectively oversee the daily activities of the unit.

3.2.3 Isheri Rehabilitation Centre (Good Boys and Girls Home)

The Good Boys and Girls Rehabilitation home is located within the isheri Rehabilitation centre in Isheri area of Lagos. There is a reception centre for the project at Lagos State Secretariat Alausa, Ikeja handled by the task force on environmental sanitation and miscellaneous offences. The centre where the programme takes place was established in 1997 by Col.Buba Marwa administration. This project is similar to the Peoples Bank Drug Addicts project of 1993 at Adeniji Adele Area in Lagos Island.

The centre was established purely with the aim of getting rid of social miscreants (area boys and girls) on the streets of Lagos and to improve on their social well-being and quality of life by engaging them in skills and other therapeutic measures. Since its inception in Alausa in 1997 to Isheri (the present site) in 1999, the centre has amanaged over 3,000 cases of drug addicts. Presently there are 235 clients attending the center's programmes either as resident or non-resident clients.

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The centre has staff strength of 15 professional social workers and Para-professionals in various departments and units of the centre. There is a detoxification and drying out centre for the programme at Majidun, Ikorodu affiliated to the main centre. The prospective clients pass through this centre before going into the *Isheri* centre.

The States Director of Social Development is the head and controller of this programme. An Assistant Chief Welfare Officer who is in charge of the daily affairs of the centre directly assists her. Under the Assistant Chief Welfare Officer there are social workers in the social welfare unit, medical officers, vocational workers, administrative/auxiliary workers and the non-professional staff including ex-drug addicts who had benefited from the programme. All these units work together in realizing the objective of their programme. The funding and policy directive of the project is from the state government.

3.2.4 Finger of God's Ministry (Drug Addicts Rehabilitation Centre)

The Finger of God's Ministry is an arm of the God's Kingdom Ministry. God's Kingdom Ministry is a Pentecostal Church located at Ijaiye area along Abeokuta road in Lagos State. The Finger of God's Ministry takes care in rehabilitating and correcting drug addicts. It is a pure faith based centre established in 1989. The major objective of the ministry is to help the addicts abstain from drug use. This mission

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helps the government in managing the growing number of drug addicts in Nigerian society.

The centre has 92 clients both residents and non-residents in its record at the time of this study. Since its inception the centre has handled several cases on which adequate record does not exist. There are 8 staff members that are in charge of attending to the clients both on spiritual and non-spiritual matters. At the top of the administration of this centre is the General Overseer of the parent ministry, God's kingdom Ministry. Under the General Overseer, there is a Provost who is in charge of the day-to-day administration of the rehabilitating arm of the ministry. There are other staffs in the vocational, medical, and religious units. These units' staff is in charge of daily trade practices, drug administration, and spiritual jobs respectively. The members of staff do not work in isolation rather they work as a team. The funding for this project comes from voluntary organizations and non-governmental agencies.

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3.2.5 Christ Against Drug Abuse Ministry (CADAM)

Christ Against Drug Abuse Ministry is one of the social welfare oriented arms of The Redeemed Christian Church of God (RCCG), ACME Parish Ikeja Lagos. The

ministry has its own centre for drug addicts' correction in Akute via Ojodu Berger, and a preliminary drying out centre at Poka in Epe area of Lagos. It was established as a faith based social rehabilitation centre for drug addicts in 1992.

The two sub-centres of the ministry at Akute and Poka play complementary role to each other in ensuring adequate rehabilitating of drug addicts. The centre at *Poka* is established as a primary unit for initial drying out process before the clients are transferred to Akute (Ebenezer house) for onward re-socialization process. The Akute centre in this regard functions mainly to re-establish drug addicts' faith in genuine human existence. This is done through teachings of the scripture (Bible) and little of vocational skills to keep them as functional able-bodied individuals. Through this centre the clients are re-integrated into their nuclear, extended families, and the larger society as productive and responsible citizens.

There are 73 clients in the record of the centre who are attending their correctional programme. These include resident and non-resident clients. Available record lacks information on the number of clients that have benefited from the activities of the centre since its inception. The centre has a total of 13 staff, 10 at Akute and 3 at Poka sub-centres. The organizational structure maintained is similar to what obtains at the Finger of God's Ministry, Ijaiye. The Parish Pastor is the head

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of all policy administration. Under him there is a voluntary committee in charge of drug addiction control vocation. A coordinator to whom the religious, medical, administrative and vocational staff members are answerable in their daily duties heads this committee. The staff members in the religious unit who function as the care staff and field officers carry out the bulk of the re-socializing and correctional works. Like in the Finger of God's Ministry, this group of people includes ex-drug addicts who have benefited from the programme as rehabilitated people.

3.3 THE STUDY POPULATION

The target population for this study is the drug addicts under rehabilitation in Lagos state. "Drug addicts" here means people who have shown symptoms of behavioural disorders and consequently labeled as drug-addiction clients seeking "treatment" in the rehabilitation centres. The population characteristics include males, females, clients from diverse socio-economic, demographic, occupational and ethnic backgrounds. They share one thing in common- addiction problem, which makes them a homogenous group on the one hand and different experiences and drug histories, which strikingly make them seem heterogeneous on the other hand. The rehabilitation centres under which the study subjects are located are

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broadly categorized as psychiatric, social welfare and religious centres. There are a total of 590 clients in the three rehabilitation centres visited at the time of this study.

3.4 SAMPLE SIZE AND SELECTION PROCEDURE

This study used 430 clients as the main research respondents selected from five rehabilitation centres in Lagos. The 430 clients were derived from 500 respondents proposed which is 85% of the total population of 590 clients in the five purposefully chosen centres. The major criteria used for selection include, that the individual has stayed for at least one month in the centres and exclusively diagnosed drug problem without mental retardation or brain damage.

A multi stage selection procedure was adopted in the whole process. Before reaching out to the sample respondents, some scientific criteria were used right from the selection of the centres used. Time, resources and manageability were considered in addition to other sampling criteria adopted. One major criterion for including and selecting the centres is their ability to provide both resident and non-resident clients. Hence, in determining the centres used, a purposive sampling method was utilized in the process. Two psychiatric centres were chosen, which are the only ones well known for drug-addicts rehabilitation in the state. These two

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centres provided adequate number of clients from where a sample representing the psychiatric clientele was drawn. These are Yaba Psychiatric Hospital and Lagos University Teaching Hospital. The Isheri Rehabilitation Centre was picked, being the only known existing government social welfare centre designated for rehabilitating drug-addicts in the state. From the religious centres, the Finger of God's Ministry, and Christ Against Drug Abuse Ministry at Ijaiye and Akute were selected to represent the faith-based centres. At the time of the selection, the two centres were the ones that had enough clients to be combined for a meaningful derivation of the sample size required of religious centres. Besides they have both residential and non-residential facilities, which qualified them for the study.

Having purposively selected the study centres, designated for the research, the second stage of the selection procedure involved reaching individual respondents in the various centres. In this case, a proportionate sampling technique was utilized to determine 85% of the population in each centre as the sample respondents. With the exception of the sex category, which was visible, other criteria like length of rehabilitation, age, type of drug used, marital status etc. were not discernible. But the gender criterion was not applied strictly because of the irreconcilable and small number of females against males, which would have made

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the sampling mechanically formed. From each of the centers, which formed the basis of stratification, the respondents were selected through a random technique. This technique was adopted because there were no comprehensive registers in all the centres to be used as the sampling frame. So available opportunities were utilized effectively to sample the possible number of respondents from each stratum at various circumstances in a census like manner. At the end of the fieldwork, a total number of 430 clients were usefully sampled which reflected a proportionate representation of the entire population in the centres chosen for the study. Below is the distribution of population and sample according to centers.

Table 3.1 Distribution of the population and sample by centres

Centre	Population	Sample size
Yaba	104	76
LUTH	86	65
Sub total I (Psychiatric)	290	141
Good Boys and Girls Isheri	235	160
Sub total II (Social welfare)	235	160
Finger of God's Ministry Ijaye	92	76
Christ Against Drug Abuse, Akute	73	53
Sub total III (Religious)	165	129
Grand Total	590	430

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3.5 METHODS OF DATA COLLECTION

Having known who the respondents would be, where and how to get them participate in the study, and the data required, the issues specifically described below include the instruments and methods utilized, the rapid assessment of the study, training of the research assistants and the procedures adopted in administering the research instruments which are all within the ambit of data collection method. However, considering the nature of the study, information required includes both primary and secondary data related to the research subject matter, which influenced the choice and structure of the methods adopted as described below.

3.5.1 Research Methods (Techniques)

Research instruments are the basic techniques or tools utilized by the researcher in a particular study. However, the field worker or the researcher is his/her own principal research instrument. The various methods of investigation are alternative techniques for objectifying and standardizing his perception (Oke, 1984). Instruments are therefore not only materials in terms of the natural science perception but include the whole ways and means adopted in course of a research. The principal methods

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used in this research therefore, are the Survey, Key Informant Interview, In-depth Interview, Written Documents (Dossier), and Observation.

I) Structured Interview (Questionnaire)

The survey was one of the major methods used for the data collection. In the survey, the questionnaire or schedule was the instrument adopted. This instrument was adopted to realize some important information, which only the questionnaire could provide. The information sought with the questionnaire is precise and amenable to quantitative analysis. As an instrument, the questionnaire aided in translating the broad research objectives to specific questions, with the instrument, all the selected respondents were interviewed, which would have been more difficult and almost impossible with some other research techniques due to the space and time dimension involved in the research. The body of the instrument was designed using behavioural responses in most sections to measure the variables of the study. The questionnaire was divided into twelve sub-sections, from A to L (see Appendix I).

Section A, has questions on the basic socio-demographic characteristics of the respondents (age, sex, residence, family type, structure, function, relationship,

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discipline, educational and occupational aspects of parents and the parental supervision etc.). In section B, information on religion and religious disposition of the respondents was collected. Section C, dealt with the educational background of the subjects (educational qualification, educational interests and performance, and troubles during schooling). In section D, the questionnaire sought information on the present occupational status and the occupational history. As section E, dealt with the marital status, history and spouse relationship, section F and G presented questions on the income and financial management; and the social network system or environment of the respondents (both past and present), which include peer relationship, type, and media exposure among others. Section H, was on the criminal justice history, while section I seeks information on the drug abuse inventory, covering year of initiation to drugs, place of initiation, the initiator, type of drug and the neighbourhood availability. In Section J, the questionnaire had the respondents' rehabilitation history, and general attitudes and belief about the present rehabilitation referred to as dynamic variables. Finally, the psychological disposition and the adjustment (response) pattern of the subjects were sought in sections K and L respectively.

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The questionnaire instrument was designed after a review of existing instruments used for similar studies. With particular reference to some sections, for instance, the drug use inventory in section I is a modified form of what NDLEA (1992), and Agomoh (1994) used in their studies. Section K, which has question on individual psychological disposition was also derived and modified from the instruments used in Chiemeka (1991) and Oyefeso (1992). Also, the socio-demographic part of the instrument is drawn from Oyefeso (1992), NDLEA (1992) and Otu (1995). The last section of the questionnaire, section L is an adopted form of the Custodial Adjustment Questionnaire (CAQ) developed by Thornton in 1985 from custodial life, which relate to the level of inmates response towards correction in the total institution and later used by Chiemeka, (1991) in a custodial adjustment studies in the prisons. The modification given to this instrument (CAQ) in regard to this study include important adjustment items obtained from the social workers (custodians) in the drug addicts rehabilitation centres, which were added and tested in a rapid assessment.

II) In-depth Interview (In-depth Interview Guide)

In order to complement the survey technique, the in-depth interview technique was adopted in the research, in which life cases were examined. The instrument designed

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for this purpose is the In-depth Interview Guide (IIG). The major information sought with this instrument is the qualitative data that gives an in-depth description of the subject matter of our research from the drug rehabilitation clients (see Appendix II). With the in-depth interview, specific and detailed information regarding changes in personal attitudes and life styles of the subjects was collected. A total of twenty interviewees were selected, and their responses analysed for case presentations.

III) Key Informant Interview (Key Informant Interview Guide)

Being part of the interview sessions conducted, key informant interviews were conducted with the key informant guide (KIG). The interview was meant to create an interaction avenue between the researcher and group of individuals that are knowledgeable in the concept and problems of this research. The type of information sought in this case is also qualitative as it was the case with the in-depth interview with the respondents (see Appendix III). The only difference is that in the key informant interview, the focus and the type of information sought changed from the client centred information about themselves to expert centred general information about the subjects of study. The key informant interview aided in

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obtaining "*informed guess*[13]" of the experts in the field of study and at the same time facilitated as checks on the information already provided by the subjects. The major information obtained from the key informants include, how the drug addicts are being remobilized and corrected. A total of ten key informants were interviewed, two from each of the centers visited.

IV) Observation Technique

The observation technique was also utilized during the data collection. It formed one of the primary tools of investigation, as the researcher was ironically the instrument in this case (Oke, 1984; Koul, 1984). This method was used to evaluate the overt behaviour of the subjects in their rehabilitation environment. There was some information, which the respondents were not able to divulge either through oral or structured interview. But through systematic observation of the situation, such information was obtained. A sketch of an observation guide was used, though with a lot of flexibility.

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3.5.2 Data Collection Procedures in the field

At this stage some crucial steps were taken to ensure that reasonable and relevant data were collected for the research project. These include selecting and training of the

[13] Information provided out of high quality experience by an expert in a particular area of investigation.

research assistants, rapid assessment, negotiating access to the centres and research respondents, then administration of the instruments.

I) Selecting and Training of Research Assistants

Three research assistants and three professional social workers were selected and trained for the data collection. The selection criteria were possession of a first degree and the willingness to participate in the project. The three research assistants involved in the project are graduates of sociology, while the three social workers are professionals from other disciplines, including guidance and counseling with not less than three years working experience. The latter were chosen from other care centers in Lagos.

After selecting the research assistants, basic in-house training workshop was organized for them. The training involved giving the research assistants the basic instructions on the focus, objectives, the ethics, time and space considerations of the research. Practical instructions were also given with regard to the research instruments they administered. Beside the sociology graduates and the social workers, the services of some ex-drug addicts who are beneficiaries of the various rehabilitation programmes were utilized during the data collection. They were

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useful in locating where some of the non-residents were engaged in work when the need arose.

II) Rapid Assessment

The instruments designed for the data collection were subjected to initial trial testing. The trial testing was aimed at ensuring that ambiguous questions and issues were adjusted. Before the trial, face validity was given to the three instruments meant for the study (Questionnaire, in-depth interview guide, and key informant interview guide) by experts in the field of social research, namely, sociology, anthropology, psychiatry, social work, and guidance and counseling. Adjustments were made on the content of these instruments in the process. When the instruments were later sent to the field, it was observed that some of the questions were not well interpreted by the respondents, either because they were not clear, non-specific to the point. The affected items and questions in the instruments were modified based on the response pattern of the assessment. The researcher, had to ask the respondents for the appropriate ways to direct some questions to tap their own understanding for the questions that were either not answered or doubly answered. The same procedure was adopted in reviewing the In-depth Interview and Key Informant Interview guides. Based on the outcome of these review after the rapid

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assessment processes, the instruments used for the data gathering were made to suit the purpose for which they were meant.

III) Accessing the Centres and Clients for the Study

Making a choice and identifying the centres that were used was quite a different issue, while gaining access into the centres and consequently buying the time of the clients became another. At the initial stage, an official introduction letter requesting for a permission to carry out this study was issued and distributed to the various centres. After this stage that involved receipt of permission to carry out the research, gaining access to the target respondents became another problem that was tackled. Buying the time of the respondents through different means and processes surmounted the problem of access.

The first process was brief preliminary visit to the designated centers, purposely to acquaint with the clients to be studied. This was done through being physically present at the centres and being informally introduced to some of the respondents, which was actually the follow-up to the initial stage. In order to get closer to the population, the research team paid regular visits to the centres to familiarize with the clients and caregivers. In this process, for instance, the researcher particularly attended church services and ministry meetings with the

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clients in the religious rehabilitation centres. Those clients in the social welfare and psychiatric centres were also interacted with at a very informal level during the visits, which opened the gate for the data collection. This approach adopted by the researcher in trying to gain access to the centre and therefore "break the ice," prompted some questions from the clients to the researcher. Such as, "Are you here too"? "Are you going to stay with us?" The clients assumed that the researcher in the process of interacting with them at a very informal level was also one of their new intakes. Thus, the problem and barrier of "*We and They*[14]" dichotomy was summarily kept off. It could also be mentioned that the social interaction process between the researcher and the clients in the rehabilitation centres was facilitated by sharing words of discussions and little materials, which they informally demanded. For instance, there are occasions when some of the clients would request for some tokens for them to use as transport fare to go and see their relations in the city or house fellowship. Other times, they may request money for petty items such as garri or bread. These requests they made were not pre-requisites for responding to the researcher, as some of them did not form part of our respondents, rather they were

[14] This is an anthropologist's assumption of the perception of research subjects about a field investigator as an outsider or an intruder into their own cultural community. It is the strong psychological feeling of discriminating between ones own people and the emphasized others.

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intervening responses to the informal interaction which also triggered up the stimuli for good communication. This phase paved way and enabled the researcher to collect the relevant data available.

IV) Administration of the research instruments and techniques in the field (Doing the fieldwork)

The questionnaire, the in-depth interview guide and the key informant interview instruments were administered in the field to obtain the primary data. The questionnaire was administered according to the sample selection process designed. Strictly, there was a major distribution operational design, which is the residence status of the respondents (resident or non-resident). The instrument was not self-administered; rather the trained research assistants did the administration.

Different approaches were used for the resident and non-resident clients. For the resident clients, the instrument was administered to them each day after their lunch time until the required numbers of respondents were obtained. A different approach was adopted in administering the same instrument to the non-resident clients. The respondents in the religious centres were reached during special services (counseling) in the church (the Christ Against Drug Abuse Ministry calls its

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own, "*digging deep*[15]", while in the Finger of God's Ministry have night vigil days, usually on Fridays). Administering the questionnaires during these occasions in the centers usually takes place before the commencement of the programmes. In the social welfare rehabilitation centre (Good Boys and Girls home), and the psychiatric centres in Yaba and *Luth*[16], the administration of the research questionnaire was similar. In both centres their resident patients were attended to after the lunch time, as it was the case with the religious rehabilitation centres. But the non-resident clients were reached for the exercise during the weekly consultation days for psychiatric centres and Fridays for the social welfare counseling. On the counseling days, every client is expected to be present to be attended to by the experts. These include clients who do not reside in the premises known as " non resident clients" in the hospital terminology. Besides, during the weekly consultation and counseling days, some non-residents were reached to respond to the research instrument at their work places. This was made possible with the aid of some field social workers that usually engage in monitoring of clients who live outside the rehabilitation centres. For instance, some social welfare (Good boys and girls) non-resident clients were

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[15] Weekday counseling session organized by The Redeemed Christian Church of God (RCCG) for its members.
[16] Lagos University Teaching Hospital

located at the *Eko F.M.*[17], Ikeja, Lagos state Agricultural project, and the Lagos state Direct Labour Agency, and also at the *cornerstone Bakery*[18] Alausa, Ikeja where they are working. At the end of the fieldwork, out of 500 questionnaires employed, a total of 430[19] valid questionnaires were used for the analysis.

The in-depth interview took place after the questionnaire administration. The respondents for this interview were also reached during the same periods and occasions utilized for the administration of the questionnaire. The only difference was that the clients, both residents and non-residents interviewed were different people from those to whom the questionnaire schedule were administered to in the first instance. Selecting the respondents, interviewed, was based on the research principle of quota, purposive and usefulness of the respondents to the issues in the project, rather than the willingness of the respondents to open up to the interviewers. Each interview seemed informal and tape recorders were used to record the

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[17] Lagos State Radio Frequency Modulation station

[18] Bread and other confectionaries factory established by the state government as income generating avenue for the drug rehabilitation clients.

[19] Even though a total of 430 useful questionnaires were analysed, all the outputs of the quantitative analysis in this study is not expected to sum up to 430. This is because all the questions in the instrument are optional. None responses were excluded in the whole analyses wherever they occurred by declaring them as system missing. Some respondents deliberately decided to provide information as much as they could without being forced to do so. Based on the above, the responses derived are used for the purpose of answering the questions and addressing the issue of research rather than the unit of analysis.

conversations after which the transcription process took place. The interview was oral and communicative involving face-to-face posture. Although there was a written interview guide, a little flexibility was adopted to accommodate other relevant questions that generated follow up information that were not in the guide.

For the key informant interview, the choice of respondents in the field was based on two criteria namely, the willingness and the disposition of the informant; and the amount of experience in the field of drug-addicts rehabilitation and the study population. The key informants selected are professionals who had had minimum of three years job experience, and who possessed effective interaction skill with the *drug clients*[20]. Usually in respect to the latter, the field social workers were used. Ten key informants were selected and interviewed at the various centres studied.

Importantly, during the fieldwork exercise, critical observations were made and classified by the researcher. Observations made depended on the nature and type of rehabilitation centre of focus and the issue observed. Prayer sessions, duty

[20] Drug clients are those receiving care in rehabilitation agencies. These are interchangeably used as drug addicts in the rehabilitation centers as the case may be in some parts of this work.

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performances and examination of clients in the religious centres[21] were observed and witnessed. While in the psychiatric centres, some group therapy sessions were observed. Mostly, they were in the form of "ox bow"[22] sessions.

Also in the social welfare rehabilitation centre, the researcher observed vocational training sessions in the centre and visited some of the non-resident clients who work at the Cornerstone Bakery, Eko F.M. Ikeja, Lagos State Direct Labour Agency and the Task Force to observe the processes they are undergoing as part of their re-socialization. These observations were carried out at series of visits made at the various centers. This method afforded the researcher an in-depth and qualitative view of the research issue. Pictures were taken at various observation points, for instance, a farewell church service conducted in the honour of one of the drug addicts at the Finger of God Ministry was observed.

Written records were also accessed during the fieldwork, although not as extensively done compare to the questionnaire instrument, the interview guides and observations. Strictly, very important information was sought, as the research is primarily an empirical study. For instance rules, duty schedules and prayer rosters of

[21] Religious centers are interchangeably used as Faith-Based centres.

[22] Ox-bow session--This is a situation where the communicator (one of the clients) will be at the centre of a semi circle audience of his fellow clients interacting and sharing life experiences.

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the Christ Against Drug Abuse Ministry (Ebenezer House) designed for the clients was extracted for some useful purposes, a sample of the clients admission form from Finger of God Ministry, showing the nature of information required by the client to provide and some basic rules (see appendix IV).

3.6 METHOD OF DATA ANALYSIS.

Different methods were used for the two main sets of data, (the qualitative and quantitative) derived from the fieldwork. The quantitative data were coded and entered into the SPSS[23]. From this, the univariate analysis was performed showing the trends and pattern of the variables in frequencies and percentages. After this stage, further statistical tools were utilized in capturing the research objectives and questions. The univariate and bivariate analytical methods (Cross tabulation and Independent samples test) were employed for the first objective. Discriminant analysis was used to capture the second and third objectives. Most importantly, the univariate analysis (percentages), One–way Analysis of Variance (ANOVA) and the independent samples test (T-Test) were selectively used for the fourth objective aimed at distilling the means of some variables. The fifth objective was analysed by

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[23] Statistical Package for the Social Sciences

using the Chi-square test of relationship, and the Logistic Regression to know the contribution of each variable in predicting pattern of adjustment. However these tools were limited to the quantitative aspects of the objective because some observations and processes were qualitatively documented and analysed.

Unlike the quantitative data, the qualitative information was collected with the electronic tape recorders and later transcribed in paper. This information was sorted, and analysed contextually, both manually and by the use of "Open Code[24]" qualitative analysis package for windows.

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3.7 RESEARCH VARIABLES' DESCRIPTIONS AND DEFINITIONS

This section deals with the description of the variables involved in the study. The variables of the study are both quantitative and qualitative. In respect to variable measurement, only the quantitative aspects could be subjected to some extent of definite measure, while the qualitative variables could only be described. Two major types of variables are in this study, the dependent and independent variables.

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[24] Open code version 2.0a is a freely distributable, copyrighted programme, known as "freeware", for handling qualitative information. UMEA and Epidemiology, Department of Public Health and Clinical Medicine, Umea University, Sweden developed it.

3.7.1 Dependent Variables

There are two groups of dependent variables: Drug Addiction Pattern, and social rehabilitation response (social adjustment pattern). ***Drug-addiction (Pattern)*** is the major dependent variable for this study. This is a state of being hooked in or illicit use of a particular drug or drugs without medical prescription in defiance of society norms and values. The emphasis here is on the drug-addiction development process. Assessing the category of drug of initiation and the category in use later on before the rehabilitation derives it. ***Social Adjustment*** is the dependent variable under addicts' process of social rehabilitation. It provided information on whether the clients are adjusting or not adjusting towards staying off drugs. It is a response of the interaction between self and a system (Chiemeka 1991). This variable was assessed in this study using two related options, namely a 19 custodial adjustment questions; and a more specific indicator assessing whether there is still an urge to take any drug as usual. The former encompasses general items in assessing custodial adjustment in general, which includes specific indicator for assessing drug addict's adjustment in the rehabilitation, while the latter contains specific module for drug use adjustment. The variable was used also as a measure of the effectiveness of the

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rehabilitation centers, by adopting the adjustment pattern of clients as the discriminating variable for the assessment.

3.7.2 Independent Variables

There are three groups of independent variables: Drug history variables[25]; social background contexts; and rehabilitation variables. The major independent variables in the process of drug addiction included from drug history group are ***Age at first drug use (Life stage of initiation)***, which means the actual age or stage in life at which the subject was first introduced to any psychoactive substances. The second is ***Venue of Initiation***, which is the place where the first drug use took place. And the third, which comes up with the above, is the ***Source of initiation***. This variable means, who introduced the subject to drug use or who provided? Requesting persons to be mentioned captured the variable. ***Length of Drug use*** is also a variable under drug history. This implies the actual duration or time spent in use of

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[25] The drug history variables were not only utilized as part of the independent variables with which the pattern of drug addiction could be described, some details were given to each of them as aspects of what drug addicts passed through at the formative stage, before they were finally hooked to the extent of seeking care. These set of variables were also used in generating some level of detail and in describing one another in this study.

drugs. It was derived from the year initiated to drug use subtracted from the year when rehabilitation began.

The second group of variables containing social background includes ***Family discipline.*** This is the extent to which individuals perceived their family members as liberal or strict. The variable was derived as a composite index of subjects childhood memories of his /her family members. The measurement was in a Rensis likert scale from Very Liberal to Very Strict. ***Family stability*** variable is about the level of stability in the subjects' families. Particular question used for this purpose was the marital condition of parents while growing up. This was measured qualitatively by conditional options from happily married to both dead as adopted by previous scholars, e.g. Adejumobi, (1992). ***Family size*** is the number of family members derived by asking question on the total number of siblings. For ***Social status,*** the educational level of both parents was used as a measure for it. The composite index parents' educational level was derived from the educational level of father, and mother put together. The ***Parental supervision***, taps how closely monitored the subjects were when growing up. It is measured by the use of parent's frequency at home from Often, to Not at all. Another variable is ***Family affection***, which implies the perceived amount of care received by the subjects from their family members.

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The variable is a composite index of subjects' perception of each of the family members care to him or her when growing up. This was also assessed by using Rensis likert scale, from Very caring to Uncaring, which is supported with questions tapping emotional content of affection in the in-depth interview guide.

Other variables include, ***Residential location (where grownup)***, which implies where the subjects lived in the early part of their lives. The options are Urban and Rural. ***Crime record (Criminal involvement)*** was also assessed. This variable was measured by the criminal record of the subjects which is a composite index of two questions, viz "ever been to prison" and "ever sent to remand" which had options of "Yes and No" each. ***Education*** is another background variable investigated. Asking for the actual educational level of the subjects to be provided, from Postgraduate down to None Formal education assessed it. ***Religiosity*** was measured using the subjects' rate of participation in religious activities from Often to Not at all. Finally for this group is ***Sex,*** which is the variable for gender[26] category as the case may be.

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[26] There is a striking difference between the concept, gender and sex. While the former is socially constructed by the society in relation to roles and cultural ascription of functions denoting masculinity and feminist, the latter is biologically defined. But they have been interchangeably used in social research as variables that mean the same thing irrespective of the conceptual differences

For the process of rehabilitation, other independent variables used include, ***Rehabilitation Milieu,*** which includes where and the major approach used for the drug addicts re-socialization. They are categorized as Medical/Psychiatric, Social welfare, or Faith based. Second variable in this group is ***Length of Rehabilitation***. This variable was measured by asking when the subjects began the social rehabilitation exercise. The year of rehabilitation given is then subtracted from the year of the study. ***Category of addiction*** is the same thing as pattern of addiction generated from the drug developmental analysis, using the discriminant model. *Rehabilitation* ***Residential status*** is the variable that distinguishes whether the client is a resident or non-resident in any of the rehabilitation center. ***Age***, the actual age of the respondents at the time of interview.

Besides measurable variables, there are some variables that are procedural and not strictly measurable. For instance how the drug addicts are managed, the problems of living with drug addiction, and some other peculiar life experiences are not subject to quantification. The combination of these two aspects of variables, qualitative and quantitative variables was adopted when required throughout the study. They are both complementary and supplementary to each other.

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3.8 PROBLEMS ENCOUNTERED DURING THE FIELDWORK

The collection of data during the fieldwork was not as smooth as the researcher anticipated. There were problems, which eventually reshaped this study to its present state. The proposed number of respondents (500) could not be realized during the fieldwork due to the decline in the number of clients in some centers.

Apart from the problem of fluctuation of clients and other problems that resulted to the inability to obtain valid five hundred clients to be interviewed as research respondents, gaining access to the key informants and the respondents, and obtaining information from them was not smooth, contrary to anticipation. Some professionals chosen as key informants refused to comment on some of the research issues for the claim of protocol. This condition was most prominent among the folks in the government based bureaucratic institutions (the psychiatric and social welfare centres). This however would have affected the quality of information collected if not for the patience exercised by the investigator.

During the fieldwork, the nature and complexity of Lagos City, especially transportation, made this work more tedious than expected. The various rehabilitation centres are located at the outskirts of Lagos State with the exception of the psychiatric centres studied, which are located in the heart of the metropolis.

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The distance between and betwixt the centres in the heat of Lagos City hustling and bustling seemed longer and excruciating. Because of this factor, the fieldwork lasted longer time than originally expected (from December 1998-September 1999)

These as described above were some of the problems, which the researcher encountered during the fieldwork exercise. In spite of these problems the researcher made some attempts through various adjustments without losing the focus and objectives of the study.

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3.9 SUMMARY

The research methodology adopted in this study was meant to tackle the necessary issues raised in the research objectives and questions. The study population consists of cohorts of drug addicts attending rehabilitation in five selected drug addicts rehabilitation centres in Lagos. Both the qualitative and quantitative data were generated for this study by the use of survey, oral interviews and observation. The data obtained in the field was analyzed by the use of some SPSS statistical tools. Major problems encountered during the field work are fluctuation of the study population, the difficulty in accessing both the centres and the clients, the sensitivity of the research issue which made responses a bit difficult, and the problem of

transportation and complex nature of the study area, Lagos. The next chapter gives account of the major findings of this study, with particular reference to knowing who the drug addicts are, processes and patterns of drug addiction and the problems of living with drug addiction to the individuals and the society,

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CHAPTER FOUR

PROCESSES, PATTERNS AND PROBLEMS OF DRUG ADDICTION

4.0 INTRODUCTION

This chapter deals with data presentation and analysis of findings from the fieldwork. It begins with the socio-demographic profile of the subjects studied. It also describes the initiation processes involved in becoming a drug addict, the pattern of drug addiction, the social background and circumstances sustaining drug addiction, and the influence of these social background on pattern of addiction. The chapter also deals with description of the pathways to social rehabilitation programmes, beginning from the period of living with drug addiction and the problems encountered, to the period of referral.

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4.1 Socio-Demographic Characteristics of The Respondents (Who are the Drug Addicts?)

We have to start by answering the question, who are the drug addicts? This is in order to provide insight into the basic profile of the subjects. From the Socio-demographic characteristics, the subjects studied are descriptively diverse. On the gender category, the majority of the respondents, 82.6% are male while 17.4% are

female. The age distribution similarly indicates some differences. From the sample, 86.2% of the respondents are adults of above 21 years, which constitutes the greatest percentage among the three groups. Young adults and adolescents constitute 11.2% and 2.6% respectively. Irrespective of the greatest number of the population being above 21 years, most of the respondents represented by 64.6% are never married, while 21.7%, 10.0%, 3.05 and 0.7% are married, separated, divorced and widowed in that order.

On the conventional values of religion and education, 1.2% of the respondents are traditional religion adherents and non-believers; on the other hand, the majority of the respondents are Christians represented by 70.5%, followed by Islamic adherents 27.2%. Based on education level, the highest cluster is within the secondary school level, which has 43.4% of the total respondents. Those with the higher national diploma and Bachelors degree constitute 24.7% while those who had post–graduate qualification are 2.8% of the respondents. However, only 2.8% of the respondents have no formal education while 14.9%, 10.3% and 1.2% of the respondents obtained Junior School Certificate, primary school certificate and ordinary national diploma grade in that order.

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Occupationally, most of the respondents 42.8% are unemployed, whereas those who are gainfully employed and still schooling are 34.7% and 22.6% respectively. The residential distribution is also marked with great differences in population. While 93.9% of the respondents dwell in urban areas, very small proportion 6.1% live in the rural settlement before rehabilitation. Having known the socio-demographic profile of the drug addicts, it is also pertinent to explicate the drug addiction life profiles of the subjects.

4.2 INITIATION PATTERNS AND PROCESSES

The initiation patterns and processes relate to the question of how drug addiction started right from the earliest stage of drug use. It involves understanding the sources of initiation, venues of initiation, types of drugs first used (drugs of initiation) and the age and stage in life when the habit started. Research question to be addressed in this section is how do people become drug addicts? In order to clarify this, the specific questions to be investigated include, what are the major sources of initiation or who led our subjects to drug addiction? Which places are remarkable for the process of initiation? What age or stage in life is most tempting to drug initiation?

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4.2.1 Sources Of Introduction (Sources Of Initiation)

Getting into drug addiction or becoming a drug addict is a social problem that starts at a particular stage and under particular circumstances in people's life, and also terminates at certain stage. There are days of the little beginning before the problem fully manifests. There is usually someone who is responsible for any drug initiation that occurs, but it could also be through self-experimentation.

In investigating the sources of initiation to drug use in this study, four major sources of introduction were revealed (Table 4.1):

Table 4.1: Distribution of Respondents by the major sources of initiation to Drug Use.

SOURCE	N	%
Can't remember	3	.8
Self	102	26.8
Other relations	13	3.4
Friends	226	59.5
Siblings	22	5.8
Parents	14	3.7
TOTAL	380	100

Source: Fieldwork 1999[27]

These include peers, self, family members and, other relations. The study indicates that friends initiated more than 50% of the drug addicts studied into drug use.

[27] As indicated above, the source of all the data presented in this report is the research fieldwork 1999.

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Another major source following peers is self-experimentation with drugs. Family members also contributed in the process, although at a very low level when compared with peers and self. The family members (parents and siblings) however contributed more than other relations who contributed insignificantly in the process. In all cases of drug types (soft and hard), peers remain the consistent major source to introducing people to drug use, also followed by self-experimentation as shown in Table 4.2, while the role of significant others (family members and other relations) remain less outstanding in all cases.

Table 4.2: Distribution of Respondents by major sources of initiation and categories of Drugs used.

Category Of drug	SOURCES OF INITIATION						
	Cant Remember	Self	Other Relations	Friends	Sibling	Parents	Total
Hard	-	3 (6.5)	-	43 (93.5)	-	-	46 (100)
Soft	3 (0.9)	99 (29.6)	13 (3.9)	183 (39)	22 (6.6)	14 (4.2)	334 (100)
Total	3 (0.8)	102 (26.8)	13 (3.4)	226 (59.5)	22 (5.8)	14 (3.7)	380 (100)

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It is interesting to note from the study that the family members and other relations did not introduce any of the respondents to use of hard drugs. This translates the fact that as hard drugs are usually substances that are regarded as dangerous, and their uses bad and illegal, family members do not wish their members to become hard drug users even though if they use it.

Further examination of the distribution of respondents' sources of initiation by sex shows that both males and females are initiated into drug use mainly through friends and self-experimentation, in order of importance (Table 4.3).

Table 4.3 Distribution of Respondents by source of Initiation to drugs, and sex

SEX	SOURCES OF INITIATION						
	Cant Remember	Self	Other Relations	Friends	Sibling	Parents	Total
Female	-	17 (25.8)	-	46 (69.7)	1 (1.5)	2 (3.0)	66 (100)
Male	3 (1.0)	85 (27.1)	13 (4.1)	180 (57.3)	21 (6.7)	12 (3.8)	314 (100)
Total	3 (0.8)	102 (26.8)	13 (3.4)	226 (59.5)	22 (5.8)	14 (3.7)	380 (100)

Other relations did not contribute toward initiating the females to drug use, while the siblings contributed least for them. Unlike the females, parents followed by other relations contributed, though the least in initiating the males. Greater

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proportion of males than females are initiated into drug use through all the sources, with the exception of friends where women have more proportion than men. This result is akin to what obtains in a typical Nigerian society where females, unlike males are protected and rarely exposed to use of even the soft drugs by their relations and family members.

Furthermore, some differences exit between the drug addicts based on their source of initiation by residence pattern. Table 4.4 shows that the majority of the respondents both from the urban and rural areas were initiated to drug use through friends, followed by self-experimentation.

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Table 4.4 Distribution of Respondents by source of Initiation and Location of Residence (where grown up)

Reside	SOURCES OF INITIATION						
	Cant Rememb	Self	Other Relation	Friends	Sibling	Parents	Total
Rural	1 (1.7)	12 (20.7)	3 (5.2)	37 (63.8)	3 (5.2)	2 (3.4)	58 (100)
Urban	2 (.6)	90 (28.8)	10 (3.1)	189 (58.7)	19 (5.9)	12 (3.7)	322 (100)
Total	3(.8)	102(26.8)	13(3.4)	226(59.5)	22(5.8)	14(3.7)	380(100)

However, the urban and rural respondents have different sources as least contributors to their drug use initiation. Parents contributed least for those drug

addicts from the rural areas, while the urban dwellers have their least support for initiation from other relations. From this result, the position of parents towards drug use initiation is not positive, especially in the rural areas where parents still stick to the mores of their society more than in the urban areas.

The in-depth interview from the fieldwork provides collaborative context with the survey. Friends influenced most of the respondents of this study, either through deceptive ideas about drug use or the need to be affiliated to friends. In the case of deception, peers do not tell intending initiates the adverse consequences of drugs they use. One of the respondents said that his friends told him that whenever he wanted to smoke marijuana he should drink milk first so that the drug will not have any adverse effect on his body system. In his words,

> "....my friends made me to try marijuana. Initially I was afraid of it. They told me that if I want to use it, I have to drink a pint of condensed milk every morning. That if I do so it will be good to my body system. Like for them, nobody can stop them from smoking marijuana, that it is good to their body".

The predominance of peers and self-experimentation as the major sources of initiation to drug use as this study revealed do not seem to be out of place with reality and the discoveries of other scholars. Peer pressure towards initiation to drugs becomes manifest when an intending drug user expresses need for affiliation

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to friends. Smoking or drinking for the first time occasionally begins when individuals think that they will be out of place within their peer network system when they are faced with the option of either using the drugs or de-linking with friends. This is very crucial especially when most of one's friends are drug users. The influence of peers as a major factor determining drug use habit cannot be underestimated. The peer factor in connection with other conditions such as environment, personality and cultural milieu come in when one considers that there must be a group through which every learning process goes. Involvement into drug sub-culture might be expected as a result of individual's participation in groups which marijuana use is commonplace. Peer pressure has a powerful influence upon the development of problem drinking among adolescent drug users, who report considerable difficulty in remaining abstinent when they are in certain social setting where drugs are used. The peer group reinforces the drug use habit through an inbuilt sub cultural support system apart from pace for the initiation, which they aid in establishing, Becker (1970), Gossop (1984), Adejumobi, (1992), Lo (1996).

Another respondent, a 43 years old drug addict retraced his use of drugs to friends when he was in the secondary school. The condition he found himself was so demanding that he had to give in to the demands of his friends in order to get along

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with them. They will see him as an " outsider" in the network if he refuses their offer. He maintained,

> " I started using drugs in 1972 when I was in the secondary school, both Indian hemp and cigarette. I was a day student then in one of the schools in Ibadan. There was a neighbour near my house, that neighbour was an electrician. So one evening in my Form III, I came back home from school on a weekend; he said that we should go out together. I agreed. As we were going out we met his friend who said that we should go to some-where (a hotel) to see his friend. So we went with him. When we got there he introduced us to a very fat prostitute in her room. After some time there, my friend called me out and asked me if I can do what they want to do. I was thinking that he was asking whether I can sleep with that prostitute, then I said yes. So he took me in. To my surprise they brought out something in a paper and that prostitute rapped it and lit it. Then she smoked and passed it round, first to my friend. When it reached my turn, I was innocent, instead of inhaling it I kept blowing it out because I was afraid of it, when I realized that it was Indian hemp. After the incident, my friend called me out and told me that I have disgraced him. Since then I stopped going out with that my friend".

Yet in the second incident or encounter, the respondent was faced with another challenge of accepting to smoke or face a boycott from his friends. He continued,

> " In my second contact when I went to the boarding house, we usually go to the Green Spring Hotel, Old Ife road Ibadan. It was there that my friend forced me to smoke marijuana. That incident took place near a swimming pool. I accepted it willingly and continued from there onward".

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However, there are various sources of initiation to drugs as highlighted earlier. In all cases, friends, followed by self-experimentation are the greatest and most visible sources of initiation to drug use, irrespective of sex, residence, and category of drug used. Family members (siblings and parents), and other relations are not considered as very important sources of initiation for all social categories investigated. Their influence from the revelations of this study is very marginal, when compared to friends and self.

There is also every indication that the venues where these drugs were taken for the first time also vary, and could also be related to source of initiation, sex, residence, and category of drug first used. This has a sociological implication in pointing out the places that are conducive for trying out and learning how to use the social drugs, and by what social categories of the addicts. The question to be investigated is, what are the important places where initiations to drug use occurred, for different social categories.

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4.2.2 Venues of Initiation To Drugs

Use of drugs is a process that takes place in different places for various reasons, especially in the first instance. Sometimes the reasons are society oriented, other times variations are as a result of convenience to the user. Where the use of abusive

drugs take place, especially for the first time, is a very important aspect of reconstructing the pathways to drug addiction in the sociological sense. The motivation to start using drugs is one thing, having someone who introduces it effectively is another, and the venue for the trial is very important.

In investigating the important places for initiation to drug use (Table 4.5),

Table 4.5: Distribution of respondents' by Venues of the first Drug Use

VENUE	N	%
Can't Remember	50	13.2
Bar/Hotel	32	8.4
Office	6	1.6
Friend's House	16	4.2
Joint	23	6.1
Party	36	9.5
School	57	15.0
Home	160	42.1
TOTAL	**380**	**100**

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home is revealed as the most prominent place where the intending initiates try out first use of drugs followed by school and party arenas. Bars and hotel are the next important places, while office is the least likely place where such an act could take place

As schools, homes, bars and hotels are known for making drug using friends and drugs available to the intending drug users, offices are known with the strict rules and regulations that are unfavourable to drinking and smoking. Drug using friends may

be in the office together, but the social environment where they are restricts them in exercising some personal habits such as smoking and drinking[28]. The above analysis shows that some social environments do influence the use of drugs more than others.

Similar to the above explanation, the place where first drug is taken could also be described in relation to sex of the persons (Table 4.6).

Table 4.6:Distribution of Respondents by Venues for the first Drug Use and sex

SEX	VENUES OF INITIATION								
	Cant Remember	Bar/hotel	Office	Friend's house	Joint	Party	School	Home	Total
Female	7 (10.6)	11 (16.7)	1 (1.5)	4 (6.1)	3 (4.5)	7 (10.6)	12 (18.2)	21 (31.8)	66 (100)
Male	43 (13.7)	21 (6.7)	5 (1.6)	12 (3.8)	20 (6.4)	29 (9.2)	45 (14.3)	109 (44.3)	314 (100)
Total	50 (13.2)	32 (8.4)	6 (1.6)	16 (4.2)	23 (6.1)	36 (9.5)	57 (15.0)	160 (42.1)	380 (100)

Note*[29]

It shows that both males and females are mostly initiated into use of drugs at home, after which schools become the next important venue. At the extreme, the office is revealed to be the least place where such habit could take place for both gender.

[28] Most public and private work organizations do not allow the use of any drug in their offices, and even within their premises. The inscriptions such as "No smoking" "Thank you for not smoking" are usually boldly written all over the conspicuous sights.

[29] The figures in parentheses are the percentages. This is applicable throughout this report.

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Difference also exists between the drug addicts with respect to their residence location (Table 4.7).

Table 4.7:Distribution of Respondents by Venues for the first Drug Use and Location of Residence (where grown up)

Reside	VENUES OF INITIATION								
	Cant Remember	Bar/hotel	Office	Friend's house	Joint	Party	School	Home	Total
Rural	9 (15.5)	8 (13.8)	1 (1.7)	6 (10.0)	4 (6.9)	3 (5.2)	5 (8.6)	22 (37.9)	58 (100)
Urban	41 (12.7)	24 (7.5)	5 (1.6)	10 (3.1)	19 (5.9)	30 (10.2)	52 (16.1)	108 (42.9)	322 (100)
Total	50 (13.2)	32 (8.4)	6 (1.6)	16 (4.2)	23 (6.1)	36 (9.5)	57 (15.0)	160 (42.1)	380 (100)

The pattern indicates that offices and homes are the least and the most prominent places for drug use respectively, for the two residence categories.

Furthermore apart from the homes that play the most prominent role as a venue for drug initiation, schools and party places are also important in the urban areas, while bars, friends' houses and schools play prominent role in the rural settlements. Another look at the venue of first drug use as it relates to who introduced the respondents to drugs (Table 4.8) makes some suggestions.

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Table 4.8:Distribution of Respondents by Venues for the first Drug Use and source of Initiation

SOURCES OF Initiation	VENUES OF INITIATION								
	Cant Remember	Bar/hotel	Office	Friend's house	Joint	Party	School	Home	Total
Cant Remember	1 (33.3)	-	-	-	-	-	1 (33.3)	1 (33.3)	**3 (100)**
Self	5 (4.9)	4 (3.9)	-	-	4 (3.9)	3 (2.9)	6 (5.9)	80 (78.4)	**102 (100)**
Other Relations	1 (7.7)	2 (15.4)	-	-	-	-	-	10 (76.9)	**13 (100)**
Friends	38 (17.3)	26 (11.8)	6 (2.7)	15 (6.8)	19 (8.6)	31 (14.1)	50 (22.7)	35 (15.9)	**220 (100)**
Siblings	1 (4.5)	-	-	1 (4.5)	-	-	-	20 (90.9)	**22 (100)**
Parents	2 (14.3)	-	-	-	-	-	-	12 (85.7)	**14 (100)**
Total	**48 (12.8)**	**32 (8.6)**	**6 (1.6)**	**16 (4.3)**	**23 (6.1)**	**34 (9.1)**	**57 (15.2)**	**159 (42.2)**	**374 (100)**

From the analysis, homes stand out as the highest place where first uses of drugs involving self, other relations, siblings and parents usually take place. This observation is with the exception of schools, which appears to be the prominent place where greater proportion of initiation took place through friends, rather than significant others when compared to other venues. Furthermore, friends are the only persons that are involved in initiating the respondents to drug use in all the existing venues, and the highest contributor in all the venues with exception of

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homes, where self-experimentation is the highest source. This observation recasts the conventional wisdom, which presupposes that friends are not likely to be the leading initiators of persons to use of drugs at home, which self-experimentation proved to be from this study. Parents were only involved in their ward's drug initiation at home. To some extent, this result shows the influence of environmental norms and persons in drug initiation. When the environment is perceived as being permissive it is expected that there would be a corresponding increase in the use of drugs applicable.

For instance more permissive perception of drinking norms is significantly associated with greater personal alcohol abuse even when controlled for personal attitudes. Thus, suggesting that perceiving a permissive environment encourages people to drink more heavily than they would otherwise do based on their personal attitudes, Wesley Perkins and Wechsler (1996). Most of the effects of drugs are shaped by social learning process. It is therefore misleading to discuss the use and abuse of drugs without taking into consideration the social environment and context in which they are taken and the meaning they have for the user. Some population characteristics are discovered to be more vulnerable to drug initiation and use than others due to their environment, Robins *et al.* (1980) Gossop (1982) Lazzari (1991).

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However, venues of initiation to drugs may vary in relation to the specific category of drugs (Table 4.9).

Table 4.9: Distribution of Respondents by Venues of initiation and different categories of Drugs

Category Of Drug	VENUES OF INITIATION								
	Cant Remem	Bar/hotel	Office	Friend's house	Joint	Party	School	Home	Total
Hard	**8** (17.4)	**9** (19.6)	**5** (10.9)	**1** (2.2)	**10** (21.7)	**5** (10.9)	**5** (10.9)	**3** (6.5)	**46** (100)
Soft	**42** (12.6)	**23** (6.9)	**1** (.3)	**15** (4.5)	**13** (3.9)	**31** (9.3)	**52** (15.6)	**157** (47.0)	**334** (100)
Total	**50** (13.2)	**32** (8.4)	**6** (1.6)	**16** (4.2)	**23** (6.1)	**36** (9.5)	**57** (15.0)	**160** (42.1)	**380** (100)

The table shows that "Soft drugs" (tobacco and alcohol) are mainly introduced at home, followed by school and party arenas, when compared to the "Hard Drugs" that have Hotels and Joints as the consistent places of their initiation, which may exclude sedatives because of their medicinal purposes at home pharmaceutical collection. The relative importance of hotels and joints for hard drugs vis-à-vis homes for the soft drugs is not a misnomer in the society. Most homes and schools do not tolerate use of drugs such as cocaine or heroine, even the Indian hemp. Besides, hard drugs are rarely available at homes, and when available, they are beyond the reach of

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the teenagers who may want to experiment with them. Adolescents do come in contact with hard drugs when they start going to hotels and joints with their friends.

This condition is quite different from what obtains in the case of the soft drugs that requires little or no secrecy to cope with. The soft drugs are regarded as socially acceptable to some extent, while the society views the hard drugs as dangerous and illicit, which connote some sociological implications, thereby affecting the venues for their usage. Therefore the venue of initiation to drugs is somewhat related to the possibility of getting and making use of the drugs in such places.

The soft drugs are shown to be more available in the neighbourhoods than the hard drugs (Table 4.10).

Table 4.10: Distribution of availability of specific types of drugs in the neighbourhood.

DRUGS	NO	YES	TOTAL RESPONSE.
COCAINE	61(33.5)	121(66.5)	182(100)
SEDATIVES	9(30.0)	21(70.0)	30(100)
AMPHATA.	13(56.5)	10(43.5)	23(100)
ALCOHOL	13(4.0)	315(96.0)	328(100)
HEROINE	45(30.8)	101(69.2)	146(100)
CANNABIS	35(11.4)	272(88.6)	307(100)
TOBACCO	9(2.5)	353(97.5)	362(100)
.HALLUCEN.	15(75.0)	5(25.0)	20(100)

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Tobacco and alcohol are the most available drugs in the neighbourhood, followed by Indian hemp, the sedatives, heroine, and cocaine. Amphetamines and the hallucinogens are least available. Drug availability is a major determinant factor for the use of particular drugs, translating that the more the drugs are available and easily accessible, the greater the spread of usage.

Clinical studies have shown that the exposure to stimulants can be the most important determining factor in the development of drug addiction and that controlled use veers towards compulsive use when the drug is more widely available and doses are consequently increased (Lazzari 1996). This situation is more effective when availability is associated with relative ease of procuring or purchasing the drugs, without the confrontation of the regulatory bodies or law enforcement agencies as it were the case even in Nigeria because some staff members of these law enforcement agencies are drug users (Raza, 2000).

The analysis on the venue for the first initiation to drug use showed that home is noted as the most consistent place where initiation to drugs takes place when compared to other venues. This is observed even against some selected variables, namely, sex, location of residence, category of drug (soft) used, and all the source

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of initiation, with the exception of friends who were mostly important at schools. Venue of initiation could equally relate to the age of initiation to drugs.

4.2.3 Age Of Initiation To Drug Use

Age and the stage in life when people get into drug use is also an important issue in retracing the antecedents of drug addiction. Important questions in this direction include, at what age are people of various social categories most likely to get into drug use for the first time, and at what age do people get into the use of specific types of drugs? In investigating these, this study reveals that use of drugs begins at a mean age of 16years, which is at the adolescent stage in life while there are differences in the mean ages observed for specific types of drugs (Table 4.11).

Table 4.11: The minimum, maximum, and mean age of initiation to different Drugs

_DRUGS	Min.Year	Max.Year.	MeanYear	STD.
Cocaine	10	53	25	7.09
Sedatives	13	35	22	6.27
Amphetamines.	13	34	22	6.92
Alcohol	5	47	15.5	6.18
Heroine	10	43	24	6.49
Cannabis	7	49	21	5.98
Tobacco	5	48	17	5.59
Hallucinogens.	16	41	26	7.69

The observation from the analysis shows that while the soft drugs (tobacco and alcohol) usage begins at average ages of 17 and 16 years, all the hard drugs are tested

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for the first time after the age of 20 years. Generally the mean age for initiation to drug use is 16years.

This shows interlink between age and categories of drugs classified as either soft or hard and the age of initiation. It further indicates that the soft drugs are the "gateway" drugs abused at much earlier stage in life when compared to the hard drugs, which usually begin later at an adult stage. This observation is in line with the conventional wisdom, which supposes that the cheaper, the more available, and societal tolerant drugs are likely to be abused earlier and by adolescents than the more expensive, scarce, and society prohibited drugs (hard drugs). Furthermore, the observation also shows that the Indian hemp possesses an average initiation age of 21 years, which is lower than the ages for the major hard drugs (cocaine and heroine) and higher than the soft drugs. The Indian hemp is therefore observed as a "bridge drug" after the "gate ways" and the most widely used among other hard drugs in Nigeria (Raza, 2000)

It is also important to know the mean age of initiation to drugs by the sexes and also to know whether there is a difference in mean age of initiation to drug use based on the sex of the respondents (Table 4.12).

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Table 4.12 Mean age at initiation by sex, and summary of Independent Samples test comparing the means

	Sex		MeanDiff.	t-value	Df	Sig.
	Female	Male	.25	.314	1	.754
Mean	16.4	16.6				
Std	(5.90)	(6.09)				

The test shows that sex of the drug addicts does not determine whether use of drugs start early or not, as both sexes commenced use of drugs at an average age of 16years (adolescence). Even though, there are research findings on the influence of sex on disposition to drug use, such revelations did not show the influence of sex on age at which drug use begins, which is what this study also did not show.

For location of residence while growing up, and its relationship with age at which drug use begins, the study (Table 4.13) shows that there is no significant difference between the mean age of initiation for respondents that grew up in rural and urban areas respectively.

Table 4.13 Mean age at initiation by Residence, and summary of Independent Samples test comparing the means

	Residence		MeanDiff.	t-value	Df	Sig.
	Rural	Urban	1.49	1.458	1	.149
Mean	17.46	15.98				
Std.	(7.05)	(6.09)				

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This is irrespective of the fact that the urban dwellers were observed to be a bit earlier in age of initiation than the rural dwellers. This observation points to the fact that, because drug use is predominant in the urban areas more than the rural settlement, it does not mean that the urban dwellers get initiated to drug use at significantly earlier age than the rural folks. These only show that the urban dwellers do get involve in drug use about one year earlier than their rural counterparts. Significant difference does not even exist between these two categories (rural and urban) with respect to the age of initiation to specific categories of drugs.

For the age of initiation to drug use and sources of initiation, no significant variation exists in the age of initiation among the respondents based on their sources of initiation to drug use (Table 4.14).

Table4.14 Mean age at initiation by sources of introduction, and summary of analysis of variance between the means

DESCRIPTIVES						ANOVA				
Sources of Initiation						**Sum Sq.**	**Mean Sq**	**Df**	**F**	**Sig**
Can't rem	**Self**	**Other Relation**	**Friend**	**Siblings**	**Parents**	218.640	40.729	5	1.100	.000
11.67	16.2	10.09	16.18	15.91	15.21					
(5.77)	(6.57)	(3.12)	(6.14)	(7.09)	(6.09)					

From the table, other relations were responsible for the earliest age of initiation, which is very low, compared to when parents, siblings, and subsequently

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friends and self-experimentation were involved in the process. This result shows that other relations, who might have met the initiates at home or in their friend's house, initiated earliest contact with drugs among the respondents. Friends were those that took the most active part compared with other persons later in the process, perhaps when the respondents started going to school and subsequently spending less time with parents.

Different mean ages are revealed also from the analysis investigating ages by first venue where the initiation took place, as shown in table 4.15.

Table 4.15 Mean age at initiation by venue of initiation, and summary of analysis of variance between the means

DESCRIPTIVES **ANOVA**

Venues of Initiation								Sum Sq.	Mean Sq	Df	F	Sig
Can't rem	Bar	Offic	Frien house	Joint	Party	School	Hom e	1406.04	200.906	7	5.056	.00
16.18	18.47	29.00	14.08	16.65	17.00	15.50	15.41					
(5.97)	(7.01)	(3.99)	(6.59)	(8.18)	(6.52)	(5.08)	(5.80)					

From the result in the table, office stands out to be the venue where the average highest age of initiation was obtained, followed by the bar, party, and joint. This result is related to an earlier revelation from an analysis in page 137 of this study, which showed that the harder drugs are initiated into at a higher mean age than the soft ones, and more in the office, bar, joint and other places other than homes and

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schools. These venues are places where persons could be associated with as adults, rather than as adolescents and young adults. On the other hand, friends, house, followed by home are the venues where earliest drug use, and with the soft types took place.

However, the points and contexts of age, venue, initiator and the type of drugs used mark the process of getting involved into use of drugs and subsequently into addiction as described above which have some sociological implications. In explaining these processes in relation to sex, and location of residence, some patterns showing variations and differences were observed as also described above. The description of this process is incomplete without highlighting the emergent pattern of drug addiction, the role of social background contexts in the process, and the extent to which these factors influence the pattern of addiction.

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4.3 PATTERN OF DRUG ADDICTION AND LIFE-PROFILE

As human behaviours and processes are not universally the same in respect to habits such as drug addiction, it is assumed that there are variations in the process of getting into drugs and staying in the habit. Against this assumption, the following questions will be addressed. What are the patterns of drug addiction? How does it

relate to initiation pattern? What are the social backgrounds factors influencing patterns of drug addiction?

Based on the above research assumption and questions, a classification statistic was employed to discern the pattern of the drug life profile of the subjects with a view of knowing the types of drug addiction in the study population. The analysis in Table 4.16 Shows that there are two types of drug addicts representing two distinct patterns of addiction.

Table 4.16: Distribution of the Respondents By the Pattern of Drug Addiction and Life-Profile

PATTERN	N	%
Progressive (Low level Beginners)	392	96
Stable hard (High level Beginners)	17	4
Total	**409**	**100**

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First there are those who started with soft drugs and ended up with the hard drugs. Their life profile is termed "Progressive addiction". This is because there is an implied process and advancement trend (graduating out of soft drug usage into the use of the hard drugs). The second category of drug addicts depicts a non-changing trend with the hard drugs being the drug of initiation and the drugs of later usage. Their drug-life profile is termed "Stable hard addiction". When the populations of

the two categories of addicts are compared, the majority of the drug addicts known (96%) are "Progressives" while few of them (4%) are "Stable hard" category. This shows that there is greater tendency of people getting initiated into drug use with the soft drugs than the hard drugs. In very few occasions when initiation is with the hard drugs there is virtually little or no tendency of retrogressing towards using the soft drugs. What is important in this classification analysis is the identification of the categories of addiction available in the centre, their proportion and the variation/heterogeneity in the drug sub-culture. The drug use sub-culture as observed in this study and similar to what other scholars have found out is also a dynamic system. It entails a continuous process of selection, and changes within the cultural system after getting involved in the sub-culture, where individuals are bound to observe and learn the stratification, social categories and relations that exist therein. Within the system, people are differentiated at major turning points, from where they enter into different social worlds and fall into different kinds of associations; take on the features of different social types; come to occupy different positions and roles; and have different runs of experience which orient them along different career lines. From the foregoing position it is appropriate to say that the drug use sub-culture like any other human grouping is not a homogenous social

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arrangement in the strict sense, rather there are variations (Suther 1969; Hochman 1972).

An important observation from the analysis is the absence of retrogressing addiction (backsliding), which means that all the drug addicts studied are hard drug users before their rehabilitation commenced. However, what gives more meaning in explicating the points and process of becoming a drug addict whether of the progressive or stable hard category is the basic understanding of who were responsible for the drug addicts' initiation to drug use, where, and at what stage in life, both on the general and specific levels.

Apart from the above analysis in investigating drug addiction pattern, the social antecedents including aspects of drug history are also important variables that could be utilized in describing the pattern. Therefore it is important to verify how these two variables are related to the emergent pattern of drug addiction.

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4.3.1 Drug History antecedents and Pattern of Drug Addiction

An examination of the interface between sources of initiation to drug use and pattern of addiction shows that self-experimentation is the most prominent source of initiation to both the progressives and the stable hard categories, followed by friends.

This trend is slightly difference from the general description of the initiation process to drug use, with the exception of the revelation that other relations and siblings contribute in the initiation to progressive addiction only, without any contribution in the case of stable hard addiction (Table 4.17).

Table 4.17: Distribution of Respondents by sources of initiation and Types of Addiction

SOURCES OF INITIATION	TYPES OF ADDICTION		
	Progressive	Stable Hard	Total
Self	**98** (96.1)	**4** (3.9)	**102** (100)
Siblings	**22** (100)	-	**22** (100)
Parents	**12** (92.3)	**1** (7.7)	**13** (100)
Other relations	**12** (100)	-	**12** (100)
Friends	**203** (94.9)	**11** (5.1)	**214** (100)
Can't remember	**3** (100)	-	**3** (100)
TOTAL	**350** (95.6)	**16** (4.4)	**366** (100)

All the sources of addiction mentioned in this study contributed towards the progressive addiction, and in a greater proportion when compared with the stable

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hard addiction, which was responsible only by parents, self and overwhelming friends.

In considering the interface between type of addiction and age at which use of drugs begins, a significant difference is found to exist between the progressive addicts and the stable hard addicts (Table 4.18).

Table 4.18: Mean ages of initiation to Drugs between the progressive addicts and the stable hard addicts, and summary of T-test comparing the means

	Pattern of addiction		Mean Diff.	T-value	Df	Sig.
	Progressive	Stable	8.29	17.06	1	.000
Mean	16	24				
Std	(5.99)	(7.12)				

Progressive addiction is more associated with earlier and adolescent stage (mean age of 16years) as the age of initiation, than stable hard addiction, which has a mean take off age of 24 years in the adult life stage. In this case, social circumstances may function as the explaining factors for the difference in the mean age of initiation to drugs observed between these two categories of addiction in this study. Circumstances rather than need for affiliation and experimentation induce individuals to using hard drugs especially when the age of initiation is taken into consideration.

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In-depth interviews reveal that people who get into use of drugs with hard drugs and at an adult stage in life do so out of frustrations. One of the research respondents traced his first use of heroine to the period when his father died. His friends who convinced him that it would make him forget the loss offered the substance to him. In complement to the drug history contexts, which provided further basis for describing the pattern of drug addiction, the social background context is assumed to be of tremendous importance in determining pattern of drug addiction.

4.4: SOCIAL BACKGROUND CONTEXTS AND DETERMINANTS OF DRUG ADDICTION PATTERN

The social background context forms the basis for every human behavioral development. The initiation processes to drug use and consequent sustenance could only thrive if the social background is directly or indirectly supporting it. Whether the initiation to drugs begins at early or later stage in life, with soft or hard drugs it is important to know whether there are distinguishing, and also common social background antecedent features in support of the phenomenon. The main question in this section is, what are the social background factors influencing the pattern of drug addiction? The discriminant analytical model shows the important determining factors and the bases under which the drug addicts studied could be distinguished. The social background factors selected for this study and their relative importance in

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determining the pattern of drug addiction is discussed with some specifications according to variables (Table 4.19).

Table 4.19: Summary of Means, Test of Equality of Means and Social Background Factors Influencing Pattern of Drug Addiction

Social Background	Progressive Mean	Stable Hard Mean	Wilks Lambda	F	Df1	Df2	Sig
FAMDSCP	3.23 (0.89)	1.95 (0.74)	.922	34.46	1	407	.000
PASTPC	5.06 (1.26)	3.35 (1.87)	.946	23.12	1	407	.000
WHERGROW	0.88 (0.33)	0.47 (0.51)	.946	23.02	1	407	.000
CRIMREC	0.37 (0.48)	0.00 (0.00)	.976	10.04	1	407	.002
FAMSIZE	5.90 (4.09)	2.88 (2.20)	.978	9.13	1	407	.003
PAREDU	2.95 (1.41)	3.94 (1.12)	.980	8.16	1	407	.004
PARSUPER	3.26 (0.70)	3.71 (0.44)	.984	6.59	1	407	.011
FAMAFFET	3.09 (0.66)	3.47 (0.47)	.987	5.35	1	407	.020
EDUCATN	4.19 (1.41)	4.82 (1.24)	.992	3.35	1	407	.068
EARLYREL	2.83 (1.01)	3.18 (0.39)	.995	2.01	1	407	.156
SEX	0.82 (0.38)	0.82 (0.39)	1.000	0.00	1	407	.982

[1] *FAMDSP – Family discipline (level of liberalism), PASTPC – family stability, WHERGROW – where lived (urban/rural) while growing, CRIMREC – criminal involvement (record), FAMSIZE – family size, PAREDU – parental educational level (social status), PARSUPER – parental supervision, FAMAFFET – family affection and care, EDUCATN – educational level, EARLYREL – early Religiosity, SEX – gender category*

Family Discipline The general pattern from the analysis shows that drug addicts are most likely to come from families that have indifferent attitude towards discipline.

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This type of families is also lax and very liberal in controlling their members including the young ones. Liberal family is a favourable ground for different kinds of indiscipline to take root including drug use among adolescents and young adults. The evidence from the in-depth interview is a mix grill of how quality of family discipline affects drug addiction. The subjects of this study expressed feelings ranging from comments such as "my father was not keen, he does not care about what you do", "and hardly can I remember being beaten once by my father or mother". Other comments from the opposite direction indicating strictness include "my father does not play, he beats as many times as you misbehave". The level of family discipline as revealed from the analysis is a major determinant factor-influencing pattern of drug addiction and life profile. Specifically, more of the stable hard addicts had strict family background, while more of the progressives have very liberal family background during their childhood. The implication of the above revelation for this study is that people from strict homes are most likely to be initiated into drug use at a later age than those from liberal families. Other social background factors such as the state of the marital relationship between father and mother could also be very important in drug use developmental analysis.

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Family Stability

The study shows that the malaise of drug addiction is also a manifestation of unstable family condition (Adejumobi, 1992). The predominant familial atmosphere of the drug addicts studied is descriptively quarrelsome. Frequent quarrels by parents at home often make children develop aggressiveness. This condition could lead to loss of love at home, which may later lead the children towards being wayward and resorting to peers for the love and emotional gratification that are supposed to be derived from home. Quarrelling parents tend to be so preoccupied with their own problems that they neglect their children's need-love, affection and psychological satisfaction. This factor is not important only in predisposing people to drug use, it also affects the later pattern of addiction as the progressive addicts share more of quarrels at home than the stable hard addicts who are more inclined towards early or childhood family breakage. Most of the later category comes from broken homes affected by divorce and parental separation. It is important to ask why is this so? However, as the analysis shows, the quarrelsome atmosphere at home exposes children to early drug use with peers. People from this type of background mostly graduate to become hard drug users, because their past familial experience reinforces their habit. But for the stable hard addicts who mainly come from broken

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homes their later initiation to drug use and perhaps with the hard drugs could be understood from an aspect. Their parents' marriage breakage might have developed their minds to become tough enough to engage in illicit drug use later in life. And also there may be lack of father or mother figure to help in guiding them against the illicit drugs when the need arose. Therefore the nature of family atmosphere with regard to the relationship between father and mother gives rise to the level of affection available in a family.

Family Affection

Another family profile found to be prominent in predisposing people to drug addiction and determining the pattern is the level of family affection experienced by individuals. This study shows that excess of affection rather than lack of it leads people to drug use and addiction. When children are spoilt, they tend towards learning helplessness that affects their ability towards taking adult roles and facing the life reality. Lavishing of affection by parents further leads to indifferent attitude of parents towards the moral attitude of their wards e.g. in smoking and drinking. Although lavishing affection supports drug addiction, the degrees of its effects differ when pattern of drug addiction is considered. It is a significant factor-affecting pattern of addiction. The majority of the respondents interviewed expressed lavishing

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affection on them by their parents when they were growing up. Various responses sum up to "I have very cordial relationship with my family", "they trust me", "they love me and trust me". One of the respondents said,

> "Before I started using drugs, my relationship with my family members was cordial. If I ask of anything from mother she will give it to me. Even before I ask she will ask me of anything I need".

The respondent above lacked nothing his mother could provide. Such a child is spoilt and brought up to be helpless and hopeless. In a similar view, a 43 years old fashion designer provided a clearer view on the difference between the amounts of affection received from father and mother. His view injects a mixed feeling, as he narrated below. The experience of affection he derived from his parents is unequal and only adequate from the mother's side. He states,

> "I had a good family background as a child. There was love in my family. It was a happy home, so I was cared for very well and have good family relationship. Although my father was indifferent about me when I was growing up, while my mother was very caring".

Irrespective of the fact that level of affection is generally high among the drug addicts studied, it does not mean that the degree is the same for every one of them and for different groups. Quite different from what obtains in the families of the

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earlier respondents in respect to family affection, 29 years old Police officer and an undergraduate expressed that he had a family that did not love. In his words,

> "I was not having a good relationship with my family members. We do have financial problems, and provocations to the extent of getting frustrated. Sometimes I do get frustrated in life. I even feel like dying because I was not loved. My parents hated me, so nobody was taking care of me. They were not favouring me in the family; both my father and mother were not lovely".

The view of the last respondent shows that frustration and hatred experienced in the family when growing up could have contributed to his present condition. When his emotions and aspirations of getting love and care from the family members were not encouraging after all these, he later pitched tent with drugs, which he thought could give him the lost succor and relief. A comparative analysis of the influence of level of family affection in determining pattern of drug addiction shows that the higher the level of affection at home the later the initiation and the harder the type of drugs used at initiation.

Parental Supervision

Also, within the realm of family context is the amounts of supervision parents give to their children while growing up. This is a functional aspect of the family characteristics that is interlinked with other functional factors in precipitating

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antisocial behaviour including drug abuse. The major observation of this study in this respect shows that irregular parental supervision expressed in the frequency of parents' presence at home is influential in the course of drug abuse. There is a lopsided revelation from this study that parents of a majority of the subjects are seldom at home. What invariably results from non-frequency of parents at home is loose control, which is inimical to children's' behaviour formation. The evidence from this study is not out of place with the conventional wisdom. This is because loosely monitored children are more likely to misbehave than the closely monitored ones irrespective of the social status of the family. Apart from feeling of being loosely monitored, children might also perceive their homes as one lacking "companionship". In this situation, such children may then turn towards their peers and feel free with them than with their parents. When they are with their parents at home they pretend that they never knew any bad behaviour, and the parents cannot detect the truth because of the low level of supervision. The in-depth interview confirms this as most of the respondents expressed their pretence at home after which they do what pleases them with their peers outside. There are however exceptional cases where irrespective of the level of parental presence at home their growing children indulge in use of various drugs in secret.

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Even though low level of parental supervision is a common prominent feature in drug addiction, it varies between groups. This study in that regard shows that drug addicts who started with hard drugs (stable hard) are associated with higher parental supervision than the progressives who are more inclined with lower parental supervision. So higher level of supervision at home is related to hard and late drug initiation while lower parental supervision is related to early initiation to drugs. The interpretation of this result in the real life situation is not different from the earlier explanation given to the observed differences above.

Parents' Social Status

Another significant pointer to drug abuse within the family context is the parents' social status. Even though children may be exposed to drug use irrespective of their social status, this study reveals a preponderance of the problem among the children with lower family social status. Social status here implies level of education of parents. Therefore low level of formal education among parents is a danger signal in children's propensity to be involved in drug abuse. Most of the addicts expressed low level of formal education among their parents when they were growing up. This condition of lack of adequate formal education among parents of drug addicts could have contributed to their children's early drug use habit. Parents that did not undergo

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formal education may tend to believe that smoking for instance is a part of the growing up activities in the high school. An examination of the categories of drug addicts and their parents' social status reveals that while most of the stable hard addicts hail from homes with averagely educated parents, the progressive addicts are associated with low parental educational status.

Family Size

The size of family commonly associated with drug addiction in Nigeria is the large type as this study reveals. When family size is large there is every tendency that there will either be unequal or lack of affection from parents to individual members. When it is very small it also breeds loneliness and feeling of inadequate companionship, which is also a vulnerable context for drug use and experimentation. The size of family makes a difference in determining the take off point and the type of drugs used for initiation. This study reveals a significant difference between the two categories of drug addicts based on their family size. Progressive addicts are associated with larger family size when compared with the Stable hard addicts that are inclined towards smaller family size.

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Residential Location

Urbanism and Urban life style plays significant role in precipitating drug abuse in Nigeria. Relating drug abuse to urban life style is almost an indisputable assumption in Nigerian case. Eighty six percent of drug addicts used for this study were brought up in an urban centre in Nigeria. In the practical sense, urban lifestyle and urban settlement tend to shield behaviours more than the rural areas. This is because of loose kinship relationship and social control in the urban centres vis-à-vis the rural areas where there is homogeneity and strong kinship relationship, which provides checks and balances on behaviour of members. Evidence from the study shows that apart from other urban centres in Nigeria, most of the drug addicts studied lived in Lagos Island, Mushin, Idioro, and Ikeja during their childhood. What matters in the urban settlement are not only the membership, but also the neighbourhood characteristics and activities, which are great, push factors for antisocial behaviour and juvenile delinquency. Location of residence is discovered as a distinguishing factor between Stable hard addicts and Progressive addicts in this study. Even though 47% of the stable addicts lived in the urban area, more of the progressive addicts than the stable hard grew up in the urban areas. It could be concluded that location of residence affects the pattern of addiction applicable to individuals.

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Delinquent Record/Criminal Involvement

Related to the urban lifestyle is the criminal involvement as it relates to drug abuse. More association was found to exist between Progressive addiction and criminality when compared to the stable hard addiction. Thirty seven percent of the progressive addicts had criminal record of remand and imprisonment, while no criminal record was found among the stable addicts. Thus juvenile delinquency coexists with progressive addiction, which is associated with early drug initiation and with the soft drugs. In the remand homes children under custody learn some antisocial acts including smoking from other inmates.

Religiosity/Morality

Generally, early religious participation was rare among the population of drug addicts. Nevadomsky (1980), and Adejumobi (1992) earlier pointed out that most of the subjects they studied who use drugs in Benin and Lagos did not regard themselves as being religious. When religious participation was regular, there would be a corresponding moral value developed positively towards the societies conventional aspirations and the route to achieving them. The conventional wisdom indicates that unseriousness in religious activities leads to uncertainty about what constitutes sin in the society. From the in-depth interview some of the drug addicts believed that their

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religious life was good, judging by church attendance, but their commitment to religious activities was low. From a comparative angle, religious factor is non significant in determining pattern of drug addiction. Whether a drug addict is of the Progressive type or the Stable hard type is not an interactive outcome of level of religiosity.

Educational Aspiration

Also the individual's educational aspiration, that is an aspect of measure of conventional values of the society, is not a distinguishing factor in determining pattern of drug addiction. The secondary education is associated with drug addiction. Perhaps, most drug addicts in Nigeria never had ambition of becoming very educated in their life. When the zeal for further education is absent, individuals will not be conscious of tomorrow in whatever thing they do. Involvement with drug abuse is therefore not regarded as an obstruction to any future ambition.

Sex/Gender Category

Gender category also has an implication for drug abuse. The conventional wisdom that abuse of drugs is a male predominated behaviour is corroborated in this study. The study reveals that the number of women involved in drug addiction when compared with the male is very small. Eighty two percent of the overall population

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studied is male, and in the drug addiction categories Stable hard and Progressive addiction that are also male dominated at the same proportion. The gender category of the respondents did not show as a significant factor distinguishing the two drug addicts' categories from each other.

Having seen the interface between drug addiction and social background contexts, it is also important to summarize the scenario by identifying the social background contexts that have influence on the pattern of drug addiction. From the Discriminant model the social background factors influencing pattern of drug addiction include Level of Family Discipline, Level of Family Stability, Location of Residence, Family Size, Parents Social Status, Parental Supervision, Criminality, and Level of Family Affection received while growing up. These are the basis on which stable hard and progressive addictions are distinguished. However, Education, Religiosity, and Gender category do not have any influence in the pattern.

After the initiation and subsequent use of drugs the next step is the consideration of a utilitarian based condition on whether a stable pattern of drug use was maintained. This condition is dependent on the utility derived by the user in the act and other social factors, which present compulsive and compelling conditions favourable to drug use. The question that follows then is, what made the drug

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addicts to continue with their drug habit? And what are the problems encountered while living with drug addiction?

4.5 MAINTAINING THE USE OF DRUGS.

Maintaining the use of drugs depends on some factors and circumstances. Among these factors include the type of peers that are maintained, the reactions of the family members, and other social circumstances. One of the major reasons why people get involved as this study revealed include "because friends are doing so" perhaps to be like them. This position constitutes what 86.5% of the subjects believed in. The new social network forms supporting environment for the individuals' mechanism of how to cope with the newfound system of drug use. Even though a majority of the drug addicts had non-drug using friends while growing up, their getting in contact with the new set of friends affected their relationship with the old friends. The in-depth interview reveals that the more the drug addicts get involved in use of drugs the more likely their "good old friends" desert them. In addition to the changing and adjusting peer network system, the availability of the drugs used within the neighbourhood is also important. Most drug addicts know where to get their drugs within their neighbourhood and in addition have opportunity of going for the best or the cheap ones as the case may be. Even those who would have quitted the drug scene could

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not do so because either the drugs are very cheap or easy to procure. One of the research respondents in a faith-based centre recounted how he and his friends usually get the drugs they used in spite of the cost of such drugs, which ordinarily they cannot afford. Their supply used to come from seized narcotic drugs by the National Drug Law Enforcement Agency (NDLEA), which are later burnt at the Murtala Mohammed Airport Ikeja Lagos. The venue where these drugs are burnt is very close to the house of the respondent and his friends. They knew that they could not afford these drugs (cocaine, heroine etc) in the market therefore they get them when needed and at any quantity in the form of *biko*[30]. They attested its efficacy in intoxication.

Family reaction and subsequent relationship in relation to drug abuse is found to be an exacerbating or inhibiting factor in this direction. When the family of drug user is not tolerant about the habit of drug use, especially when such habit is not prominent in the family history there is a distancing attitude of the family towards their deviant member. This brings about feelings of worthlessness on the drug user. When this feeling ensues the drug user fully continues with the habit, with the defiant feeling that after all his family members have rejected him, so no

[30] Biko is the remaining of burnt cocaine and heroin.

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point stopping. This feeling consequently makes drug users refuse any offer for treatment especially from family members and solidifies their bond of camaraderie within the drug use social network system. They believed that they are wasted people waiting for death to come, so there is no point trying to be alive again, as some of the respondents revealed. The perceived loss of confidence by the family members also worsens the condition. A respondent replied to a question in this direction saying

> "Imagine that you are sent to an errand by your father, and he (your father) decides to hand the money for the message to the driver instead of you, how would you feel".

He regretted having such an experience in the past before his rehabilitation. Other social conditions that increase the tendency of a new drug user staying in it include, unemployment, business failure and loss of job.

Membership in illegal drug use sub-cultural system survives and it is maintained through its common sub-cultural norms, values and motives which bind the individuals together among other factors that may be external to the sub-group. The public policy and societal reaction further strengthen the members through a process of resistance by the sub-culture in response to the public policy, which significantly influences the behaviour of illegal drug use. Good to be mentioned is

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that the addict sub culture evolved to deal with the common problems of adjusting to criminal status, stereotypes as dope fiends and to the illegal market on the streets, against the prescription of the law of the society. The addict sub-culture has within it a "circulatory system" of role relationship, through which addicts buy, sell and use illegal drugs. Through this, the system is being sustained and maintained by a close social system that contains what is called a "survival system" that wards off distractive and destabilizing forces emerging from the larger society. Some vital elements of survival within the system include an "ideology of self justification" which helps street addicts to explain their predicament without shame, deal with their stigmatized social and legal status and sustain morale; a "reproductive process" which operates to recruit new members into the addict sub-culture by a magnetic pull, which attracts adolescents by "subversive values" and other mechanisms; "defensive communication" that develops in form of a special language "argots" which minimizes the risk of exposure and differentiates members of the sub-culture from the rest of the society; and "neighbourhood warning system" which operates to protect addicts from the law enforcement agents (King,1953; Eldridge 1962; Fiddle1962; Lindersmith,1965; Schur,1965; and Smith ,1966; Ground, 1993).

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Apart from the social equilibrium system that helps in sustaining individuals in the drug sub-culture, factors specific to the individuals themselves, such as their personality characteristics and level of knowledge of drug market are also important determinants of sustainability (Becker, 1970; Westerman, 1970; Smith, 1986; UNESCO, 1987; Olaniyan, 1991; and Wood *et al,* 1995). However, notwithstanding the combination of social forces that might have contributed to the sustenance of members in a drug sub-culture, the duration of stay in drug use differs, especially with particular reference to the type of drugs used, sex, location of residence, age of initiation to drug, and pattern of drug addiction.

4.5.1 Duration of Drug Use

Whatever happens to the drug addicts in facilitating their initiation, and sustenance in the use of drugs, the length of stay in the system varies specifically with different drugs (Table 4.20).

Table 4.20: Mean Duration for Use of Specific Drugs.

DRUGS	Min.Year	Max.Year.	MeanYear	STD.
Cocaine	.000	32	7	4.74
Sedatives	.000	18	8	5.64
Amphetamines.	.000	14	4	4.08
Alcohol	.000	32	13	4.89
Heroine	.000	32	5	4.22
Cannabis	.000	35	7	5.34
Tobacco	.000	37	11	6.45
Hallucinogens.	.000	9	4	2.95

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From this study the mean duration of stay in drug use by the drug addicts is 12years. Observation on specific drugs shows that the popular drugs are used for longer period than the less popular ones. Mean ages of 13, and 11 years are observed for alcohol and tobacco, while sedatives and Indian hemp are used at average period of 8 and 7 years. Cocaine, Heroine, Amphetamines and the Hallucinogens have 6, 5, and 4 years respectively. The data shows a consistency in the difference between soft and hard drugs based on their duration of use, which implies that the soft drugs are used longer time than the hard ones. This observation is in consonance with other findings of this study that soft drugs are initiated earlier than the hard drugs, more available and accessible in the neighbourhood, less restricted and more permissive for use in the laws and conventions of the society.

Length of drug use could also be related to the sex and the residential location of the drug addicts (Table 4.21).

Table 4.21:Mean length of drug use by sex, and summary of Independent Samples test comparing the means

	Sex		Mean Diff.	T-value	Df	Sig.
	Female	Male	-4.42	-5.308	1	.000
Mean	8.61	13.02				
Std	(6.09)	(7.15)				

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In comparing males with females, it could be deduced that male drug addicts stayed almost two times longer than what is observed for the females. This result shows that significant age differences exist between males and females with respect to the average age of initiation to drugs. Males, as this result has shown possess the tendency of sticking longer to drug use when they are affected by the habit than the females. This presupposes that the society is more tolerant to males' use of drugs than the females through its norms, and regulatory mechanisms.

Significant difference also exists on the length of drug use between those that grew up in the urban areas and their rural counterparts, even though no significant difference was found between them in terms of their age of initiation to drug use. Table 4.22 shows that those who grew up in the urban areas stay longer in the use of drug than their rural counterparts whose stay were relatively brief.

Table 4.22:Mean length of drug use by Residence, and summary of Independent Samples test comparing the means

	Residence		Mean Diff.	T-value	Df	Sig.
	Rural	Urban	-1.06	-1.041	1	.001
Mean	11.36	12.42				
Std	(7.2)	(7.15)				

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This result is related to the socio-environmental difference between the two types of residential location, especially in connection with availability of drugs and social control mechanisms. Drugs are more readily available in the urban areas and attract relatively less disapproval than in the rural areas, so persons getting involved and staying long in it is somewhat expected in the urban areas.

Similar to the location of residence, the source and the age of initiation to drug use are also important variables that could equally depict a pattern. Table 4.23 shows the mean length of drug use by different sources of initiation and the analysis of variation among them.

Table 4.23:Mean lengths of drug use by sources of introduction, and summary of analysis of variance between the means

DESCRPTIVES **ANOVA**

Sources of Initiation							**Sum Sq.**	**Mean Sq**	**Df**	**F**	**Sig**
	Can't rem	Self	Other Relation	Friend	Sibling	Parent	771.64	154.328	5	3.072	.01
Mean	14.67	13.33	14.69	11.08	14.86	15.00					
Std	5.86)	(6.96)	(6.91)	(7.10)	(6.00)	(9.00)					

The result from the table indicates that there is a significant variation in the number of years spent in the use of drugs by the respondents based on who initiated them to drug use. Respondents that were initiated by parents have the highest

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observed number of years when compared with the rest potential sources. The least years occurred among those that had their initiation through friends.

A closer look at the data further shows that those initiated by their siblings and other relations stay closer number of years as those initiated by their parents. With this result, it means that individuals could hardly give up a habit transmitted from the significant others such as parents, even though the later reinforcement of such habit relies on the peers. At the time of transmitting habit from parents, siblings or other relations, there is always a strong belief and confidence by the imbiber that such transmission is devoid of deceit and misleading. Besides, it is possible that most of the initiations to drug use involving the parents and siblings are usually with the soft and more socially accepted drugs, which are used longer, and earlier than the hard, socially non-acceptable ones.

Further examination of the relationship between length of drug use and age of initiation to drugs (Table 4.24), shows an inverse relationship.

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Table 4.24:Summary of correlation between length of drug use and age at first drug use

	Length of drug use	Age of first drug use
Length of drug use	1.000	-.369**
Age at first drug use	-.369**	1.000

**Correlation is significant at the 0.01 level (2 tailed)

Precisely, the lower the age of initiation to drugs, the longer the number of years spent in drug use in the subsequent years. Implicitly, habits that are picked up earlier in life are hard to shake off than those acquired at later stage in life, because they would come to form a part of the individual's personality property, which grows with the individual. As time goes on, these habits acquired through years do often become sources of worries and problem for the individual, family members, other relations, and the society in general. The respondents to this study have lived with the use of drugs for some years, which they acquired mainly through friends, and other potential sources as the case may be, and are also initiated at different places, and at different stages in life. In the process, they also run into some social, and economic problems, which were investigated in the course of the study.

4.5.2 Problems of Living With Drug Addiction

When considering the pathways to social rehabilitation of drug addiction, there is a need to start with examining the various problems encountered by the group in the process of their addiction. The question arising from the above is, what are the prominent problems encountered by people living with drug addiction?

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If there were no problems there would not have been any need for the re-socializing efforts as mentioned earlier in this report. Before the drug addicts are sent to the rehabilitation centres, most of them suffered adverse social conditions in their familial, peer network system, economic and work relationships. The adverse consequences of the drug use further reach out to the entire society as perceived social problems. Drug addiction created so many problems in the people's lives. These problems as they affect different facets of their life are intricately interwoven, which is proved in some respondents' case histories. Below are presentations of six case histories in relation to drug addicts' route to drug addiction and some of the problems they encountered in the process.

Case Presentations[31].

Case 001

John is a 36 year old photographer, with senior school certificate as his maximum qualification. He was doing very well in his chosen profession as a photographer with notable agencies known in Nigeria for advertising production. He is married with children and lives in one of the sub-urban of Lagos metropolis. He got into the use of drugs through his friends. He first started by smoking cigarette, then to marijuana before he finally found himself using cocaine and heroine. He enjoyed using the drugs frequently until his family relationship went very bad and grew worse as the days passed by, and his resource accumulation for several years of working got ruined. As a result of drug use, he lost his rationality and fights frequently with his wife whom he loves so much. John who previously had a cordial relationship with his brothers, sisters, and parents with all trusts vested on him could not have that from them any longer. According to him, the relationship became soar, he could not get along with them, and they developed hatred for him and in every action that he takes. They could not relate with him, he was no longer relevant to the activities of the family. John's good old friends who are disciplined and religious left him. He developed association with the carefree night crawlers who are also involved in heavy drug usage. When he got hooked to drugs,

[31] The names used in this case presentation are fictitious; they only represent real persons interviewed in the centres.

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he became lazy and eventually dropped out of his job. John liked his children so much, but at the height of the problem he cared less about them and his wife. Also John fore goes all his notable functions in the church as a bandleader. He stopped going to the church. According to him joint became his church, instead of going to the church on Sunday he goes to the joint. His addiction problem further stressed his pocket and financial responsibility. He spends all his money in cocaine. He could not even pay his children's school fees. He sold his only hard-earned plot of land, his wife's clothes and property up to the cutlasses. When this problem and happenings continued and became unbearable, his wife and other family members talked him into accepting a rehabilitative measure. He later decided on his own to "chill out."

Case 002

Ibrahim is a 42 year old businessman with Higher National Diploma. He is married to two wives with four children. He got into contact with heroine through one of his friend who was a medical doctor. Before then he was smoking Indian hemp and drinking so much. He continued using these substances until 1989 when he started selling his property in order to finance his habit. For several occasions he tried to quit drug use but only succeeded in stopping the use of cocaine while the use Indian hemp and heavy consumption of alcohol persisted. Ibrahim feels that he disappointed his family who expected so much from him; instead they have nothing in return. He kept levelheaded career friends until his problem started. However he did not make new set of friends among drug addicts because he does his smoking alone. He was totally withdrawn leaving no room for making new friends. His first marriage broke up (though not because of his addiction problem because she left before the problem started). His second wife whom he was living with at the heat of the problem started nagging him whenever there is nothing at home to eat. He was not giving his children the attention they required. He was neither paying their school fees regularly nor getting material items which worth money for them. He spends all his money in buying drugs. Ibrahim who was into film production business had his business crumbled. According to him things fell apart, he even sold his film machine and the television he was using for the business for a fee of drug purchase. He had a bakery that was yielding money, which later flopped during his drug problem due to lack of attention and reckless spending. His religious background was strong as a growing youth, born into the Jehovah Witness family, a regular pioneer, and a good Christian. Unfortunately his religious life became void during the addiction problem. Having tried to stop using drug on his own Ibrahim was brought to the rehabilitation centre through someone he calls "a Christian sister". He believes that it was God that brought him to the woman that because according to him, he had really had a long-term experience and was touched by God. Before he came to the religious centre he had previously attended both government and private owned psychiatric hospitals for treatment.

Case 003

Bright is a 32 year old accounts clerk with school certificate. He is single. He had been smoking cigarettes in the school since 1989, and later his friends introduced him to marijuana. Since then he had been smoking frequently and enjoying the sensation derived from it. In 1994 he started noticing some problems, which had been initially complained of by his parents. When his parents discovered his problem their loving character on him changed, which was cordial initially. Bright cut off from his old friends who were not using drugs. He started going out with "bad friends". To him he did that as a kind of way ward ness because he did not want to be novice of any thing. He was smoking cigarettes even before and during his service. When he left his job, he stated using marijuana and subsequently got hooked to it. He became very lazy; he did not make any effort again in getting another after he had been fired. The addiction problem

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however did not make him to stop attending church service on Sundays. But he became less serious and unfaithful to the church. After each church service he goes to the joint, buy some raps of hemp and comes back to the church to smoke. Then people would have all gone home. All the little money he receive go into buying marijuana and eating food, and drinking milk so that I can smoke very well. Bright had no previous knowledge about the rehabilitation centre where he is. His brother brought him after series of persuasion

Case 004

James is a 29-year-old undergraduate/Policeman. He is still single at the time of this research. He started feeling a compulsion to stop using drugs since five years ago. He tried but could not stop even at trying to convince himself that it is not a good habit. Right from time James had no cordial relationship with his parents. He does get frustrated sometimes about life issues. At the time of his drug problem, his relationship with his family members grew worse. He was not eating at home, and sometimes not sleeping at home as well. His religious life, which was not strong, grew worse. According to him, he was going to church but not committed at all. At a time people in his work place started complaining. He started receiving official warning, query, and threat of termination of appointment very often. Because of his drug problem his appointment was proposed for terminated by his employers. James was naturally a prudent spender, but by the time he had the drug problem his money gets exhausted easily. According to him he spends every thing he gets every day. When he collects his salary it only lasts for a few days. He could not keep a bank account any longer because of his lavishing nature. He argued that his drug use did not disturb him in his academic pursuit. Officially James was placed on a psychiatric hospitalization from where one of his family friends introduced him to the present social welfare place where he is receiving care. He said that it was very difficult for his friend to convince him to come to the present centre.

Case 005

Bisi is single and 43 year old fashion designer with advanced diploma in Industrial design. He had been using various drugs especially cigarettes and Indian hemp since 1972 through friends when he was in the secondary school. He continued to use the drugs frequently until when his people started noticing a different behaviour in him. He did not know that the drugs were giving him some problems. Bisi did not notice any change in his personal relationship with his people probably because he felt that they did not notice what he was doing. He kept bad friends who introduced him to the various drugs and still got more involved during his frequent usage of the drugs. Bisi believed that his use of marijuana did not disturb him from doing his job well. He was not doing any job when he started using marijuana. For him the use of marijuana even enhanced his academic performance as he claimed. He was an average student before he knew marijuana, but with the use of marijuana he became more brilliant and passed out of school with six credits (first Division). The only areas Bisi believed the drugs affected him seriously is in his spending habit. He spends so much in his fashion and the drug using accessories. According to him, it is on the accessories that he spent money. He had moulder, raisers, in different flavours (chocolate, wheat, and white papers). Although his religious life was not very good *abinitio*, he further lost contact with God. Bisi complained of developing fear of looking up to the sky (sky phobia) during the drug problem. If he looks up to the sky he will feel that the sky would fall on him. He also had loss of genital erection, loss of appetite, and insomnia. Bisi had been in a psychiatric hospital before his present rehabilitation exercise in a faith-based centre. He came to the present centre through his aunt. He had a pre conception of the Rev. gentleman who manages the centre, but did not know about the place.

Case 006

Benson is a 50-year-old civil Engineer. He is married with children. He started using cocaine and heroine in 1980s'. But he had been using marijuana since 1963. He happened to know about cocaine and heroine through one of his cousin. He continued to use cocaine in large scale with stopping for one day until in Jan.1999. He had thought of leaving drugs and appreciated that he had a problem when his matrimonial home broke up. He could not help himself out of the predicament. His once good relationship with his wife got severed and problematic as a result of his newly acquired habit. He was no longer thinking about his family's welfare (wife and children), he neglected them. His social network of relationship changed. He kept at distance with his old professional friends who are not involved in drug use and made new friends from drug addicts (though of a class). Benson was doing well as a civil engineer until his drug problem. According to him he sacrificed every thing he had to the Idol and Satan of drugs. He became very unserious with his profession, sold some of his work machines and equipment and used the returns on drugs. Unfortunately Benson became lazy, he only goes to his work place to collect money every day to smoke rather than to work. He later sold his only car to offset his much-accumulated debt, and smoked the rest money off. Infact he became a reckless spender. Benson regretted that he mismanaged all that he amassed throughout his life to keep on using drugs. He became psychologically captured in the drugs with a feeling that he will die if he leaves drugs. Benson had not been to a rehabilitation centre before on drug abuse related problem. He came to the rehabilitation centre where he is through his friend who also owns a church. He is one of the few voluntary clients who seek help on their own.

As evinced from the case histories, the problem of living with drug addiction is enormous. It causes strain in social relationships, exhausts funds, among other issues. Drug addicts even indulge in selling of hard earned property and begin to tell lie and indulge in petty stealing in order to satisfy their compelling urge. Wives and children are beaten at home, thereby aiding the phenomenon of domestic violence; the work place becomes unfavorable with incessant breakdown in work relationships. It is at the observation of these disgraceful, antisocial, and criminal behaviours that lead relatives, friends, and concerned individuals into either forcing or convincing the drug addicts into social rehabilitation.

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It is conceivable that some people with conscience and appreciable moral scruples stop the habit voluntarily, or seek help to stop the habit. The option given to the drug addicts by their relatives on either stopping or accepting a rehabilitation exercise is a major turning point in their life. This option serves as the detachment point of the individuals from the drug use social network system and sub-culture. The drug addicts then faces the entry into the rehabilitation centres through various sources and persons.

The findings of this study could be viewed not in isolation, but in relation to what obtains in other research discoveries of earlier scholars. In considering the initiation patterns into drug addiction based on the sources of initiation, it was found that peers, self and family members were the three leading factors that provided the drug addicts the means of experimenting with the drugs. Overall and for specific categories of addiction peers factor was found to be the most prominent. This finding corroborates common wisdom and studies of other scholars. Becker (1984), Gossop (1984) and Bank *et al* (1985), NDLEA, (1992), Adejumobi (1992), and NDLEA, (1997) evinced that peer pressure has a powerful influence upon the development of drinking behaviour among adolescent drug users who reported considerable difficulty in remaining abstinent when they are in certain social setting

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where drugs are used. Individuals, as they maintained, may see their friends both as models to imitate and as sources of drug using norms. For the age of initiation to drugs as earlier pointed out, use of drugs start at adolescent stage, especially with the soft categories, which coincides with the findings of Raza, (2000) who reported that people get into use of drugs in Nigeria as adolescents and even as early as 10 years. Difference in mean age of initiation to drugs was found to exist between the progressive and stable hard addicts. The former were initiated averagely as adolescents (16years) while the latter had adulthood (24years) as their average entry age into addiction business.

In investigating the patterns of drug–addiction, two major categories were observed, the progressive hard addiction and stable hard addiction marked by soft to hard drug use and hard drug use respectively. By implication all the drug addicts studied had used hard drugs at one stage of their drug history or the other, while some of the subjects had not used soft drugs at all as a habit. It was discovered that the majority of drug–addicts are grouped under the progressive pattern of addiction. This means that most drug addiction problem take the course of a progressive pattern from soft to hard drug use described in the stepping stone hypothesis of drug addiction as shown in the works of Kandel (1975), and O'Donnel and Clayton

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(1982). Few people are however, likely to get into drug use through the hard drugs. The reason behind the prominence of soft drugs at the initiation stage and the involvement of the majority of people into it stems from the relative availability of such drugs, price and cultural interpretation of use of such drugs (Suther 1966). For instance, Adejumobi (1992) found a relationship between type of drugs used and socio-economic status in Nigeria. According to him, people from higher socio economic status are more inclined towards use of expensive drugs. And also, the availability and easy procurement of drugs influences the use of such drugs as this study already showed. "The cheaper and more available drugs, especially the soft ones are the most widely used"[32]. The disposition to becoming a progressive or stable hard drug addicts is also a function of the age of initiation to drugs.

Furthermore, investigation of the social background contexts distinguishing the two categories of addicts revealed that level of family liberalism is the most influencing factor. Progressive drug addiction is associated with lower family discipline and higher liberalism more than the stable hard addiction with strict family background at the opposite. Relatively, the progressive addicts had more opportunity of experimenting with soft drugs at a more tender age than the stable

[32] Emphasis is mine, from the field observation in chapter four.

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hard subjects who probably had no chance of such experimentation at a younger age, because of the strength of family authority on them. Rather they resorted to drugs at an older age due probably to life pressures and other circumstances.

The level of family stability was also discovered to be an important factor that determines pattern of drug addiction. The progressive hard drug addiction is more associated with intact stable homes than the stable hard. However, it could be noted as shown in chapter four of this thesis that the addiction problem of the former developed as learning and gradual process, unlike the latter who suddenly got into the problem at a later age in life. Thus, the involvement of the latter into hard drugs as a starting point may be as a result of dissatisfaction with family life issues. The progressive addicts would have started experimenting on soft drugs even if the parents are happily married. This finding is related to those of Bowlby (1957), Rutter (1981b) McCord, Wells and Rankin (1991) and Kolvin *et al* (1998) who found that marital disruption such as divorce or separation of parents in adolescents early years may predict later delinquent act and deviance such as hard drug abuse.

Another distinguishing factor as revealed from the study is the residential location while growing up. From the analysis, both progressive and the stable addiction are associated with urban affiliation, but more of the progressive addicts

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grew up in the urban areas than the stable hard addicts. Thus associating progressive addiction as an urban phenomenon more than the stable hard could be as a result of difference in exposure to drugs, the level of family authority as related to the age of initiation. It could be recalled that the progressives possess other social backgrounds that could lead to early experimentation with soft drugs more than the stable hard that mostly stayed in the rural areas. Correlating this fact to other variables, the family authority in the rural areas was stronger which hindered the subjects who lived there from early experimentation with drugs, so by the time they did they started with the hard drugs perhaps when they came to the urban centres at a later age. The control, anomie, and social disorganization theoretical underpinnings could explain this finding. As it were, in the urban areas, there is value inconsistency that creates confusion on what standard should be followed, which is favourable to deviant breeding in the society, when compared with the rural settlements that are intact and highly homogenous.

It was discovered that no criminal record was associated with the stable hard addicts, while the progressive addicts were associated with some level of criminality while growing up. This result however may not be surprising because as young adolescents, the stable hard addicts were not yet into drug use. The progressive

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addicts were into it early in life at the adolescent stage and were perhaps involved in other criminality, which led to their going into remand homes as children. The stable hard addicts never went to remand homes. The progression from soft drug to hard drug may be as a result of the individuals contact with other delinquent youths in the custody or that the individuals developed more resistance to the social norms after the custody. Earlier studies of Becker (1970), Gossop (1984), Kandel and Andrews (1987) and Dulman *et al* (1991) pointed out that peer network system could be very influential in drug use.

Family size was found to be a distinguishing factor of drug addiction pattern. Progressive addiction from the study is associated with higher family membership when compared with the stable hard addiction problem. Perhaps the progressive addicts were able to learn their addictive behaviour from one of the family members due to its relative size. Moreover over crowding in families may lead to decrease in feeling of family authority, hence more tendencies to get into drug use early. As Farrington (1996) argued, as the number of children increases, the amount of parental attention that could be given to each child decreases. He further stressed that as the number of children increases, the household will tend to become more crowded, possibly leading to increase in frustration, irritation, conflict and crisis

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which might induce the adolescents into looking out for distracting experience such as drug usage.

This study identified the social status of parents as one of the determinant factors distinguishing the two drug-addiction patterns. Stable hard drug addicts are associated with higher level of parental social status when compared with the progressive addicts, although both categories are not high in parental social status. The relative higher education of the stable hard addicts would have contributed in their delay of getting into drug abuse as early as those of progressive addiction get. Even when they started they got into the problem with a hard drug and probably an expensive one. This finding however corroborates earlier findings of Chein *et al* (1964), Halim (1991), Adejumobi (1992) and Albrecht et al (1996). They found that socio-economic status makes a difference in question of initiation to drug addiction.

Similar to the above, the level of the family supervision as exercised by parents significantly relates to either becoming a progressive addict or stable hard addict in drug-life profile. From the study, stable hard addiction is more associated with higher parental supervision than the progressive addiction. Thus the stable hard addicts would have grown up with higher level of parental supervision, which prevented them from initiating into early drug use, unlike the progressive addicts

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with lower parental supervision. It could be recalled that this particular social background context correlated with the level of family liberalism as earlier discussed, which also was lower among the stable hard addicts translating in strict family authority. This finding is consistent with that of Stouthamer–Loeber (1986), Wilson (1980) and Utting et al (1993). They found that lax parental supervision, lack or absence of good parental supervision in childhood is a predictive context and setting for experimenting deviant activities.

The quality of affection received during childhood was also found to be a distinguishing factor in the process of determining the pattern of drug-addiction. Although both categories did not receive very sufficient care during childhood, the stable hard addicts were found to have received a bit higher family affection than the progressive addicts have. This position is however related to what obtains in the case of parental supervision. As Adejumobi (1992) reported in his study conducted among high school pupils in Lagos Nigeria, a disturbed or weakened relationship with parents or guardians was conducive to formation of drug use habit. In the study, significant difference in drug use was found between students who reported that they were close to their parents and those who were not. About half of the former group compared with two third of the latter reported use of drugs.

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Other social background factors, such as the early religious participation and gender were not found to be distinguishing factors of drug-life profile pattern. The study, for instance, showed that both categories are 82% dominated by the male gender category. The predominance of men in this case is consistent with the earlier observations made in other cultures about gender differences in drug abuse (Gossop 1984; Lensky, 1988; Anderson 1994; Lo 1995; and Albrecht et al 1996). According to Lo, for instance, men are more likely to continue in drug subculture more than females due to certain reasons. Firstly, the more likelihood of males than females to be associated with others who present problem drinking norms and drinking models; secondly females are more likely to be influenced by their parents and in association with parents more restrictive norms which result in less favourable alcoholic and other drug use definitions. The discriminatory socialization influence of patriarchal culture could equally explain the finding. There are more protective elements of cultural values for women against drug use in the society *vis-a-vis* the male population.

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4.6 SUMMARY

This chapter described the main sources of drug addiction among which friends is the most prominent, for both sex, location of residence, and even for almost all

categories of drugs. It was discovered that homes are the commonest places where drug experimentation usually begins in most cases, both for urban and rural dwellers, especially with the soft categories of drugs through other relations. Mean ages of initiation to different drugs were obtained, with the soft drugs having lower average when compared to the hard categories. The discriminant analysis showed that drug addicts under the rehabilitation centres studied, can be classified into two, namely the progressive hard addicts (low level beginners), and the stable hard fellows (high level beginners). This is the benchmark for establishing the patterns of addiction that is influenced by some social background and dug antecedent factors, with the exception of sex, and education. After initiating to drug addiction, duration of stay in the process vary between sex, residence and source of initiation, although at a mean duration of 12years. Various problems emanate from the drug habit as time goes on, especially on the family and economic lives of the subjects, which eventually lead to their referral to the rehabilitation centers. What then is being done by the designated rehabilitation centers to correct the drug clients depends on the methodological orientation of the centre, which comes up in the next chapter. These findings and discussions necessitate policy and academic recommendations in chapter six.

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CHAPTER FIVE

SOCIAL REHABILITATION AND ADJUSTMENT PATTERN

5.0 INTRODUCTION

This chapter describes the referral system and main approaches undertaken by the five selected drug addicts rehabilitation centers in helping towards re-socialising the deviant subgroup through some behavioral change interventions (BCI) programmes. These centers do not differ in their main aims and objectives that border on achieving a total "chilling out" for the addicts, but their modes of operation and effectiveness in rehabilitating drug addicts and the adjustment outcomes, may vary. Three approaches discovered to be the regular methods in rehabilitating drug addicts include, Psychiatric, Social welfare, and Faith-based approach as introduced in chapter three. The psychiatric approach is the main preoccupation of Yaba Psychiatric Hospital and Lagos University Teaching Hospital (psychiatric Ward); the social welfare approach is the major instrument of the Good Boys and Girls rehabilitation centre Isheri. The Finger of Gods Ministry and Christ Against Drug Abuse Ministry (CADAM) are involved in the faith-based approach. The major

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questions in this section are what is the referral pattern or pathway to the rehabilitation centers? How are the drug clients being managed in these centres? Which of the approaches is most effective? And how are the various social, drug and rehabilitation related factors affect how clients are adjusting in the rehabilitation process?

5.1 ENTRIES AND REFERRAL TO SOCIAL REHABILITATION

Drug addicts' referral to rehabilitation centres depends on the level of problem, which is observed either by relatives, the individual himself, or other concerned persons and groups. The drug addicts rarely seek treatment on their own volition (Odejide, 1998). It takes time to convince them into accepting drug rehabilitation because of the pleasure they derive from the effects of the drugs. Besides, the withdrawal syndrome is fearful to them to the extent that they think that they are going to die if they quit the drugs. For instance, the "*jouncing*"[33] experience of drug addicts when they try to *"chill out"*[34] of heroine is always very hard and gruesome to them.

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[33] Jouncing is the epileptic like fit that occurs to drug addicts when their body is out of the addicted substance. It is also perceived as a craving effect of use of a particular substance, especially heroine and other Opium puppy derivates.

[34] Chill out is an argot used in the drug use sub culture to mean staying off drugs completely.

Drug clients undergoing rehabilitation are brought to the various centres through different avenues. The result of the investigation of the various means through which the clients come to the centers shows that while few individuals voluntarily surrendered and seek re-socialization and care, others are forced or sent by various agencies and individuals (Table 5.1).

Table 5.1: Sources of referral Among the Subjects

SOURCE	N	%
Law Enforcement	99	23.5
Community Leader	25	5.8
Religious Leader	32	7.5
School Authority	14	3.3
Employer	13	3.0
Friends	41	9.6
Family Members	164	38.3
Self	40	9.3
TOTAL	**428**	**100.0**

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Of all the sources recorded, the family members are more involved in the process than any other group or individuals in taking their affected members for rehabilitation. The next significant source is the law enforcement agencies, followed by friends and self. While religious leaders contribute little, employers are the least to take care of their drug addict staff by sending them for treatment. An examination of the gender category in relation to sources of referral shows that females' highest source of referral is either their parents or siblings, after which the law enforcement

agencies become important. Community leaders and employers are the least sources of referral, while none of the women came through a spouse (Table 5.2).

Table 5.2:Distribution of Respondents by source of referral and sex

SEX	SOURCES OF REFERRAL									
	Law Enf	Comm leader	Spouse	Rel Leader	Sch Auth	empyer	Friends	Parent/ Sibling	Self	Total
Fem	19 (25.7)	2 (2.7)	-	5 (6.8)	8 (10.8)	3 (4.1)	12 (16.2)	21 (28.4)	4 (5.4)	74 (100)
Male	80 (22.6)	23 (6.5)	11 (3.1)	27 (7.6)	6 (1.7)	10 (2.8)	29 (8.2)	132 (37.3)	36 (10.2)	354 (100)
Total	99 (23.1)	25 (5.9)	11 (2.6)	32 (7.5)	14 (3.3)	13 (3.0)	41 (9.6)	153 (35.7)	40 (9.3)	428 (100)

This could mean that their husbands sent the affected women out of marriage when they were discovered. From the community broad perspective, the evidence that the community leaders are of little help depicts the patriarchal cultural background of the subjects, where community elders would not yield for assistance to any woman unless it is the wish of the husband. The male folk share the same highest source of referral with the women, but have school authority as the least concerned persons. Unlike the females, spouses to the men showed concern for their husbands' problem by taking them to treatment centres, even though the contribution

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is meagre when compared to other sources. There is higher proportion of male to female in the sources including self, parents/siblings, community leader, and the religious leaders' contribution, while females are more in other instance.

The outstanding contribution of the respective individuals and agencies could be seen in the light of the relative trouble experienced. The family members could be understood from the relative disadvantage, pain, and stigma the families are experiencing. On the part of the employers, perhaps they sack their respective employees who are hooked on drugs. This attitude reduces the number of clients that would have come through them.

Some drug addicts are on first admission to rehabilitation without previous similar treatment, while others have undergone through such treatment couple of times. The route to rehabilitation therefore is not conclusively direct and fresh always. The majority of the drug addicts (65%) have undergone treatment previously, while 35% are fresh cases without previous experience in rehabilitation for drug related problem. Under rehabilitation, the drug addicts are introduced to different system depending on type of rehabilitation centre where they are. This may affect how the drug clients respond to their various systems.

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5.2 SYNOPSES OF THE SOCIAL REHABILITATION APPROACHES

In a categorical analysis, there are three forms of drug addicts rehabilitation process identified and studied in this work namely, psychiatric, faith-based and social welfare represented by the various centres chosen. An examination of the *modus operendi* of these centres will inform us on how these drug addicts who are under their care are managed.

5.2.1 The Psychiatric Approach

Psychiatric cum medical approach takes place in the medical centres. The aim of this approach as realized does not differ from that of others, but it is distinct based on some basic characteristics. Firstly, it is discovered to be the oldest known approach adopted for the care of the drug addicts, dating as earlier as 1960s in Nigeria (Boroffka 1966; Oviasu 1976; and Asuni, 1978). Secondly, the approach exclusively uses drugs (Chemotherapy) for the rehabilitation, and thirdly, it involves total institutionalization (locking up and confining the clients behind walls, sometimes in chains).

The first step in this regard is drying out process. This process involves locking the drug addicts up in a room for a designated period of time during which drugs or chemical substances and fluid are administered to the subject to purge the

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system of the illicit drug contents. It is also referred to as detoxification. The second step after the detoxification is the release of the subject and administration of other conditioning drugs to further neutralize the body system of the effects of the drugs. At this stage also other subsidiary rehabilitation measures such as skill training, counseling and even prayers become part of the entire package. Even though other measures exist side by side with the chemotherapy, they only function as fostering and facilitating opportunities to the drugs administered.

One important aspect of this approach is the social relationship observed that exist between the drug addicts (Clients), and the medical officers (Patrons). Indeed there is a typical orthodox hospital setting clientele relationship that exists therein. The clients who are regarded as patients' have very little control over what is being done to them. They are made to believe that what is given to them is in accordance to what is diagnosed by the medical experts. There is a highly formalized structure in the social network. The inter-clients relationship also was found to be least informal because individual's social status and family background are still functional in the system. The cost of rehabilitation under this system was estimated to be affordable only by the affluent families, as it is the case with the conventional medical system because of the use of drugs, which are relatively expensive.

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5.2.2 The Social Welfare Approach

Another major rehabilitation approach is the Social Welfare. This approach is the main concern of the Good Boys and Girls Rehabilitation centre Isheri, under the Ministry of social welfare. What is mainly involved in the social welfare approach is skill training and employment programme. Even though these are the targets of the social welfare approach, other processes such as drug administration and prayers are also part of the whole system. The rehabilitation of the drug addicts here also starts with the drying out process. One of the key informants highlighted.

> "We start with detoxification which entails drying out the clients to calm them down. This process helps in keeping them calm in drying room for period of about six weeks or more depending on their attitude towards changing. After that we engage the pastors and preachers of word of God. After this stage we engage the clients in occupational therapy where they are exposed to learning different skills (carpentry, electrical, shoemaking, hairdressing, baking, farming etc.) later we sort them out and get them employed.

Similar to the above comment, another main issue in the social welfare programme is counseling. Counseling according to the professionals is one way to let the drug addicts know the effects of taking drugs. There are also games and recreational therapies. The resources and equipment required for the social welfare rehabilitation approach are mainly vocational tools. Human resources were also very

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expedient. A surprising observation in the crew of the care staff is the membership of ex-drug addicts who were earlier beneficiaries of the programme, unlike in the psychiatric set up where entirely medical experts and social welfare officers who have not been certified to have contact with drugs are staffed.

Summarily, as the rehabilitation centre also involves the medical and spiritual aspect of rehabilitation in the bid to re-socialize and retract the drug addicts, their major approach as observed is the vocational, counseling and settling for employment scheme. In active rehabilitation process some of the clients are under social welfare work at various state government and private agencies. The government under the integrated programme created a bakery (known as cornerstone bakery) at Alausa Ikeja for the addicts and fixed some other clients into the direct labour agency, Lagos State tricycle transport system, and agricultural scheme at Badagry, while others such as the ladies were attached to Salons as apprentices.

5.2.3 Faith-Based Approach (Religious)

The third approach investigated in the rehabilitation of the drug addicts is the spiritual approach. This technique is the major instrument used by the religious organizations, even though such organizations sometimes include other rehabilitation techniques in the package. As the name of the technique suggests, it

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involves prayers and other religious activities in the process. Fasting, confessions, bible study, and evangelism are all aspects of the approach.

The major aim of the spiritual approach is to "chill out" the drug dependent person through the teaching of word of God. In this technique the drug addicts are kept under surveillance, and prayers made for them for about two weeks at the initial state to prepare them for four months compulsory spiritual growth training. According to one of the "care givers".

> "When they come here we introduce them into morning and night devotion. After a month they will be doing it for themselves. Then we will start the disciple-training course (which involved teaching them bible and how to become a real Christian) twice daily, morning and evening. This will last for three months. Then we start counseling and group therapy".

When this rehabilitation process ensues, the clients will be totally cut off from their previous social network system. They usually feel challenged with the new social network and authority structure, which usually cause discomfort for them.

From the words of the professionals, there is less of integrating other rehabilitation measures into the spiritual system. Almost every activity hinges on prayers, which is believed to be the most effective "medicine". In substantiating this claim one of the "care givers" maintained

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> "... Here we use the word of God to counsel them. For instance using some bible references such as 'know you not that your body is the temple of God which is in you, which you have of God, and you are not your own? (I Corinthians 6:19). So, that they will accept God with their whole heart. We keep them in fasting every Friday so we use fasting, prayer and religious counseling".

Hence, the word of God in the Bible is the major instrument for rehabilitation apart from other instruments and materials required. Interestingly the materials needed for the spiritual therapy are inexpensive particularly the Bible when compared to what obtains in the psychiatric and social welfare scheme. Most of the staff and "care givers" involved in the re-socialization of the drug addicts are ex-drug addicts and beneficiaries of the centres. This affected the cost of rehabilitation as no money is collected as charge fees, owing to the fact that "the gift of prayer and healing from God is free, the services rendered through them should equally be free", according to the key informants.

Within the spiritual rehabilitation system, there is an observed nature of relationship therein and among the clients. There is also a good clientele (client–patron) relationship between the drug addicts and the "care givers". The clients are sometimes allowed to express their wishes in respect to the ways they feel about issues concerning their rehabilitation and how it should be done. The situation is not permanently fixed on the structure that power always flows from the top. For

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instance, as part of the rehabilitation exercise, the clients are given compulsory assignment one after another to lead in morning devotion and prayers. Even the house fellowships and group prayers are organized among themselves.

Among the drug addicts themselves, there is good network of relationship. There is maximum freedom of interaction, expression and movement that is part of the rehabilitation policy of the religious centres. Under the spiritual therapy there are no lockups and claims, or even high walls. There is no strict exit permit. It is expected that the level of re-socialization and adjustment depend on the personal willingness of the receiver, rather than on the magnitude of punishment introduced in the process.

In summary, there are areas of similarities as well as differences in the approaches studied. While there is uniformity of aims, objectives and purposes, there are differences in the ways and means of achieving these objectives, even the cost of rehabilitation. For instance, while no money is required for the services rendered by the religious centres, those of the psychiatric hospitals attract heavy charges, although depending on individual cases. It was also generally observed that ex-drug addicts are effectively integrated into the "care staff" system of the religious and social welfare centres, whereas such does not obtain in the psychiatric system.

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There are the observed concepts of "cure" "cope" and "repent" for the psychiatric, social welfare, and spiritual rehabilitation of drug addicts in that order when referring to their quitting the habit of drug abuse "chilling out" completely.

Having examined the various rehabilitation options and opportunities available to the drug addicts it is also important to determine the effectiveness of these centres to know which among them is most suitable in managing drug addicts, and the one that is least effective in the process. This is done through a comparative analysis of the level of adjustment among drug addicts in the three centres.

5.3 Comparative Analysis of Effectiveness of The Three Categories of Rehabilitation Approaches

Part of what this study set to do is to determine the effectiveness of the existing rehabilitation approaches in order to ascertain the most effective method among them. This is translated on the influence of type of centre on the adjustment pattern of the drug addicts. Based on this objective, it is hypothesized that there is no difference in the effectiveness of the three rehabilitation methods discovered. But if there is a difference, under which type of rehabilitation approach do drug addicts cope best and least respectively? In verifying this question the chi-square test of

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relationships was used to determine whether there is significant difference in the adjustment pattern of the clients in the three rehabilitation centers (table 5.3).

Table 5.3 Relationship Between Rehabilitation Approach and Adjustment Pattern

Rehabilitation Approach Utilised	Adjustment Pattern		Total
	Low	High	
Psychiatric	44 (47.3)	49 (52.7)	93 (100)
Social Welfare	46 (41.4)	65 (58.6)	111 (100)
Religious	10 (13.5)	64 (86.5)	74 (100)
Total	**100 (36.0)**	**178 (64.0)**	**278 (100)**

Chi-square, 22.840, df 2=, P=. 000

The analysis shows that clients in the three rehabilitation centres are not responding the same way towards the care being given to them, even though the proportion of clients adjusting well are more than those who are not adjusting in all the rehabilitation centers. There is therefore a significant relationship between rehabilitation approach utilized and adjustment pattern, which depends on it.

It is evident that more clients utilizing the religious method have ceased to crave for drugs of any type, than those in the social welfare and medical/psychiatric methods. Only 13.5% of those utilizing religious method still feel like taking any substance, which is the lowest when compared with 41.4% for the social welfare,

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and 47.3% for the psychiatric methods respectively. It could then be concluded from this analytical attempt that the religious option of rehabilitating drug addicts is the most effective among the three methods because more clients there are adjusting positively than in any other one. The psychiatric/medical approach is the least effective followed by the social welfare approach.

Further analysis of the relationship between rehabilitation approach utilized by the clients and adjustment pattern include controlling for length of rehabilitation. This was in order to know the effect of this variable on the observed significant relationship between rehabilitation approach utilized and the adjustment pattern (table 5.4).

Table-5.4 Relationship between type of center utilized and adjustment pattern, controlling for length of rehabilitation

Length of Rehabilitation							
Adjustment Pattern	**Brief (0-1year)**			**Longer (>1year)**			**Total**
	Type of care utilized			**Type of care utilized**			
	Psych	**Social**	**Religious**	**Psych**	**Social**	**Religious**	
Low adjust	41 (49.4)	41 (41.4)	9 (15.0)	3 (30.0)	5 (45.5)	1 (71.1)	**100**
High adjust	42 (50.6)	58 (58.6)	51 (85.0)	7 (70.0)	6 (54.5)	13 (92.9)	**177**
Total	**83 (100)**	**99 (100)**	**60 (100)**	**10 (100)**	**11 (100)**	**14 (100)**	**277**

Chi-sq, 18.598, df=2, P=.000 **chi-sq, 4.868, df=2, P=.088**

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Controlling for length of rehabilitation, significant relationship still exists between the centre utilized and the adjustment pattern at .000 levels, but only for clients who have not spent more than one year (brief) in the rehabilitation exercise. No significant relationship was observed between the two, types of center or method and adjustment pattern for the longer staying clients at .088 confidence level. This means that the adjustment patterns of clients utilizing the three types of rehabilitation approach are significantly different only for a brief period of time. But more of clients who are utilizing the religious method (85%) are responding positively towards social rehabilitation, when compared with others in the social welfare (58%) and psychiatric method (50%). From the above, the significant relationship between rehabilitation method utilized and adjustment pattern is true for a brief period of time, usually not more than one year in the rehabilitation. But the longer staying clients, in the three rehabilitation methods are not responding significantly differently from one another, even though, more of those utilizing the religious method are adjusting better than those utilizing social welfare and psychiatric approaches. Therefore the longer the stay in the rehabilitation center irrespective of type the more likely the difference in the effectiveness of specific centers disappear.

It could be concluded from the above attempt in control analysis that the significant relationship between rehabilitation method and adjustment pattern diminished completely as the length of rehabilitation becomes longer than one year.

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This result replicates what may be the case in the true-life situation in the rehabilitation centers. The most effective status ascribed to the religious method in handling drug addicts could be restricted to the earlier period of rehabilitation when those under it do respond better than those utilizing other methods. This may be because of high level of moral teachings and methods adopted by the religious groups, which usually encapsulate the new clients when they report to the religious groups for correction. Coupled with the above is a high hope at the initial stage of rehabilitation by the clients in the religious centres that they will overcome their problem as soon as they are admitted. But the result of this study indicates that the performance of the religious method when compared with what obtains in other methods become the same in the long run. Thus those clients in the religious centres who adjust well do so as soon as possible after which the tendency of rolling back on adjustment becomes more apparent.

5.4 INFLUENCE OF SEX, AGE, DRUG HISTORY AND SOCIAL REHABLITATION FACTORS ON ADJUSTMENT PATTERN

A general observation was made on how the entire population of addicts studied is adjusting in the rehabilitation process. The observation shows that 37.2% of the clients are not adjusting well by showing symptoms of urge to take one substance or another, while 62.8% adjusting better by not showing any symptom of crave for a

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drug or substance. From the above revelation, the clients are not adjusting considerably well because, ideally client undergoing rehabilitation suppose to be adjusting towards an attempt at staying off drugs. As the adjustment pattern of the clients is not impressive there must be some social categories of exception, and as such all-social categories would not be responding exactly the same way. This point therefore demands an examination of the relationship between adjustment pattern of the clients and selected social categories. Thus, apart from knowing the rehabilitation approach, which exerts the most significant influence on the adjustment pattern of the drug addicts undergoing social rehabilitation, there are other social factors that are also important for consideration. Based on this assumption, it is hypothesized that sex of clients, age, age at first drug use, category of addiction, and rehabilitation residential status of clients individually have significant influence on adjustment pattern. The attempt in verifying this is important with a view to determining which categories of drug addicts are more problematic than others. First, this study seeks to know whether there is a significant relationship between sex of clients and adjustment pattern. In other words, is there any significant difference between male and female clients with respect to their adjustment pattern in the social rehabilitation process? If there is, who are likely to respond better than the other?

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The analysis of difference (table 5.5) shows that females are not significantly different from the male clients in the number of people who do not have urge to take any substance, and vice versa, which means that there is no significant relationship between sex and adjustment pattern. In other words, how a client is adjusting or will adjust in the rehabilitation centers does not depend on whether the client is a male or female.

Table 5.5 Relationship between sex and adjustment pattern

Sex	Adjustment Pattern		Total
	Low	High	
Female	23 (31.1)	51 (68.9)	74 (100)
Male	135 (38.5)	216 (61.5)	351 (100)
Total	**158 (37.2)**	**267 (62.8)**	**425 (100)**

Chi-square, 1.425, df 1=, P=. 233

Second, the study also investigated the relationship between age of clients and their adjustment pattern, in order to know whether rehabilitation outcome in terms of adjustment pattern depends on the age of clients in the centers (table 5.6).

Table 5.6 Relationship between age of clients and adjustment pattern

Age Set	Adjustment Pattern		Total
	Low	High	
<22years	22 (37.9)	36 (62.1)	58 (100)
22years above	136 (37.1)	231 (62.9)	367 (100)
Total	**158 (37.2)**	**267 (62.8)**	**425 (100)**

Chi-square, .016, df=1, P=. 898

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The analysis shows that there is no significant relationship between age of clients and their adjustment pattern. In other words there is no significant difference on how the clients who are below the age of 22 are responding towards rehabilitation when compared with those who are above 22 years old. Therefore rehabilitation outcome in terms of adjustment does not depend on the age disparity such that a client being old or young does not have any significant influence on whether the client will adjust well or not.

An investigation was conducted in other to ascertain whether the adjustment pattern of clients depends on the stage in life when the clients were initiated into drug use, or to know whether those who were initiated at an earlier stage in their life respond quite differently from those who were trapped in the habit at a later stage, and who does better?

Table5.7 Relationship between age at first drug use and adjustment pattern

Age At First Drug Use	Adjustment Pattern		Total
	Low	High	
Early (<18years)	75 (33.6)	148 (66.4)	223 (100)
Later (18above)	72 (41.6)	101 (58.4)	173 (100)
Total	**147 (37.1)**	**249 (62.9)**	**396 (100)**

Chi-square, 2.662, df=1, P=. 103

The results of the chi-square (table 5.7) above shows that the early and the late initiate into drug use are responding almost the same way without a significant

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difference between the two categories. Thus, in spite of the fact that more of the early initiates than the late initiates do not have the urge to take any drugs again there is no significant relationship between the stage in life when people begin to use drugs and how they respond to rehabilitation attempts on them. Whether the initiation took place when one is below the age of 18years or later than that does not make much difference in enhancing or hindering the client's adjustment pattern.

Fourth, it is also important to know whether there is a significant difference between the resident and non-resident clients in the rehabilitation centers with respect to their adjustment pattern. And if there is, what category is adjusting better than the other counterpart?

Table 5.8 Relationship between Rehabilitation Residential status of clients and Adjustment Pattern

Residential Status	Adjustment Pattern		Total
	Low	High	
Resident	68 (33.5)	135 (66.5)	203 (100)
Non Resident	90 (40.5)	132 (59.5)	222 (100)
Total	**158 (37.2)**	**267 (62.8)**	**425 (100)**

Chi-square, 2.252, df=1, P=. 133

The Chi-square analysis (Table 5.8) shows that there is no significant relationship between client's rehabilitation residential status and adjustment pattern. In other words, how the clients are responding in the rehabilitation centers (whether low or high) does not depend

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on whether the clients are resident or non resident in status. The two types of clients are not responding significantly different from each other. But a closer look at the table further suggests that more of the non-resident clients than the resident ones still have the urge to take drugs and vice versa although at a non significant margin. This could be because taking drug addicts back to their social network when they are still undergoing rehabilitation process is inimical, as they come in contact with drug using friends who do not want to chill out of drug use.

Fifth, further inquiry into the relationship between category of drug addiction and the adjustment pattern of the drug clients was investigated in the study. This was to know whether there is a significant difference between progressive hard addicts (low level beginners) and the stable hard category (high level beginners) on the ways they are responding towards their rehabilitation. If there is a significant difference who adjusts more than the other and vice versa?

Table 5.9 Relationship between Category of Addiction and Adjustment Pattern

Category Of Addiction	Adjustment Pattern		Total
	Low	High	
Progressive Addiction	154 (39.7)	234 (60.3)	388 (100)
Stable hard Addiction	2 (11.8)	15 (88.2)	17 (100)
Total	**156** **(38.5)**	**249** **(61.5)**	**405** **(100)**

Chi-square, 5.369, df=1, P=. 021

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In verifying this, the chi-square test (Table 5.9) shows that there is a significant relationship between category of addiction and adjustment pattern, such that significant difference exists between the clients who began with soft drugs and those who began with the hard drugs on their urge to take or not to take drugs again. The table further shows that while the clients who began with the hard drugs are more in response towards staying off drugs completely, those who began with the soft drugs are more in responding negatively towards rehabilitation. Therefore, it could then be concluded that whether drug rehabilitation clients respond positively or negatively depends on the category of addiction where the clients belong. When the drug of initiation is of the hard category, there is more likelihood of adjusting in the rehabilitation centers than when the initiation is with the soft category and later graduates to the hard type.

Further elaboration analysis of the relationship between category of drug addiction and pattern of adjustment was performed by controlling for length of rehabilitation, age of clients, length of drug use, sex, rehabilitation residential status, and the type of care utilised as the possible intervening variable that could affect the observed relationship (table5.10).

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Table 5.10 Relationship between category of addiction and adjustment pattern, controlling for length of rehabilitation

Length of rehabilitation					
Adjustment Pattern	**Brief (0-1year)**		**Longer (>1year)**		**Total**
	Category of addiction		**Category of addiction**		
	Progressives	**Stable hard**	**Progressives**	**Stable hard**	
Low adjust	123 (41.3)	2 (15.4)	31 (34.8)	-	156
High adjust	175 (58.7)	11 (84.6)	58 (65.2)	4 (100)	248
Total	**298(100)**	**13(100)**	**89(100)**	**4(100)**	**404**

Chi-sq, 3.474, df=1, P=.062 **Chi-sq, 2.090, df=1, P=.147**

Controlling for length of rehabilitation, the analysis shows no significant relationship between category of addiction and adjustment pattern, for both brief and long staying addicts. This means that the number of years spent in rehabilitation has an impact on the relationship between category of addiction and pattern of adjustment. The Progressive addicts (low level beginners) and stable hard addicts (high level beginners) do not significantly differ in the ways they are responding to rehabilitation, when the number of years spent in the rehabilitation (whether brief or long) is put into consideration, even though there is a likelihood for differences when the rehabilitation duration is brief. So the significant relationship between category of addiction and adjustment pattern does not hold when length of rehabilitation is considered.

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In controlling for age, as shown in Table 5.11 significant difference was found between the progressive and stable hard addicts among clients who are 22years and above, vis-a-vis those that are below the age of 22.

Table 5.11 Relationship between category of addiction and adjustment pattern, controlling for age of clients

AGE OF CLIENT					
Adjustment Pattern	<22years		22 above		Total
	Category of addiction		Category of addiction		
	Progressive	Stable hard	Progressive	Stable hard	
Low adjust	22 (42.3)	-	132 (39.3)	2 (12.5)	156
High adjust	30 (57.7)	1 (100)	204 (60.7)	14 (87.5)	222
Total	**52(100)**	**1(100)**	**336(100)**	**16(100)**	**405**
	Chi-sq, .723, df=1, P=.395		**chi-sq, 4.648, df=1, P=.031**		

Therefore the significant relationship that earlier observed between category of addiction and adjustment pattern only holds for the adults, and not for the adolescents and young adults where there is no internal difference within the group. This result reflects that people who are young do have similar pattern of thinking and responding to stimuli because they are not yet matured to distinguish between what they want and what they do not want.

Controlling for length of drug use, the observed significant relationship between category of addiction and adjustment pattern does not hold (Table 5.12).

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Table 5.12 Relationship between category of addiction and adjustment pattern, controlling for Length of Drug Use

Length of Drug Use					
Adjustment Pattern	Brief (<5years)		Long (5yrs above)		Total
	Category of addiction		Category of addiction		
	Progressive	Stable hard	Progressive	Stable hard	
Low adjust	19 (35.2)	1 (8.3)	126 (40.6)	1 (20.0)	147
High adjust	35 (64.8)	11 (91.7)	184 (59.4)	4 (80.0)	234
Total	54(100)	12(100)	310(100)	5(100)	381
	chi-sq, 3.352, df=1, P=.067		chi-sq, .872, df=1, P=.351		

This means that there is no significant difference between the progressive and stable hard addicts on how they adjust towards staying off drugs, irrespective of whether they were brief (lee than 5years) or longer in the use of drugs before undergoing social rehabilitation. Although the analysis showed that there is greater likelihood of having a difference at a significant level of .044 when the years spent in the use of drugs is adjudged to be brief. Unlike the case of length of drug use, partial relationship was found between category of addiction and adjustment pattern, controlled for sex (Table 5.13).

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Table 5.13 Relationship between category of addiction and adjustment pattern, controlling for sex

Sex					
Adjustment Pattern	Female		Male		Total
	Category of addiction		Category of addiction		
	Progressive	Stable hard	Progressive	Stable hard	
Low adjust	23 (33.3)	-	131 (41.1)	2 (14.3)	156
High adjust	46 (66.7)	3 (100)	188 (58.9)	12 (85.7)	249
Total	69 (100)	3 (100)	319 (100)	14 (100)	405
	Chi-sq, 1.469, df=1, P=.222		chi-sq, 4.010, df=1, P=.045		

In other words, the relationship appears to be true only for one of the sexes, male rather than for both sexes. Females, whether progressive or stable hard adjust alike while their male counterparts are adjusting significantly different based on the category of addiction.

Also considering the influence of rehabilitation residential status no significant relationship exists between category of addiction and adjustment pattern, for both resident and non-resident clients (Table 5.14).

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Table 5.14 Relationship between category of addiction and adjustment pattern, controlling for rehabilitation residence status

Rehabilitation Residence Status					
Adjustment Pattern	**Resident**		**Non Resident**		**Total**
	Category of addiction		**Category of addiction**		
	Progressive	**Stable hard**	**Progressive**	**Stable hard**	
Low adjust	66 (35.7)		88 (43.3)	2 (16.2)	156
High adjust	111 (64.3)	5 (100)	115 (56.7)	10 (83.3)	241
Total	**185(100)**	**5(100)**	**203(100)**	**12(100)**	**405**
	Chi-sq,2.733, df=1, P=.098		**chi-sq, 3.315, df=1, P=.069**		

Thus, the clients do not differ in their pattern of adjustment irrespective of whether they are resident or non-resident in the rehabilitation centres. However, the control analysis shows a likelihood ratio of .037 and .069 for the resident and non-resident groups respectively.

Finally, controlling for method of rehabilitation, the significant relationship between category of addiction and adjustment pattern only holds among clients who utilise the psychiatric/medical approach (Table 5.15).

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Table 5.15 Relationship between category of addiction and adjustment pattern, controlling for type of care utilised

Type of Care Utilised							
Adjustment Pattern	**Psychiatric**		**Social Welfare**		**Religious**		**Total**
	Category of addiction		**Category of addiction**		**Category of addiction**		
	Progressiv	**Stable hard**	**Progressiv**	**Stable hard**	**Progressiv**	**Stable hard**	
Low adjust	43 (52.4)	1 (10.0)	46 (45.5)	-	10 (14.9)	-	100
High adjust	39 (47.6)	9 (90.0)	55 (54.5)	1 (100)	57 (85.1)	3 (100)	164
Total	**82 (100)**	**10 (100)**	**10 (100)**	**1 (100)**	**67 (100)**	**3 (100)**	**264**
	chi-sq,6.43, df=1, P=.011		**chi-sq, 830, df=1,P =.362**		**chi-sq, .522, df=1, P=.470**		

The fore going analysis reveals that the way drug clients in the social rehabilitation centers are responding towards their correctional exercise is significantly related and also dependent on the method of rehabilitation utilized, and drug development category, *vis-à-vis* sex, age, age at first drug use, and residential status of the clients, which do not exert significant influence on adjustment pattern.

The relationship between adjustment pattern and some selected factors, and how these factors influence adjustment was earlier studied through bivariate analysis in chapter four. This however is not sufficient to be used as a basis for drawing conclusions with respect to some questions such as, what is the relative impact, and contribution of each of these factors on adjustment pattern? In order to address this question, the Logistic Regression Model was utilized (Table 5.16).

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Table 5.16: Logistic Regression table showing the impact and strength of the selected factors on the adjustment pattern

	B	Wald	Df	Sig	R	Exp (B)
Rehab Approach	.9365	20.7128	1	.000	.2384	2.5509
Category of Addiction	2.7727	6.6643	1	.009	.1190	16.0026
Age at first drug use	-.0655	.0468	1	.828	.0000	.9366
Age	.4081	1.2081	1	.271	.0000	1.5039
Sex	-.4369	1.4821	1	.223	.0000	.6461
Residential status	-.4771	2.7396	1	.097	-.0474	.6206
Constant	-.1234	.0692	1	.7926		

	Chi-square	Df	Sig
Model	37.865	6	.000
Block	37.865	6	.000
Step	37.865	6	.000
-2 Log Likelihood		291.275	
Goodness of fit		243.400	
Cox and Snell –R^2		.142	
Nagelkerke –R^2		.193	

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The Logistic model shows the relative impact of each of the factors in the analysis on level of adjustment. The Regression coefficient and the Wald statistic suggest that only two factors in the model (rehabilitation method utilized and category of addiction) have significant impact in determining adjustment pattern. But between these two significant factors, the contribution of rehabilitation method is higher, and highest when considered in the whole model. Other factors do not affect adjustment patterns of the clients in the rehabilitation centres.

Investigating the relative adjustment patterns of the drug addicts based on the selected variables may not serve the whole purpose of identifying where more

rehabilitation effort should be directed, but could only provide clues to specific group need, which are internal issues to the system. On a more general note, what then are some of the obstacles that militate against effective drug addicts' rehabilitation in Nigeria?

5.5 OBSTACLES TO DRUG ADDICTS SOCIAL REHABILITATION IN NIGERIA.

In practice some problems exist in the social rehabilitation of the drug addicts in Nigeria. The general performance of the drug addicts in the rehabilitation centers is observed to be below expectation even though there are degrees of differences between the various methods. For instance, if the rehabilitation programmes are very effective we would not still be observing the number of fallouts from our rehabilitation centres on the streets. The causes of this incessant problem to social rehabilitation may be as a result of both internally or externally generated factors as discovered during the oral interview.

Internally, the social relationship between the clients and the management is discovered to be problematic indeed in the psychiatric hospitals. There is a typical orthodox hospital setting relationship between the two groups. The clients have very little control over what is being done to them. They are made to believe that what is

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given to them is diagnosed by the medical experts. The same thing goes for the social welfare centres and to a very little extent with the faith-based centres. The clients complained that the care staff is in most cases adamant in response to issues of client's personal interest and welfare. They see very minimal opportunity in participating in decision making which makes them feel dehumanized.

Another problem is cost of management incurred by the centres. Because there are financial commitments required in the process of rehabilitation, many families abandon their addict members in the various centres where they referred them for care. The cost of the drugs needed in the chemotherapeutic therapy is enormous. The government finds it very difficult to go it all alone in offsetting the bills for these drugs without appreciable contribution of individual's family members. This however makes the psychiatric approach an expensive venture. As a result of this problem, clients are sometimes discharged even when they are not yet sound so far there is no means of sustaining the cost of the drugs prescribed.

There is also lack of basic logistics in the centres. For instance, the equipment required for the skill training in the centres is not adequate. This is owing to breakdown and non-functional conditions of the existing ones, or non-existence of

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them. A professional social worker in the social welfare centre lamented in regard to the state of equipment and material resources in the centre that,

> "The vocational tools have been very inadequate. At present there are only four vocational training available in practice (electrical, carpentry, shoe making, and barbing) out of about ten in the plan of the centre ".

From the opinion of the caregivers taken in the key informant interview, what the government provides for the scheme is grossly inadequate for full realization of the goals and objectives of the rehabilitation project. The facilities are not only lacking in the technical areas but also in the recreational facilities. There are no in door games even in the psychiatric and faith-based centres. Coupled with the above problems is the problem of feeding in the whole centres visited. The clients believed that they do not need to depend on the food from the centres. The clients also complained of the non-availability of an information system for awareness. Because of this singular factor the clients in the social welfare center, for instance, lack of awareness of what happens outside. Lack of freedom of movement is also an observed obstacle to the rehabilitation efforts. This problem is most particular among drug addicts under the psychiatric rehabilitation. In these centres they are kept behind high fenced compound, as it is the case with T. Asuni and A. Lambo wards in the Yaba psychiatric Hospital. Clients are found in chains to minimize their

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movement. This system is found to be counterproductive especially to the psychological make up of the individuals.

The number of trained personnel in drug addicts' rehabilitation is inadequate. In spite of the co-opting of the ex-drug addicts in the care staff of the faith-based centres they still suffer the same problem facing the psychiatric and the social welfare centres. Life experience in the problem of drug addiction is necessary for any staff to contribute better in the correction of the drug addicts themselves. A psychiatric doctor intimated the researcher that he has never seen cocaine for the first time before. Knowing the theories of these drugs reaction without corresponding practical life experience by the caregivers probably creates more problem than solution in the process.

Apart from some of these internal factors and conditions discussed above, there are also some exogenous factors that create some problems in the rehabilitation effort. Of all the problems, the clients are mostly concerned with the stigma the society attaches to a drug addict. Particularly among those who are undergoing psychiatric rehabilitation, they believe that the society at large has an impression that they are mad. One of the clients said,

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"I think the learned people will know what we are going through here, but the illiterates might think that anybody coming in and out of this place is mad".

With this kind of notion in mind the clients experience low self-esteem, which invariably disturbs the speed of their recovery in the system. Another client succinctly maintained,

"To Nigerians they rate drug addicts as second class citizens and irresponsible people. They will also be clouded that ex-drug addicts are not totally out of drugs. They will refer to the old habits in what ever they do in their work places".

The stigma is even more defined within the family than in the larger society. Some of the clients are abandoned by their people and stigmatized as wasteful children, father, mother, brother, sister, etc. The drug addicts also have a peculiar problem of lack of home support. Usually the presence of the problem of lack of home support translating in lack of sense of belonging creates frustration and disappointment, which inhibits the rehabilitation exercise. Closely related to the above is the worry about the feelings of their family members when they are finally discharged. The clients feel so strongly that they are wasted and not trusted, even if they are discharged their people will not still forgive them for their previous misdeeds. So the level of co-operation given to individual addict by his or her family

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during and after rehabilitation affects their decision to stay off or remain in drug use. A client who views the level of cooperation in the families as important opined that,

> "It varies from family to family. In Christian or religious homes there is high sense of forgiving. While in other families, it is not easy to forgive and forget. The Christian homes appreciate the act of deliverance. They will give and provide you with homestead jobs with trust. You know the drug addict would have done any thing before. But his family will still forgive him. Some even go as far as declaring their father dead (I know about one). Even they could sell their land only to struggle to recover it later."

Respective families that have people living with drug addiction should always be in close contact in order to avoid a gap being created between them and the ex-drug addicts. Ex-drug addicts need cooperation of every one in order to recover and re-adapt to the society.

Another obstacle is the fear of unemployment when finally discharged. This fear as observed is deep rooted in the minds of the drug addicts to the extent that they feel it is better for them to be known as drug addicts than to be known as unemployed persons. Various experiences of the drug addicts show that employers do not re-absorb ex-drug addicts into their work system after their rehabilitation. All of them who were working before their drug problem have lost their respective jobs in both private and public sector organizations. Coupled with this job problem after

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rehabilitation is lack of desired type of skill training by many within the centres. Some of the clients who are graduates and post graduate degree holders complained that they couldn't go and start learning shoemaking and carpentry when they are originally professionals. There is lack of academic training opportunity for those that would want to have more academic qualifications. Many show dissatisfaction about the types of skill training or trades available, which will not help in boosting their already diminished self-esteem.

These among others are some of the major problems observed to be militating against the entire rehabilitation efforts of the care agencies in Nigeria. The whole problems could be subsumed under poverty, and lack of proper understanding of the plight of the drug addicts in our society.

The findings of this study with respect to the social rehabilitation process could be viewed not in isolation, but in relation to what obtains in other research discoveries of earlier scholars. However, the drug addict studied varied in their response pattern Specifically, in relating level of adjustment or response pattern to rehabilitation context and method it was discovered that a significant relationship exists between method of rehabilitation and adjustment pattern. From the analysis, the religious centres or spiritual rehabilitation is the most effective approach when

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compared to the social welfare and psychiatric approaches, while the psychiatric approach is the least competent. The findings of this comparative analysis may be linked up with particular contexts. In the first place most of the drug addicts under religious/faith-based rehabilitation were either self reported or brought on total conviction from the deviant pathway. This instance when compared to what obtains in the social welfare or the psychiatric centres is quite different, where most of the clients reported either being brought by the law enforcement agencies or by force against their consent by some relatives. Secondly, there is marked difference between the social relationship that exists in the religious centres and others. The clientele relationship under the religious centres is most cordial as observed. In the Religious centres, information and suggestions about rehabilitation policy do not only flow down from the top, rather a bottom–up approach is also adopted. Clients participate considerably in deciding what happens to them unlike in the psychiatric centres where there is a striking gap between the clients and the patrons. Besides there is less conception of "we-they" dichotomy among the clients and patrons in the religious centres as most of their "Care Staff" are ex-drug addicts who have benefited from the same programme and repented as role models.

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There is also freedom of movement and interaction among the clients in the religious centres more than other centres of rehabilitation. For instance while the drug addicts are kept behind high walls and in chains in the psychiatric centres totally, and in the social welfare to some extent, they are left free to even attend house fellowships outside their centres in the religious rehabilitation. Above all the major instrument of re-socialization might have made the difference. The religious centres use prayers and spiritualism, which is humanly unlimited in supply and has direct bearing with morality and repentance. The other centres use either chemotherapy (psychiatric centres) or mere counseling and job creation, (social welfare centre) which are found not as effective as prayers in human cognitive restructuring. This instance made the faith-based rehabilitation obtainable in the religious centres least expensive and non-exploitative. These conditions would have made the religious centres most conducive and effective for drug-addicts rehabilitation.

Under the rehabilitation process, having observed the variations and the effectiveness of the rehabilitation centres, the level of adjustment of the subjects based on their drug life profile was revealed. From the study it was found that the progressive drug addicts are more problematic in adjusting towards the

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rehabilitation norms than the stable hard drug addicts. This may be as a result of some reasons stemming from the relative difference in age at which initiation occurred and the circumstances surrounding initiation. It is a truism that habits formed at tender age are always difficult to dispense with than those of the later years. Besides most initiation into hard drugs may be as a result of later adult life circumstances including alienation and stress. When these problems are solved or when the victims are taken good care of (counseled and consoled) they may show more tendency of leaving the addiction, which they embraced as a temporary measure to their problems. Unlike this group, the progressive addicts have passed through stages and have therefore perfected the art. Their getting into drug use usually at a tender age as we have seen is more of a function of self-interest than paradoxical problems.

Finally, some of the obstacles discovered in the rehabilitation centres include lack of skill training equipment for the social welfare, cost of drugs, specialized staff and stigmatization of clients in the psychiatric centres. Generally there is lack of fund following lack of government interest and the fear of not getting job after the rehabilitation.

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5.6 SUMMARY

This chapter described how the drug addicts are brought into, and are taken care of in the three categories of rehabilitation approach studied. The study revealed that parents/siblings consistently appeared to be the major source of referral to the rehabilitation centre. An evaluation of the effectiveness of these three categories shows that faith-based approach is the most competent among them, followed by social welfare, and lastly the psychiatric system. The investigation of the response patterns of the subjects revealed that there are no significant differences on the adjustment pattern of the drug clients based on all the social categories and groups included in the hypotheses, with an exception of category of addiction. This implies that category of addiction is an important aspect of drug antecedents of intending clients that should be considered properly before the rehabilitation exercise commences. The progressive addicts are found to be having more problems in adjusting towards staying off drugs than the stable hard people, especially those that are 22 years old and above, and males. Among all the factors, rehabilitation methods followed by category of addiction are factors that significantly predict adjustment pattern through the logistic regression analysis. These findings and discussions necessitate policy and academic recommendations in the next chapter.

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CHAPTER SIX

SUMMARY AND CONCLUSIONS

6.0 INTRODUCTION

This chapter contains the summary of the major findings of the study based on the objectives and the questions set and addressed in the course of the analysis. From the summary of the major findings, conclusions were drawn and some recommendations spelt out towards the end of this chapter.

6.1 SUMMARY OF MAJOR FINDINGS

This study was carried out in an attempt to investigate the initiation processes, pattern of drug addiction, and the social background factors influencing this pattern. It also attempted an examination of the problems of living with drug addiction, and the social rehabilitation opportunities in Nigeria, with a view of knowing their effectiveness. Furthermore, the study investigated the influence of socio-demographic variables on the adjustment level of the drug clients. The influence of drug history variables (age at first drug use and category of addiction) and

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rehabilitation status (residential status) on level of adjustment was also investigated. The research questions of this study seek clarifications in the following direction.

How do people become drug addicts? What are the patterns of drug addiction? What are the social backgrounds factors influencing patterns of drug addiction? What are the prominent problems encountered by people living with drug addiction? How did they get to the rehabilitation centers? How are the drug-addicts being managed presently, and how effective are the methods employed? How are the various categories of drug addicts adjusting under the rehabilitation process?

Based on the objectives and questions of this study, the major findings are as follows.

- Generally, involvement in drug use begins at a mean age of 16years. For drug categories, the soft drugs (alcohol and tobacco) use begin at the same period in the general pattern while none of the hard drugs was used before the age of 20, the earliest being Indian hemp used as from the age of 21, showing that it is a bridge drug that links the soft and the harder drugs. Average ages of 16 and 24 year are found for the Progressive and Stable hard patterns of drug addiction respectively. People in the urban areas, and

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males get involve in drug use much earlier than their rural, and female counterparts respectively.

- Second, drug addiction mainly begins with soft drugs and later ends up with the hard drugs. This confirms the stepping stone theory of drug addiction. At the time of attending rehabilitation programme all the drug addicts had used any of the hard drugs at one stage or the other. There was no case of retrogressive addiction confirmed.
- Third, the study reveals that peer group is the most consistent source of initiation into drug use followed by self-experimentation for and all categories of drugs, sex, residential location, and patterns of addiction.
- Fourth, home is found to be the most prominent place where initiation to drugs takes place, followed by schools and party arenas. This is especially so for the soft drugs, because the study further revealed hotels and "joints" as the consistent venues for the hard drug types.
- That there are two patterns into which drug addiction could be described, namely "Progressive Addiction" and "Stable Hard Addiction" also viewed as low level beginner and high level beginner addiction respectively. The first connotes a process starting from the use of soft drugs to the hard

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drugs, while the latter involves initiation into drug use with hard drug without a shift in later usage.

- Pattern of drug addiction is a function of family discipline, family stability, location of residence, criminality, family size, parental social status, parental supervision, and family affection of the subjects.
- Having got hooked in drug addiction the addicts' behaviour as this study revealed was further reinforced and conditioned by social circumstances. Prominent problems associated with living with drug addiction are health and social life problems. Precisely, breakdown on work and familial relationship are found to be common in the period of drug addiction. One uncommon striking health complication discovered is the problem of "Sky Phobia" revealed as a result of excessive use of marijuana, which has not been commonly reported in drug abuse literature.
- The study reveals the importance of family members as the most prominent source of referral to rehabilitation, even for both sexes.
- In comparative analysis of the relative effectiveness of the various rehabilitation options, the analysis of difference showed that faith-based milieu and approach is the most effective place of rehabilitation. On the

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other side, the psychiatric approach is the least among the three with regard to effectiveness. Besides, significant relationship was found between type of center utilized and adjustment pattern. But when length of rehabilitation is put into consideration, significant difference only exists in the case of those who have not spent more than one year in the rehabilitation centers, while no difference exists when the rehabilitation becomes longer than one year.

- The study found that the Stable hard addicts are responding better than the Progressive addicts, which shows that pattern of addiction influences the level of adjustment among the clients in the rehabilitation centers. But this influence did not hold when length of rehabilitation is put into consideration. This was also the same when controlled for rehabilitation residence status and length of drug use. Sex, age of clients, and the type of care utilised are where there are partial significant difference only for male, 22years and above clients, and psychiatric approaches in that order. Therefore, the most problematic people are the progressive addicts in the rehabilitation centres, especially those who are males, 22years and above, and in the psychiatric centres.

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- The socio-demographics, sex, age; drug history variables, age of initiation; and rehabilitation residence status have no influence on the clients' pattern of adjustment.
- Among all the contexts and variables, rehabilitation approach contributes more than any other variable in influencing the pattern of adjustment, followed by category of addiction. However they are the only variables that have significant impact on adjustment pattern.

6.2 CONCLUSIONS

Following the major findings of this study, it is evident that peers, homes and schools, and the adolescent age brackets are the important factors on which most of the drug use initiation is based, with respect to who provides the first drug, where taken, and the age or stage at which this habit starts. Most drug addiction started with the use of soft categories of drugs, and later develops to the use of the hard categories. It is only in few cases that drug use starts with the use of the hard category. Evidence of retrogressing from hard to the soft drugs is not characteristic of drug addiction development pattern. This difference in the subsequent pattern of addiction is a function of some social background antecedents, and drug history variables. Continuation of the use of drugs is a pivotal problem for other social, and economic troubles for the individual and the society.

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Attempt in rehabilitating the drug addicts proved most successful in the religious/faith based centres, which are also non-governmental, voluntarily-run agencies, *vis-à-vis* the government run social welfare and psychiatric centers. This is an indication that the government has fallen short of providing basic social needs of its citizens, which are being taken over by voluntary agencies. Generally, the drug clients are not adjusting excellently in the process of their rehabilitation, but some factor are found to point at who are adjusting well, and who are not, comparatively. The study reveals that there is need for more attention to be paid to the progressive addicts, and those that spent longer years in drug use, who are associated significantly with low level of adjustment.

The rehabilitation environment is not friendly, especially in the government run agencies, where there is lack of freedom of suggestion by the clients on matters bordering on their welfare. This obstacle is coupled with inadequate feeding and nutritional care. The adjustment of the clients is also disturbed by external factors, which include stigma and non-acceptance by family, friends and the society at large that face them on their discharge from these centers. Enough love, car, and trust were usually not given to them by their family members and the society in general, which leads to their relapse "revolving door syndrome".

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Following these findings among others and the obstacles to social rehabilitation of drug addicts identified, scholars could develop further research studies from these findings as the study has left some impressions and conclusions subject to further investigation.

6.3 RECOMMENDATIONS.

The results of this study have policy and academic implications for sustainable care and support programmes for drug addicts in Nigeria. Generally it shows the influence of drug history and social background contexts on drug addiction, which is an important clue for designing a successful rehabilitation programme. From the performance evaluation of the rehabilitation centres it is obvious that the state and its structural apparatuses have failed even in social provisioning, and therefore cannot be left alone in the providing social services including drug addicts rehabilitation. This study therefore makes the following recommendation with policy and academic implications.

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- Social rehabilitation programmes should be designed to suit and accommodate the individual and group differences, which this study

among other things has discovered. These differences could be traced back to the social background, and drug history antecedents that are important for specific and target oriented programme designs. For instance, adjustment pattern among the clients is not yet total as expected, but more attention should be paid in sorting out the progressive addicts in general. Specifically clients that are 22years and above, and males for more intensive care, especially in the psychiatric centres where they show more signs of difficulties in staying off drugs. Besides, it is suggested that progressive addicts in the psychiatric centres may be referred for faith-based care, but strictly under personal arrangement.

- Rehabilitation exercise should be designed to be brief (less than one year) in order to hasten up the process and avoid or discourage long stay in rehabilitation that was discovered as being instrumental to relapse, which is inimical to the adjustment effort of the clients and their caregivers. This recommendation is however based on the findings of this study, but no matter how long the rehabilitation process stays the final evaluation of the process would be taken after the rehabilitation exercise.

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- The study also suggests a comprehensive social rehabilitation approach that will involve the integration of the faith-based, social welfare and psychiatric approach in one process. This will be in order to cover up the lapses of each of the approaches with the advantage of the other, especially for the lapses discovered in the psychiatric approach. This approach is presently an on going process in some orthodox medical centres.
- In the alternative, the government should pay proper attention to its agencies, which are performing below expectation in other to improve their capabilities in handling drug addicts effectively. This aspect of attention as the findings of this study suggest borders on subsidizing treatment in these centres and encouraging the staff members by building their professional capacity, and updating the available equipment.
- Besides, as it is the case with other health related problems, treatment of drug addiction could also be made free of charge in order to reach out to those who would not be able to pay for their treatment, yet languishing in the coma.

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- Civil society organizations should be encouraged through enabling legislation to participate in this effort especially now that their presence and performance is felt in Nigeria in view of the failure of the state owned agencies to deliver their mandate.
- Social rehabilitation of the drug clients should be designed to carry family members along through establishing family therapy where the family system is incorporated as a "holistic client" that also needs to be rehabilitated. The affected family members should do this through counseling that will aim at healing the family of the wounds of wrong deeds. Professional assurance of possible clean record will also be provided to facilitate acceptance and family reunion.
- Half way houses should be established in order to prepare the out going clients against the realities of the larger society. It is suggested that individuals should train in the areas of their choice rather than restricting every body to few available artisan works. This should involve re-training in professional and academic disciplines.
- Public enlightenment and education on drug abuse should include reducing the harm of the society on the rehabilitated drug addicts, which

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is perpetrated through suspicions, discrimination and denials of rights. Under the public enlightenment, there should be a focus on peer education and management, as the peers were found to be the most consistent source of initiation to drugs among others.

Apart from the action-oriented recommendations spelt out above, there are few suggestions emanating from this study that borders on academic research as follows,

- From academic point of view, further research into nation wide study of the specific *modus operandi* of the various rehabilitation techniques is recommended.
- The eclectic and triangulation methods employed in this study especially the integration of social anthropological methods in the research is recommended to be fully utilized in future drug abuse studies in Nigeria.
- The roles of Islamic religion and traditional medical practice in drug addicts' rehabilitation, which are not covered in this project, need to be visited.
- Further research should also be geared towards understanding the problems and prospects of ex-drug addicts in the larger society after

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rehabilitation, especially the stigma and discrimination, which they are facing.

- Similar to the above, further studies may focus on the coping mechanisms of ex-drug addicts in the labour market, family affairs, etc.
- Using these rehabilitation centres as the contact point, the incidence of HIV/AIDS in the drug subculture could be estimated from this population.
- Also further inquiry into the interface between social background factors and adjustment pattern will be fruitful and rewarding.

Finally, if the major findings of this study, the conclusions and recommendations are put into proper consideration in view of drug addicts rehabilitation programme in Nigeria, a more sustainable care and support apparatus could be established and built to help the "chilling out" process of the people living with drug addiction. This is crucial because the existing system is not yet very supportive, and causes continuous loss of human resources that would have been channeled for the development of Nigerian society.

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APPENDIX I
Department of Sociology
University of Ibadan

QUESTIONNAIRE SCHEDULE FOR DATA COLLECTION ON DRUG ADDICTION AND SOCIAL REHABILITATION IN NIGERIA

Dear Respondent,

This research questionnaire is designed to elicit information on the above titled subject matter. Please provide honest information. All information provided will be treated with utmost confidence.

Thank you and God bless.

(Answer all questions applicable to you)

SECTION A

1. What is your sex?_____
2. What is your age?_____
   Date of birth_____
3. What is your ethnic group_____
4. Where were you living when you were growing up?

   (a) Name of town/city_____
   (b) State_____

5. Who were you living wit when you were growing up?

   Both parents ( ) Father alone ( ) Mother alone ( )
   Grand Parent ( ) Foster Parents ( ) Others
   Specify_____

6. Where are you living presently ?
   Name of place/town_____State_____

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7. Who are you living with at present in your residence?

Both parents ( ) Father alone ( ) Mother alone ( )
Grand Parent ( ) Foster Parents ( ) Wife and children( )
Others specify_____

8. How many of you are born your father/mother?_____

9. What is your birth position?
Only ( ) First born ( ) Middle born ( )
Last born ( )

10. How many wives has your father?
Only one ( ) More than one ( )

11. What was the marital condition of your parents when you were growing up?
Happily married ( ) Divorced ( ) Quarrelsome ( )
Separated ( ) Widowed ( )

12. What is the present marital condition of your parents?
Happily married ( ) Divorced ( ) Quarrelsome ( ) Separated ( )
Widowed ( )

13. What was the usual occupation of your parent when you are growing up?

	Farming	Professional	Trading	Snr Civil Servant	Jnr Civil Servant	Others specify
Father						
Mother						

14. How frequent were your parents present at home?

	Often	Sometimes	Rarely	Not at all
a. Father				
b. Mother				

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15. In the early years of your life, how would you describe the crying attitude of the following members of your family towards you? This include people you have lived with

	Very Caring	Caring	Indifferent	Un caring
Father				
Mother				
Siblings				
Uncle/Aunty				
Others				

16. What is the educational qualification of your parents?

	Educational Qualification
Father	
Mother	

17. What childhood memories do you have about your family members or other persons you have ever lived with?

	Very Liberal	Liberal	Indifferent	Strict	Very Strict
Father					
Mother					
Siblings					
Foster Parents					
Uncle/Aunty					
Grand Parents					
Others					

18. How would you describe your parent's reaction towards your drug use when they discovered.

	Approved of it	Indifferent	Disapproved of it	Disapproved of it	Hated me
Father					
Mother					

19. Is "use of drugs/substances" a common practice among members of your family or other persons you grew up with? Yes ( ) No ( )

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20. How would you describe the reactions of your family members at your drug use habit recently?

	Approved of it	Indifferent	Disapproved of it	Disapproved of it	Hated me
Father					
Mother					
Siblings					
Grandparents					
Uncle/Auanty					
Other Relatives					

21 How would you describe the actions of your following family members at present towards your condition?

	Very Cooperative	Cooperative	Indifferent	Uncooperative	Very Uncoopera tive
Father					
Mother					
Siblings					
Grandparents					
Uncle/Auanty					
Other Relatives					

22 How interested are your family members in your rehabilitation?

Very interested ( ) Interested ( ) Indifferent ( )
Uninterested ( ) Very uninterested ( )

SECTIONB

23 What is your religion?

Islam ( )
Christianity ( )
Traditional Religion ( )

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None ( )

24 How frequent were you participating in your religious activities during early times in our life?
Often ( ) Sometimes ( ) Rarely ( ) Not at all ( )

25 How strong were you in religious activities then?
Very strong ( ) Strong ( ) Indifferent ( )
Weak ( ) Very Weak ( )

26 Did you at a time stopped believing or attending religious activities some years ago?
Yes ( ) No ( )

27 If yes, what year?_____

28 How frequent do you attend religious activities presently?
Often ( ) Sometimes ( ) Rarely ( ) Not at all ( )

29 How strong is your belief in your religion presently
Very strong ( ) Strong ( ) Indifferent ( )
Weak ( ) Very Weak ( )

SECTION C

30 What is your highest formal educational qualification?
None ( ) Primary school ( ) J.S.S. ( )
S.S.C.E. ( ) HND/B.Sc. ( ) Post Graduate( )

31 a. Are you interested in furthering your education? Yes ( )No ( )
b. If yes, to what level?_____

32 What was your general academic performance in school?
Very Good ( ) Good ( ) Average( ) Fair ( )
Poor ( )

33 How frequent were you getting into trouble in school?
Very often ( ) Sometimes ( ) Rarely ( ) Never ( )

34 Into what kinds of trouble were you getting into?
Fighting ( ) Suspension ( ) Truancy ( ) Expulsion( )
Others specify_____

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35. How did you perceive your school climate especially when you were growing up?
Disciplined ( ) Quiet ( ) Norm less/Troublesome( )

36. How is your present academic performance?
Very Good ( ) Good ( ) Average ( ) Fair ( )

SECTION D

37. What is your preset occupational status?
Employed ( ) Unemployed ( ) Schooling ( )

38 What is your usual occupation?
Teaching ( ) Trading ( ) Driving ( ) Farming ( )
Senior Civil Servant ( ) Junior Civil Servant ( )Professional
( ) Others specify_____

38. How many jobs have you had or worked?
Many ( ) Few ( ) Once ( ) None ( )

39. Have you ever had occupational problem/problems at work place?
Yes ( ) No ( )

40. If yes, which of the following have you ever experienced? Fill the column as appropriate. Fill the year

	Yes	Year
Job stress		
Suspension		
Dismissal/Sack		
Warning		
Accidents		
Co-Workers Hostility		
Failed Business		
Others Specify		

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41. How would you describe your occupational condition at present?
Peaceful ( ) Quiet ( ) Quarrelsome ( ) Un peaceful ( )

SECTION E

42. What is you marital status?
Married( ) Separated ( ) Divorced ( )
Widowed ( ) Never married ( )

43. How many children do you have?_____

44. How many husband/wide have you had? _____

45. Have you ever had marital problem?
Fill in the column as appropriate. If yes fill the year.

	Yes	Year	
Divorce			
Separation			
Fighting.			

46. If currently married how is your marital life?
Very happy ( ) Happy ( ) Neither Happy nor Sad ( )
Sad ( ) Very Sad ( )

47. How would you describe your relationship with your children?
Very Good ( ) Good ( ) Just O.K. ( )Very poor ( )

49. How would you describe your spouse and children's reaction towards your drug use?

	Approved of it	Indifferent	Disapproved of it	Hated me
Husband/wife				
Children				

50. Have you observed any other members of your family (husband/wife or children) frequently using any of the drugs?

Yes ( ) No ( )

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51. How would you describe your marital condition?

Peaceful	( )	Quiet	( )
Quarrelsome	( )	Un peaceful	( )

52. When did you get married? 19.....

53. How would you describe the actions of your husband/wife and children towards your present condition?

	Very Cooperative	Cooperative	Indifferent	Un Cooperative	Very UnCooperative
Husband/ Wife					
Children					

54. How interested are your husband/wife and children in your rehabilitation?

Very interested	( )	Interested	( )
Indifferent	( )	Uninterested	( )
Very uninterested	( )		

SECTION F

55. Were you getting good amount of money for your up keeping?

Yes ( ) No ( )

56. If yes, about how much monthly_____

57. How were you coping financially before your rehabilitation?

Very Good	( )	Good	( )
Just o.k.	( )	Bad	( )
Very Bad	( )		

58. How are you coping financially at present?

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Very Good	( )	Good	( )
Just o.k.	( )	Bad	( )
Very Bad	( )		

SECTION G

59. Would you agree that your childhood friends were good children your own view?

Yes ( ) No ( )

60 Were most of your friends involved in use of drugs (e.g. smoking) when you were growing up?

Yes ( ) No ( )

61. Is use of drugs a common thing in the area you grew up?

Yes ( ) No ( )

62. How would you describe the reactions of these categories of your friends towards you drug use?

	Approved of it	Indifferent	Disapproved of it	Hated me
Drug using friends	( )	( )	( )	( )
Non drug using friends	( )	)	( )	( )

63. Are you fund of watching films and television adverts showing how people used drugs?

Yes ( ) No ( )

64. How would you describe the actions of most of your good friends towards you at your present condition?

Very cooperative	( )	Cooperative	( )
Indifferent	( )	Uncooperative	( )
Deserted me	( )		

65. Are some of your friends attending this rehabilitation together with you?

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Yes( ) No( )

SECTION H

66. Provide information in relating to your criminal justice history and whether you have ever had problem with the enforcement agencies listed below, viz:

Have you had problem with (Agency)	No	Yes	Year	Types of offence
The Police				
Customs				
NDLEA				
SSS				
NAFDAC				
Others (Specify)				

67. Were you ever sent to a remand home when you were growing up?

Yes ( ) No ( )

68. Have you ever been unprisoned?

Yes ( ) No ( )

69. If yes, what year was the first time _____

70. How many times have you gone to the prison?_____

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SECTION I

70. Indicate your response by ticking ( ) in yes or No columns and fill in the rest columns appropriately

Have you been using			Year of first intake	Place of first intake	Who introduced you to it	Is it available in your neighbourhood	
	Yes	No				Yes	No
Tobacco							
Alcohol							
Cocaine							
Indian hemp							
Heroine							
Amphetamines							
Hallucinogens e.g. LSD, PCP							
Tranquilisers/ Sedatives							
Others (Specify)							

71. When you first used these drugs, what made you to do it?

Peer/ Friends pressure ( ) Curiosity ( )
Ignorance ( ) To belong ( )
Others specify_____

72. Why were you using the drugs?

To relax ( ) To cool temper ( )
Don't know ( ) To be guy ( )
Because my friends are using It ( )

SECTION J

73. What year did your friends and relatives start complaining about your behaviour?
_____

74. What year did you start attending rehabilitation?_____

75. Who brought you to the rehabilitation center?

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Nobody	( )	Parents	( )
Friends	( )	Employer	( )
School authority	( )	Religious leader	( )
Husband/Wife	( )	Community Leader	( )
Law enforcement agency	( )	Other relatives	( )

Others specify_____

76. Who is taking care of you and your bills here?_____

77. Have you been admitted for a similar problem in any centre before

Yes ( ) No ( )

78. If yes, into what facility?

Psychiatric ward	( )	Traditional healing	( )
Spiritual/church centre	( )	NGO	( )
Welfare home	( )	Others	

speacify_____

79. What types of treatments were given to you then?

Drug therapy	( )	Occupational therapy	( )
Cognitive therapy	( )	Psychotherapy	( )
Behaviour therapy	( )	Others specify_____	

80. What type of treatments are being given to you presently?

Drug therapy	( )	Occupational therapy	( )
Psychotherapy	( )	Behaviour therapy	( )

Others specify_____

81. How satisfied are you with sworks of the rehabilitation center on you?

Very satisfied	( )	Satisfied	( )
Indifferent	( )	Very satisfied	( )
Very UnSatisfied	( )		

82. Do you agree that the types of treatments you are receiving can make one stay off drugs?

Strongly Agreed ( ) Agreed ( )

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Don't know ( ) Disagreed ( )
Strongly Disagreed ( )

83. How interested are you in the activities of the rehabilitation Centre?

Very interested ( ) Interested ( )
Indifferent ( ) Uninterested ( )
Very uninterested ( ) Strongly uninterested ( )

84. How beneficial do you think this program will be to you?

Very beneficial ( ) Beneficial ( )
Indifferent ( ) Unbeneficial ( )
Strongly unbeneficial ( )

85. How distant is your residence from this center?

Very far ( ) Far ( )
Ok ( ) Near ( )
Very near ( )

86. how free are you in telling people that you are part of this rehabilitation programme?

Very free ( ) Free ( ) Fairly Free ( )Unfree ( )Very unfree( )

87How frequent do you contribute in suggesting what should be done about your condition to the centre staff?

Often ( ) Sometimes ( )
Rarely ( ) Not at all ( )

88. How accessible are the social workers to you when you have to make a complain?

Very accessible ( ) Accessible ( )
Fairly Accessible ( ) Inaccessible ( )
Very inaccessible ( )

89. How frequent do you participate or attend the centres programmes and activities?

Often ( ) Sometimes ( )
Rarely ( ) Not at all ( )

90. Do you agree that e work of this centre is very valuable?

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Yes ( ) No ( )

91. How cooperative are the staff to you ?

Very cooperative ( ) Cooperative ( )

Indifferent ( ) Uncooperative ( )

Very Uncooperative ( )

92. How frequent do you move with your old friends who use drugs?

Often ( ) Sometimes ( )
Rarely ( ) Nil ( )

SECTION K (Answer all Questions)

	Psychosocial Properties	**Often**	**S/times**	**Never**
93	Do you like to avoid situations where you are expected to do things in conventional way?			
94	Do you like to be independent of others in deciding what you want?			
95	Do you like feeling so free to do whatever you want?			
96	Do you avoid responsibilities and obligations?			
97	Do you ever do things without regard to what other may feel?			
98	Do you like participating in groups?			
99	Do you like having strong attachment with your friends?			
100	Do you like sharing thing with your friends?			
101	Do like doing things with your friends rather than yourself alone?			

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102	Do you feel that your efforts always produce poor results?			
103	Do you what people expect you to do in order to get along with them?			
104	Do you rely on your friends/others to advice you on how to solve your personal problems?			
105	Do you believe and trust your ability?			
106	What you are in a group, do you feel to talk less for the fear of saying the wrong thing?			

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	SECTION L		
	Custodial/Social Adjustment Properties	**Yes**	**No**
107	Some center's staff is helpful to me?		
108	Do you respect most of the center's staff?		
109	Would you trust the center's staff with a secret?		
110	I feel I am treated unfairly?		
111	Do you use to chat with the centre's staff		
112	Do you mix freely with other client?		
113	Do you prefer keeping to your self?		
114	In the last week did you feel like taking any substance/drug?		
115	In the last week have you deliberately broken one of the rules of the center?		
116	In the last week have you had a fight?		
117	Are you having an easy time here?		
118	In the last few days do you feel relaxed?		
119	Do you feel very lonely at he moment?		
120	Are you sleeping well at the moment?		
121	Can one stop smoking or drinking finally?		
122	Are you eating well at the moment?		
123	Do you think of doing a good job now?		
124	Are you tired about your life?		
125	Can you refer another client to this Centre?		

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Name of Interviewer_____ Date of terview_____

Institution/Centre_____ Respondents Code_____

Type of Client_____ Researcher's comment_____

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APPENDIX II

Department Of Sociology
University of Ibadan

Drug Addiction and Social Rehabilitation

Instrument II—In-depth Interview Guide For The Subjects.

1. Name of institution.
2. Type of institution.
3. Type of client.
4. Age of client.
5. What is the client's sex?
6. Marital status.
7. Highest educational level.
8. Usual occupation.
9. Place of residence.
10. How did you come to this centre? Give details.
11. Did you know about this centre before you came?
12. What are the things that this centre is doing for you clients?
13. Into what types of activities does the centre engage you in?
14. Give details about your experience here.
15. Can you refer any of your friends or relations who have drug problem to this centre?
16. How long have you been attending this rehabilitation Programme?
17. What are actually happening here?

A) Give details about your relationship with your fellow clients, including the good and the bad experiences.

B) Give details about your relationship with the staff, including the good and bad news.

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18. Can you remember any incident or story about two of your fellow clients, that is how they behave here and the bad things that they are still doing?

19. Please we know and have observed that so many clients come and go out of rehabilitation centre like this, but after sometime they go back to drugs again. Can you tell us what normally cause this situation?

20. What are the major problems that clients are facing here?

21. How do you think drug clients could be managed so that they cannot go back to drugs again?

22. What do former clients that attended this rehabilitation centre do after their discharge?

23. From your experience what impression do you think people have about clients who have attended rehabilitation process, for instance in giving jobs, trust etc?

24. When did you smoke or drink last?

25. Which are your favourite drugs when you were constantly on it?

26. How did you start using drugs? Explain how it all started and the stages. And when you stated using it more frequently.

27. When did you start noticing being disturbed by the consumption of drugs?

28. When you noticed that the drugs are not good to your body system, what did you do?

29. What are some of the bad effects using drugs have on the users? Give details with any practical example you know.

30. From your own personal experience, what effects did it have to your following aspects of life viz-. Family relationship, social network/peers, work and occupation, marital life and relationship, religious life, financial management, and education (for students).

31. When you were using drugs frequently about how much do you spend on it in a day?

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Supervisor/Interviewer's Remark----------

Respondent's Code----------

Date Of Visit/Report----------

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APPENDIX III

Department Of Sociology
University Of Ibadan

Drug Addiction and Social Rehabilitation.

Instrument III—In-depth Interview Guide For The Professionals.

1. Name of Institution.
2. Type of Institution.
3. Name of professional
4. Designation
5. Educational qualification.
6. Professional training.
7. Years of experience on the job.
8. Nature of duties.
9. What are the major aims and objectives of this rehabilitation centre?
10. Since its inception, about how many clients has the centre handled?
11. How many clients do you have in the current session?
12. How many staff do you have on your pay roll? Let us know their functions.
13. Please, we want a description of the organizational and departmental structure of this rehabilitation institution from you.
14. What do you understand by the following concepts?-Drugs, drug addiction, drug addicts, rehabilitation of drug addicts, and adjustment of drug addicts under rehabilitation.
15. Can you give us an estimate from your record on how many drug addicts treated here relapsed?
16. What are the major sources of referral of your clients to you?
17. When clients are admitted and treated, do you keep their records?, if yes, how?

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18. Can you discuss about at least two known cases of drug clients you know very well? Focusing on a) how they became drug addicts, b) how the addiction affected their social life issues such as their family, job, etc.
19. What are the types and categories of individuals that are likely to abuse drugs?
20. Mention some of the conditions and circumstances or environment that precipitate drug abuse and addiction? Give as many reasons as possible in order of importance.
21. In your personal opinion how do you think the drug addicts perceive their action within the community?
22. Please name the commonest sets of drugs abused by you clients?
23 what are the processes involved in drug addicts management in your centre? Give full details of the processes.(or what are the techniques your centre adopts in managing the drug addicts under their care?).
24. What are the materials/resources generally required for drug addicts rehabilitation exercise in your centre? How adequate are the available materials and resources?
25. What are the minimum and maximum expected periods through which a normal rehabilitation can take place?
26. During the clients' rehabilitation, what characteristics of people are more likely to be problematic or responding poorly to rehabilitation?
27. Then what types of people are more likely to adjust well under rehabilitation?
28. What criteria can one use to determine whether a client is responding poorly or well as the case may be?
29. What are some of the social factors or conditions that may influence clients' response or adjustment pattern during rehabilitation?

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30. From your personal experience, what should the community or civil society do to ensure more effective drug addicts re-socialization in Nigeria?

31. What methods do we adopt to ensure better result in drug addicts rehabilitation in Nigeria?

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Supervisor/Interviewer's Remark----------

Respondent's Code----------

Date Of Visit/Report----------

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FINGER OF GOD MINISTRIES INTERNATIONAL

LIFE REHABLITATION / VOCATIONAL TRAINING CENTRE

(For Drug Addicts)

Motto: "The Dry Bones Shall Rise Again" Ezekiel 37:5

8, Awodiya Close, Ijalya Ojokoro, Alagbado, P. O. Box 6224 Ikeja, Lagos.

ADMISSION FORM

ADMISSION NO. _____ DATE _____

Full information on the following is required.

1. NAME IN FULL: .....
2. RESIDENTIAL ADDRESS: .....
3. AGE: ..... RELIGION: .....
4. VOCATIONS / QUALIFICATIONS: .....
5. TYPE OF DRUGS USED
6. PERIOD OF DRUG ABDICTION: .....
7. HOW DID YOU GET INTO DRUG ABUSE? .....
8. CHOOSE A VOCATION TO LEARN: .....
9. NAME & ADDRESS OF SPONSOR / GUARANTOR: .....
10. RELATIONSHIP OF SPONSOR / GUARANTOR: .....
11. HOW DID YOU OBTAIN INFORMATION ABOUT US? .....

To The Sponsor / Guarantor

Our aim and objective is to bring a drug addict to a total state of deliverance in Spirit, Soul and Body. This is achieved through: Counselling, Daily Exhortation, Group-Theraphy as well as Spiritual Theraphy and Bible Study Workshop / Seminar. This is done in an environment full of love but subject to both Spiritual and Physical disipline; if the need arises.

This centre is not profit oriented and without government support at present, hence, we need and expect your regular support in the centre finaclally, materially, morally and above all, Spiritually at very good intervals.

The patient will be trained on a vocation during his stay in the centre, so that he will be economically independent and socially acceptable after his stay in the centre.

All enquiries should be directed to the Provost and or the President of the centre.

President: HOLY GHOST | Vice President: REV. (DR.) KAYODE ABIOLA PELLEH

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RULES AND REGULATIONS

1. Minimum duration in the Rehabilitation / Vocational Centre is 6 (Six) months 3 (Three) months for rehabilitation and 3 (Three) months for Vocational Training. There may be extension of the duration, if the need arises;

2. You are not allowed to have any physical cash with you for the 6 (Six) months of your stay in the Centre; and it may be extended if the need arises thereafter.

3. You will not go out of the Rehabilitation Centre in the 6 (six) months of your stay. A special permission may be given by the President of the Centre to go out after the 6 (six) months with a guide / monitor.

4. No smoking of any kind nor drinking of alcohol; it leads to instant punishment and possibly expulsion from the Centre.

5. Cleanliness is next to Godliness; hence, you are expected to partake in the cleaning of the environment and it is also compulsory that you take your bath in the morning daily.

6. It is compulsory for you to participate in all the Spiritual activities at the Centre / Church e.g. Daily Morning / Evening Devotions; Bible Study / Workshop; Fasting and Prayer; Outside Ministration; Night Vigil; Vocational Training.

7a. You must comply with all the instructions of your trainers / supervisors at the Rehabilitation / Vocational Centre always.

7b. You must not bargain / discuss with any customer / visitor to the Rehabilitation / Vocational Centre.

7c. All assignments given to you at the Rehabilitation / Vocational Centre must be completed promptly; failure may lead to severe punishment.

8. Respect is reciprocal; respect yourself and other Inmates. Also obey the authority with respect always.

9. Finally, failure to abide to this rules and regulations is subject to both physical and spiritual discipline and continued disobedience may lead to your expulsion from Rehabilitation / Vocational Centre.

10. If in distress, you are free to inform the Provost of the Centre, who is on call 24 hours daily.

11. The Vocational Training is to prepare you for your future endeavours hence, no payment or allowances will be given to you from the Centre during the training period.

12. Anyone that runs away from the Centre does so at his / her own risk.

13. We expect every Inmate to cooperate with the authority to achieve this DIVINE GOAL.

REHABILITATION PATIENT UNDERTAKING

I hereby agreed to abide with, and obey all the above rules and regulations of the Centre.

PATIENT'S SIGNATURE & DATE

WITNESS SIGNATURE & DATE
NAME & ADDRESS

GUARANTOR / SPONSOR'S SIGNATURE & DATE

PRESIDENT SIGNATURE & DATE

PROVOST SIGNATURE & DATE

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APP. V.

Table 4(a)

DRUG CONTROL POLICY IN NIGERIA

1. Dangerous Drugs Ordinance, 1935
2. Indian Hemp Decree (No. 19, 1966)
3. Indian Hemp (Amendment) Decree No. 34, 1975
4. Indian Hemp (Amendment) Decree, 1984
5. Special Tribunal (Miscellaneous offences) Decree 20, 1984
6. Special Tribunal (Miscellaneous offences) Amendment Decree 22, 1986
7. National Drug Law Enforcement Agency (NDLEA) Decree 48, 1989.

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8. National Drug Law Enforcement Agency (Amendment) Decree No. 33, 1990.

9. Money Laundering Decree 3, 1995

10. National Agency for Food and Drug Administration and Control (NAFDAC) Decree 15, 1993.

11. Pharmacists Act No. 26, now CAP 357 LFN 1990.

12. Dangerous Drugs Acts CAP 91 LFN 1990

13. National Drug Formulary and Essential Drugs List Decree CAP 252 LFN 1990

14. Food and Drug Act CAP 150 LFN 1990

15. Counterfeit and Fake Drugs Act (Miscellaneous Provision Act CAP 73 LFN 1990)

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16. Pharmacist Council Decree No. 91 of 1992

17. Tobacco Smoking (Control) Decree, 1990.

Adopted from Odejide (1998)

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SOCIAL WELFARE

Statistical Analysis of Good Boys and Girls' who have been Rehabilitated by the Task force

No. passed through Operation Weed For Flowers	2,817
No. placed on employment	416
No. placed on further training	164
No. of plants planted to date (seedlings)	10,988

Statistical Analysis of Juveniles who have passed through the Task Force

No. arrested	713
No. released to parents on supervision	397
No. treated	316

Statistical Analysis of 'Good Boys & Girls" Under Permanent Employment

	Male	Female	Total
Lagos State Direct labour Agency	10	5	15
Lagos State Environmental Protection Agency	3	1	4
Lagos State Waste Disposal Authority	7	4	11
Ministry of Environment and Physical Planning (Drainage Control Dept.)	15	1	16
Lagos State Civil Service (Task Force)	2	-	2
Lagos State Water Corporation	18	1	19
Fan Milk Plc.	11	-	11
Lagos State Printing Corporation	5	2	7
Graduates of Livestock Training	36	12	48
Cornerstone Bakery	5	-	5
Distributors for Cornerstone Bakery	5	1	5
Total	117	27	143

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Source: Task force on Environmental Sanitation and Special Offences in Pictures Vol 2, 1998

I. Good Boys and Girls undergoing training as Livestock Farmer

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II. Good Boys and Girls undergoing training as Livestock Farmer

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II. Good Boys and Girls undergoing training as Livestock Farmer

III. An instructor in Livestock Farming giving lectures to the trainees

VI. Good Boys and Girls getting ready to receive their weekly allowance

IV. A cross-section of the trainee receiving lectures

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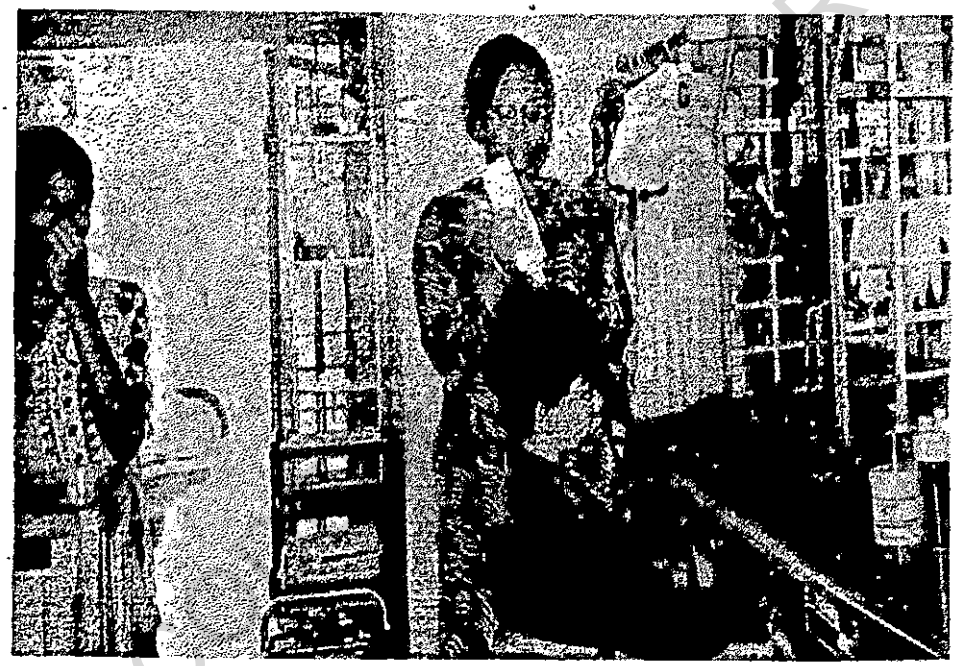
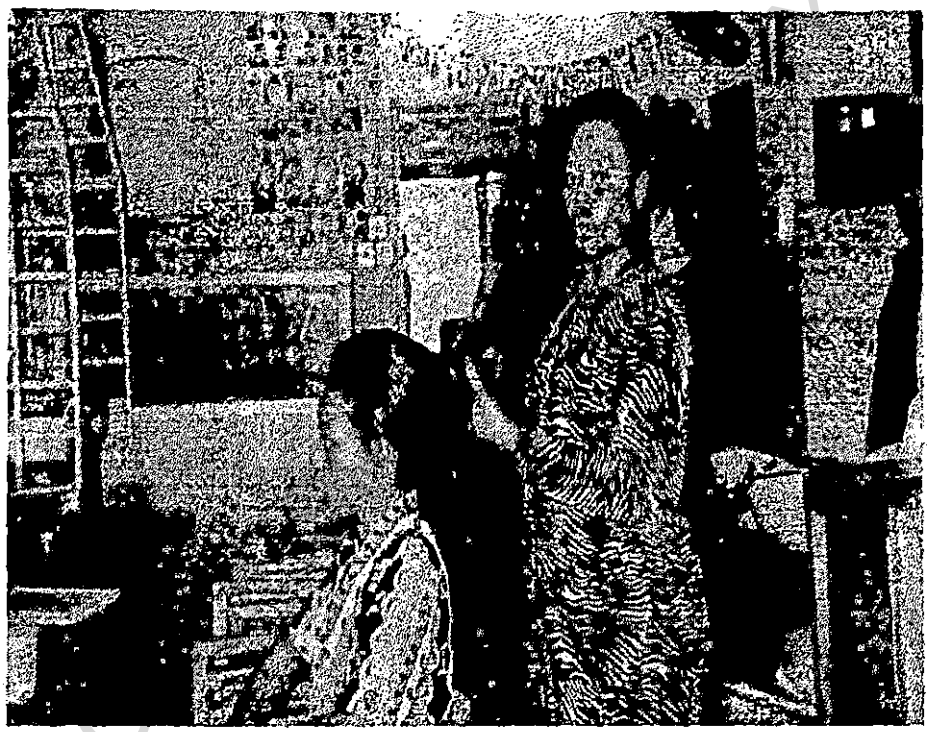
V. Good Boys and Girls queuing for their food after lectures

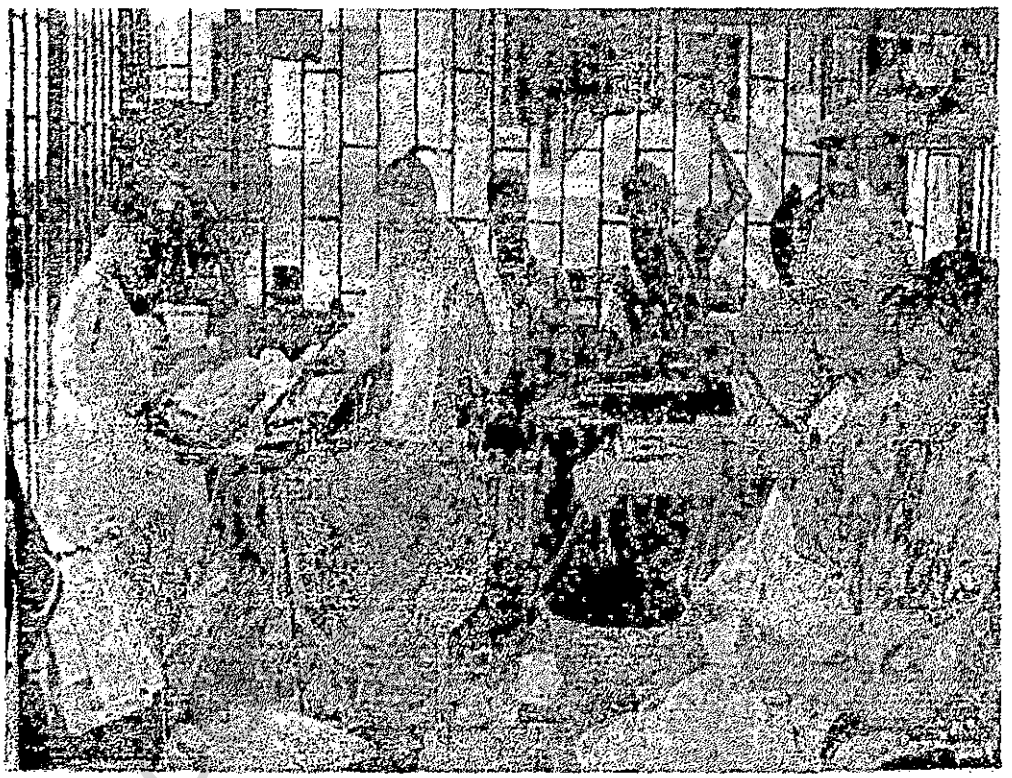
VII. Time for signing and receiving allowance



VIII. Good Girls undergoing training in hairdressing



IX. Good Girls undergoing training in hairdressing



X. Some Good Girls being trained for knitting

XI. A former Good Boy being re-trained by LSWC

XII. More Good Girls being trained for knitting

XIII. Good Boys training in panel beating

Task Force men recover N4m from area boys

By [illegible]

MEN of the Lagos State Task Force on Environmental Sanitation and Special Offences has recovered about N4 million from area boys and hoodlums who snatched the money from their owners as they walked around Martins street and Idumota in Central Lagos.

Sources at the Lagos State Secretariat told us that the money was recovered in two operations.

About N1.5 million was recovered at Martins Street while about N2.5 million was recovered at Idumota and the money had been returned to the owners after identification by the Task Force.

However, because of the method employed by the hoodlums which is a new dimension to robbery, the Task Force yesterday swooped on commercial vehicle operators in [illegible] parts of Lagos including Idumota, Ceic bus stop, Oshodi and Obalende to fish them out.

It was learnt that the hoodlums took advantage of the chaotic traffic situation at these places to lay ambush on their victims and rob them of their belongings.

It was disclosed that as unsuspecting would-be victim or victims approach their position, the hoodlums who number between five and 10 come out from their positions and snatch money or belongings of their victims and run into the crowd of vehicles and people thus making it difficult for them to be apprehended.

Chairman of the Task Force, Major Abayomi Opeolu who confirmed the recovery of some money by his men at Martins Street, however stated that it was returned to the owners through the Lagos Garrison Command after proper identification.

He disclosed that the practice had been going on for long, adding that following complaints to his office, his men were deployed to Central Lagos to mount surveillance which has resulted in the recovery of the money and the arrest of some culprits.

On the arrest of bus operators and seizure of some commercial buses, the chairman stated that the measure was aimed at clearing the roads of traffic offenders, thereby creating unfavourable environment for the hoodlums to snatch people's money and other belongings.

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XIV. Vanguard 18 – 02 – 97, pg. 5

To Marwa, a good turn by 'good boys and girls'

XV. Guardian of 24th December 1997, pg. 11

Marwa reassures reformed 'area boys'

By
Musa Azeda

LAGOS State administrator Col Mohammed Marwa on Monday in Lagos reiterated his administration's resolve to gainfully employ reformed ejectments in the state commonly called "area boys and girls" in different communities and eyesores of the state.

Col Marwa who gave the assurance when reformed hoodlums in the state now called 'good boys and girls" visited him in his office, called on such people still in the street to desist from harassing innocent citizens and submit themselves to the authority concerned with their reformation.

Col Marwa congratulated the good boys and girls for turning over a new leaf and promised that about 1000 of them would be given jobs next year.

He said steps must be taken to address the issue of area boys and girls promising that many of them would be used by Direct Labour Agency DLA).

He said his government would intensify efforts to rehabilitate thousands others still in the street and called on them to submit themselves adding that anyone caught in bad behaviour would be treated like a common criminal.

Addressing the state administrator earlier, the chairman, Lagos State task force on environmental sanitation and special offences Major A. A. Opeolu said successive administrations in the state have tried several measures to addressing the menace of hoodlums in the state but this time has been an honest one the present administration's which he said has high potentialities of success.

Major Opeolu presented about 1400 good boys and girls who have passed through their information programme to the administrator and said the initially engaged 33 participants have grown to 200 with 40 of the boys and girls employed by DLA, LAWMA, LASEMA and drainage department of the MEPP.

He said five of the boys who have acquired rudimentary knowledge in vehicle maintenance and panel beating are presently undergoing further training which would make them to be self employed after their training.

According to Major Opeolu, two of the good boys and girls are expected to join a hair dressing salon while about 110 are presently in "operation weed for flower", 50 of who would start training in poultry husbandry techniques, and would be employed by the present administration as casual workers with the newly established Direct Labour Agency (DLA).

According to him, the DLA engaged about 700 miscreants as casual workers during the operation 180 while 230 were engaged to date under operation 250.

He said the present administration later launched operation weed for flower to cater for permanent employment of the boys and girls and to beautify the state as well as acting as a spring board to ensure their efficiency for other jobs.

He said Ministry of Agriculture, Co-operatives and Rural Development was expected to train the boys and girls in poultry management

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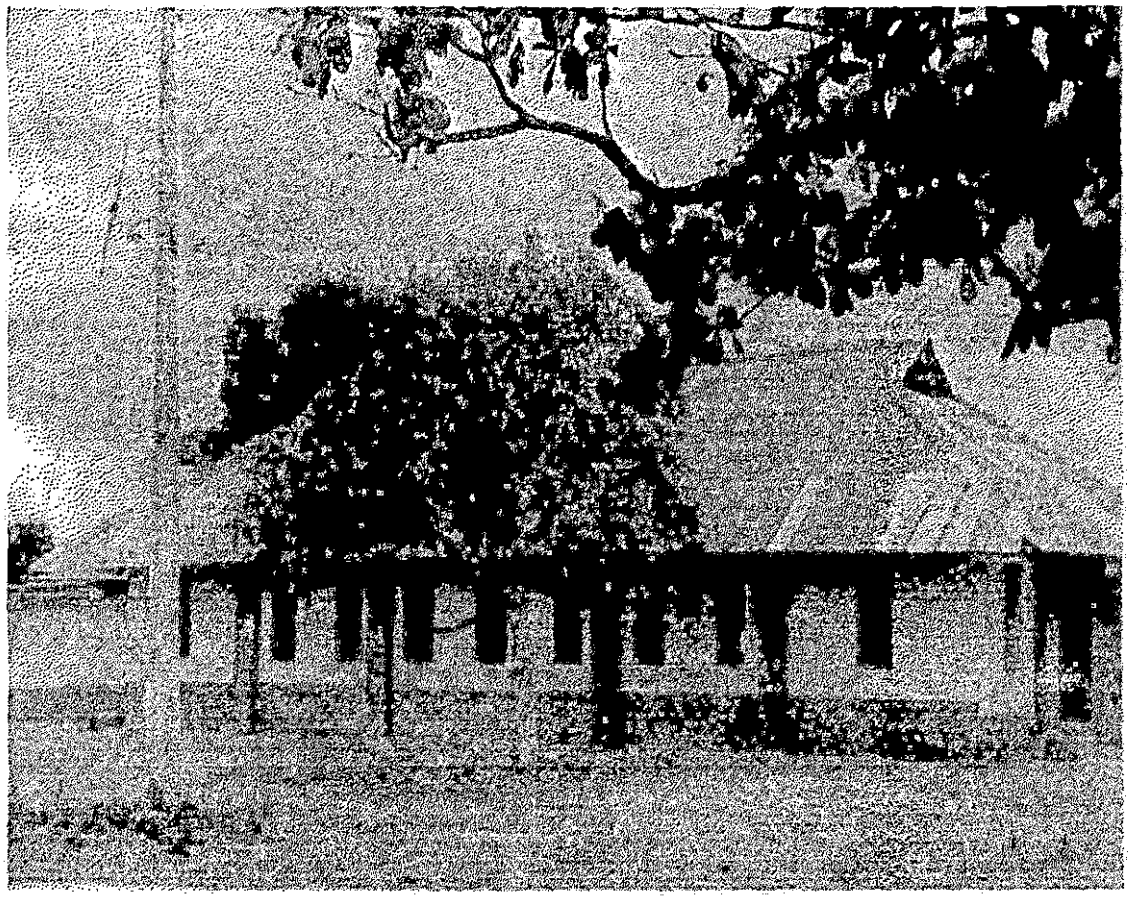
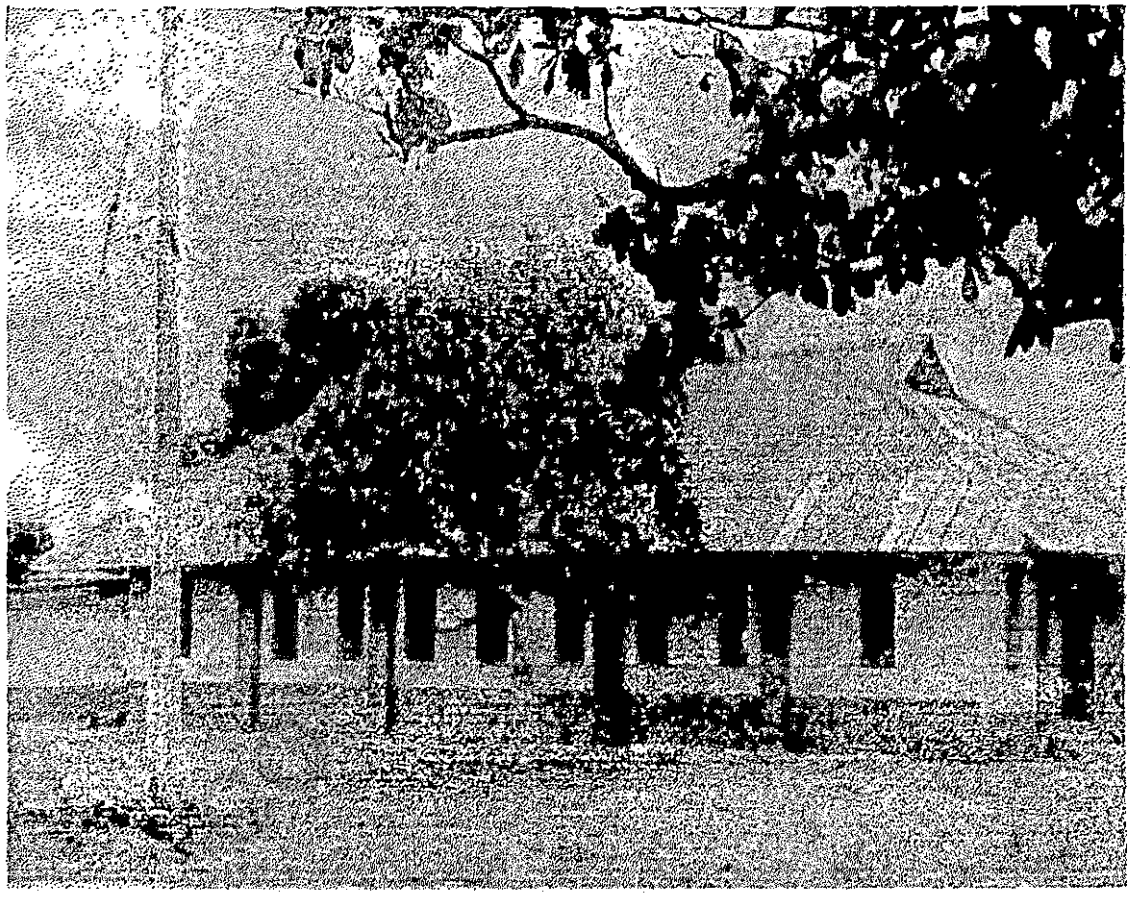
XVII. Champion December 24 – 1997, pg. 3 contd.

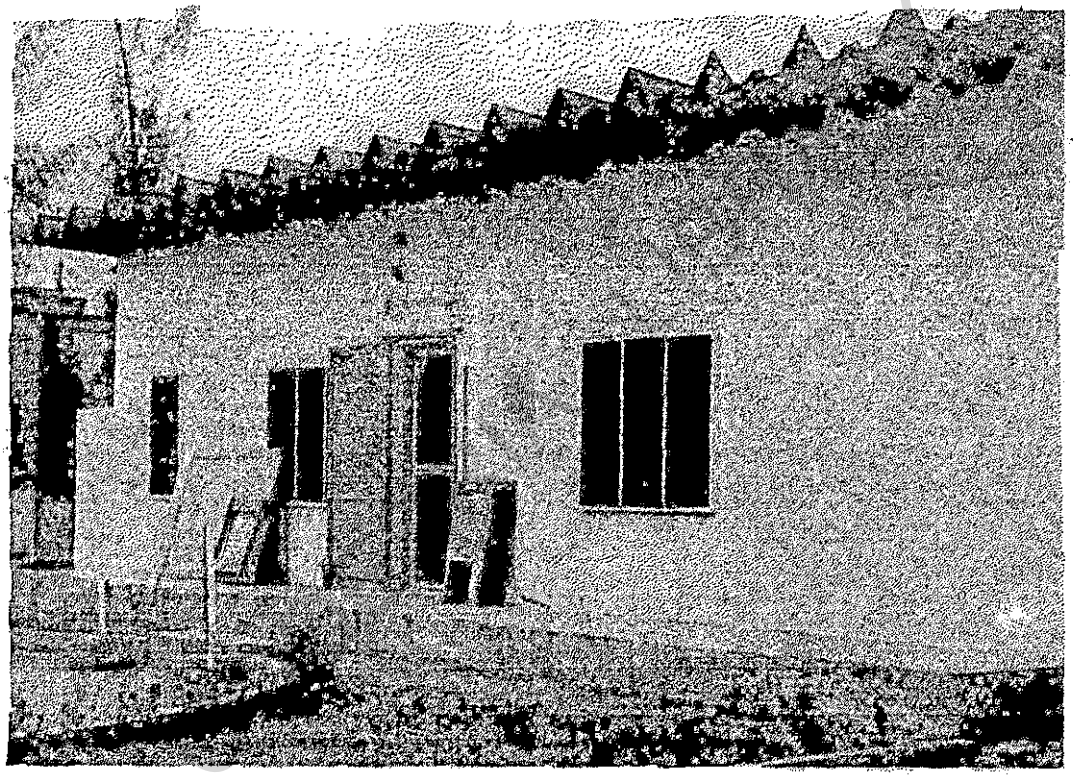
XVIII. View of Isheri Rehabilitation Centre



XIX. View of Isheri Rehabilitation Centre



XIX. View of Isheri Rehabilitation Centre



XX. Cornerstone Bakery

XXI. Loafs from Cornerstone Bakery

Appendix VII

Guardian on Sunday, July 4, 1999.

KALEIDOSCOPE

Christ Brings Succour To Drug Abusers

● Rehabilitated men at CADAM training centre

—By—
Temitope Ogunsi

LIKE zombies each day was the same routine. Their only task was how to get more of the life-gripping substance they had come to depend on so much. They cared for little, were willing to trade their last property to get it and like a moving train were ready to crush anything that tried to obstruct their path.

Programmed by drug dependence, these unfortunate tragedies of the drugs of civil society lived a life of self-contentlessness and shame. Wishing to quit, but hardly having the power to, they could only hope for a bearable end.

Hundreds have trudged through this miserable path of drug addiction to a tragic end, but what makes these "zombies" peculiar is the encounter they were privileged to have which turned their lives around.

No longer in the grips of the drug demon, these beneficiaries of Christ Against Drug Abuse Ministry (CADAM) shared their story with *The Guardian On Sunday*.

Very little about them, as at the time *The Guardian On Sunday* visited could depict that they had ever slept at joints, in gutters, or even went without a bath for several days. They were handsome, clean and cheerful looking young men, full of life and good expectations for the future. Even they confessed they did not expect the change could be as rapid as it has been.

"I've grown fatter and fresher since I joined this rehab. I used to be very tough-looking. You wouldn't have had the courage to ask me any questions back then. I was quite ferocious," said Festus Okaro, who had been introduced into drugs by his family friend. "It was really rough while I was hooked," he explained. "I came to Lagos in 1981, worked with the NTA till 1985 before I got hooked. I had my own camera and equipment which I used for private jobs, but as soon as I got into a drug habit, I began to sell all my equipment till I sold my last pair of shoes."

Okaro, was at the second phase of his rehabilitation when he spoke. Already, he had completed the first lap of six months at a remote site in Poka village some few kilometres before Epe town.

According to Mrs. Winka Ajibola, the secretary of CADAM, beneficiaries were rehabilitated in two separate places, Poka and Akute. She explained that it was necessary to isolate the beneficiaries for the first six months away from their familiar surroundings as they can manage the urge to go back to the habit better.

CADAM was set up in 1991 by Pastor F. A. Odeyemi of the Redeemed Christian Church of God (RCCG) who had a burden for "Area boys" to come to Christ. Ajibola explained: "Odeyemi and some of us used to talk drug issues and preach Christ to the addicts and in the process of time, some came to accept the gospel. But we needed to help them out of their drug problems so we took them to Adeniji Adele camp which Lagos State had then. We visited, counselled and generally took care of them but it was difficult to monitor their progress and that brought about the need to set up our own rehab centre." The name "CADAM," Ajibola said, "is to remove the stigma of drug habit rehabilitation from the people and to focus their attention on the fact that Christ could solve a drug problem."

The interesting aspect of CADAM operations apart from it being Christian is that the rehabilitation is absolutely free.

CADAM's success is based on a practice of *no-drugs-no-freedrugs*. The ministry's peculiar brand of rehabilitation involves prayers, exercises and heavy feeding.

According to Ajibola, although the rehab is open to people of all religions, its therapy includes an encouragement for the addict to embrace the Christian faith and cultivate a deep spiritual relationship with God. "We make no mistakes about that."

Although largely run by freewill gifts from concerned citizens and organisations, CADAM enjoys a meagre subvention of 50,000 naira from RCCG. "This is hardly enough, but it is an encouragement to us, at least we get to pay staff salary from it."

CADAM also have part of the money it receives to maintain a vocational training centre in Akute, where beneficiaries are trained in tailoring or shoe making so they can earn their living after rehabilitation. The vocational centre in turn yields some profit when it is lucky to get some jobs and the money is either used to set up a small business for beneficiaries or it is re-ploughed into general upkeep of the two centres.

When *The Guardian On Sunday* visited Poka, it was evident that a lot more really needed to be done. The permanent building which will house 40 beneficiaries is on 300naira land and needs to be roofed. Both the Akute and Poka buildings were barely furnished, but CADAM is not so concerned about the furnishing as it is about getting the permanent structures in place. "We're paying a lot for rent and the money can be employed elsewhere as soon as we move into our permanent site," Ajibola explained. "The beneficiaries don't need many luxurious furniture for their brief stay here; this is to prevent them from getting too comfortable and forgetting the reason they are being rehabilitated," she added.

The centres are maintained by the beneficiaries to the strictest hygiene standards.

"Cleanliness is very important here," said CADAM staff, Mr. Femi Thomas, in Poka, "we ensure they clean the place twice a day and they take their bath twice at a." This, he explained, is to shake off the sedary habit often noticed with addiction.

"I got into drugs" said Wallen, "because I wanted to belong. Actually, I was introduced to herbal as by a friend from the Benue. He had some leaves for a holiday and he suggested we get high."

Wallen, whose friend introduced him to cocaine, had while in secondary school taking his A Levels being on marijuana.

The friend also introduced him to the joint where he could get some, but as he said, "I needed courage to get them by myself. Initially, Yomi got them for me but when he was about to return to the States, I was already hooked and I had to get it myself."

However, Wallen said, Yomi has since solved his drug problem while he himself still wondered about helplessly. According to him, "I desperately wanted to quit but couldn't on my own. Then a cousin told me about CADAM since he knew about my personal effort to stop the habit. He told me I needed a permanent solution."

But his father wasn't too keen about CADAM. "He refused to be convinced into putting more money on me to solve this problem because he thought it would be like other rehab centres — with a short solution."

Luckily, Wallen's father having heard that Christ was involved in this rehab became less adamant. Said Wallen: "I also knew I needed Christ by the way but other centres had failed." Knowing he was fast losing his grip on life and going down the drain, Wallen put in for the CADAM centre.

Beyonds, went to CADAM for a spiritual rehab. "I stopped taking drugs seven months before I got here. However, I am glad I came here because I've gained a lot by being here."

When asked how he started, he responded, "I wouldn't know. It's a little bit complex. It could have been curiosity, fear, recognition. All I know is that I liked it when I inhaled it and this is just before my mid-isolation in the university."

John, middle-aged father of two, started his addiction as a negative response to cultural pressures put on him by family members when he came here. "When I was given to start on cocaine, it happened I had come to bury my father and as his only son, I was expected to perform some rites I knew nothing about. I had lived in the United States with my parents and they didn't tell us much about our tradition. So, I was unprepared for most of what I encountered then. I became depressed. Incidentally, a friend of mine who knew I was on marijuana offered to take me to a joint to chill out. But I wasn't getting what I really wanted and I noticed he was taking doses of cocaine." John was offered eight grammes of cocaine by that friend and "instantly I felt better. You know cocaine works very fast. That's how I dropped marijuana for cocaine."

Just as a good work speaks for itself, CADAM beneficiaries have been able to convince other addicts to come for the programme. Even dropouts who didn't finish the programme before relapsing have returned to joints only to convince others to give it a try.

Peni, a relapsed beneficiary came back for a second rehab. He told *The Guardian On Sunday*: "I didn't finish the first time before running away and I thought I could go back to bodies hangs about, but before long I was hooked on cocaine but [illegible] I came back."

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