MANUAL ON COMMUNITY ACTION
AGAINST DRUGS AND ALCOHOL
(First Version)
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in collaboration with the
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International Labour Office
Geneva
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This set of manuals is a response to the need to introduce measures against drug and alcohol abuse in developing countries. In those countries a large number of programmes must be started quickly with limited resources. Lacking well-established programming practices of their own, their planners and service providers must study the work and ideas of others; they must analyse what that work means for their own cultures and adapt it to their needs. These publications are designed to help them in their task.

The four manuals are described briefly below.

"Manual on addiction rehabilitation programming" by Fred Zackon.

This volume is intended for the staff of addiction rehabilitation programmes. It is designed to be used by all service staff, although it is mainly a tool for programme leaders. The text provides a guide for the development of model programmes based on the author's Reference Design. It describes the key issues and actions for building such programmes. Most of the approaches described have already gained wide acceptance in the field of addiction rehabilitation. Some attention is given to administrative issues, but the primary focus is on client services. The context is integrated and all the elements derive from a unified perspective, which means that staff must operate as a team with a common understanding and purpose.

"Manual on community action against drugs and alcohol" by Sam Lauthan.

Those who live in communities where drug and alcohol abuse occurs must feel concerned at the situation and be aware of the dangers of allowing it to deteriorate further. Community action to combat substance abuse means that individuals and groups must work together to find social responses to the problem and to provide healthy alternatives to alcohol and drugs. All segments of the community must be motivated to develop a total commitment to the task of protecting vulnerable groups and individuals from the dangers of substance abuse.

The manual provides guidelines on forming local associations of the widest possible variety of expertise and good will as the best way to develop the multidisciplinary approach which is necessary to tackle this complex problem. It describes a step-by-step methodology to be followed in planning and implementing a community-based demand reduction
programme. It also gives a brief introduction to the role of government agencies and nongovernmental organisations in the fight against drug abuse. The manual includes some basic information about substance abuse generally, as people involved in community action need to be well informed about the realities of the situation in order to tackle their work with confidence and competence.

"Manual on drug and alcohol policy development" by Ragnar Waahlberg.

The social effects of substance abuse are well known and clearly documented. For example, there is no doubt that a high level of alcohol consumption in a country correlates with a high level of social and health problems, with violence and criminality.

This manual is designed to help decision makers formulate a national policy on alcohol and drugs and to develop a preventive strategy. The aim of a national policy on alcohol should be to restrict the damage caused by excessive consumption, and the aim of a drug policy should be a drug-free society. The manual includes chapters on reducing the supply of alcohol with the objective of preventing excessive drinking, and on preventing people from ever beginning to use illicit drugs. The focus is on prevention, rather than cure, as the foundation of a national strategy. It offers a step-by-step guide to drawing up a policy and creating the instruments needed for implementation.

"Manual on the design, implementation and management of alcohol and drug programmes at the workplace" by Sverre Fauske.

The aim of this volume is to help managers, union leaders, occupational health professionals and social workers to design and implement programmes on the prevention of drug and alcohol abuse at the workplace. It is also intended for local resource personnel to help them in their collaboration with government, management, union representatives and consultants on alcohol-and drug-related problems at the workplace.

Concern for the welfare of people at work is central to the activities of the International Labour Organisation. This concern includes taking measures to combat substance abuse. ILO involvement in this field is based on the agreement of governments, employers and workers that workplace initiatives are an effective means of preventing and reducing alcohol and drug abuse. The scale of the problem should not be underestimated, as drug-related issues affecting workers have become a serious concern in many countries. The costs to industry and the community have been estimated in billion dollar terms; they
involve lower productivity, absenteeism, accidents and staff replacements as well as sickness and accident insurance claims. In human terms the costs to individual workers and their families are also great if they lose their jobs as a result of drug and alcohol abuse.

The focus of this manual is on prevention rather than cure. It distinguishes between primary prevention (awareness), secondary prevention (assistance) and tertiary prevention (rehabilitation), and provides guidelines and suggestions for those responsible for introducing workplace programmes.

The title page of all four volumes indicates that the publication is the first version of the manual. The manuals are designed in such a way that they can easily be adapted in the light of experience with their use and the second edition will incorporate new developments in the field. The ILO encourages and welcomes the ideas of all those who use this material. Readers are invited to submit their comments and suggestions for the second edition to The Vocational Rehabilitation Branch, International Labour Office, CH-1211 Geneva 22, Switzerland.
INTRODUCTION

Substance abuse is an extremely complex problem which affects every part of the world today. In the search for solutions it is necessary to take account of the medical, psychological, social and legal dimensions of the question as well as the economic aspects. Abuse of drugs and alcohol occurs on a large scale in the industrialised countries and has become a real threat to developing nations in recent decades. Most of the countries of Southern Africa have serious problems with alcohol, cannabis and methaqualone (mandrax), and some of these countries have begun to experience cases of heroin and cocaine trafficking.

Those who live in communities where drug and alcohol abuse occurs must feel concerned at the situation and aware of the dangers of allowing it to deteriorate further. The quality of life of all members of the community is threatened when substance abuse is rife and every individual suffers the consequences of inaction. Communities in many countries are already facing natural disasters such as drought, which are compounded by economic disasters such as inflation and unemployment; such communities cannot afford to ignore the issue of drug abuse and cannot allow their precarious economic situation to be eroded further by the social disasters of drug addiction and alcoholism.

Community action to combat substance abuse means that individuals and groups must work together to find social responses to the problem and to provide healthy alternatives to alcohol and drugs. Young people in particular need facilities for physical exercise and recreation, stimulation for their creative talents and mental abilities, and an environment which provides aesthetic satisfaction. Their spiritual needs also must not be overlooked in the effort to provide a positive outlet for the energy and enthusiasm typical of the young. Young people and workers are statistically most at risk of falling into dependency, but there is no social group which is free of the threat of substance abuse.

All segments of the community must be motivated to develop a total commitment to the task
of protecting vulnerable groups and individuals from the dangers of alcohol and drug abuse. A large number of people can give assistance in this effort. They include psychiatrists, doctors, primary health care workers, psychologists, anthropologists, sociologists, school administrators, teachers, the business community, labour leaders, trade unionists, police and customs officers, youth club leaders, religious leaders, social workers and parents. Professional groups and private individuals can all participate in community action if they can spare a few hours every week or every month to work on an advisory board or as resource persons on a Community Action Committee. Forming an association of the widest possible variety of talent, expertise and good will is the best way to develop the integrated, multidisciplinary approach which is necessary to tackle such a complex problem.

The Community Action Committee

Prevention activities at grassroots level are the responsibility of local Community Action Committees.

In order to set up a Committee the project takes the initiative by making a simple survey of existing resources in the local community, concentrating on potential human resources. A list is then drawn up of the local organisations whose members could make a valuable contribution to prevention activities. The list is long: it includes professional bodies and associations such as the police and customs authorities, the educational system, primary health care services, the media and the local business community, as well as voluntary clubs and organisations such as amateur sports clubs, youth groups and parent-teacher associations. Nongovernmental organisations involved in charity work and religious bodies can also play a vital role in preventing substance abuse in the community.

The social worker attached to the national drug prevention project contacts all the local associations identified by the survey and invites them to a seminar or a public meeting in order to discuss the situation and the possibilities for action. The objective of this preliminary meeting or meetings is to establish a consensus on the need for action, before any specific steps are taken to initiate activities. Once such a consensus is clearly established the social worker invites the associations which have demonstrated their interest and concern to nominate one of their members to serve on the Community Action Committee. When the Committee is formed it should elect a Chairman and hold regular meetings every month or so. The project coordinator should be appointed Secretary of the
Committee.

From this point on the active involvement of the national project is gradually phased out; the project remains in the background, concerned only to maintain the motivation of Committee members and advise them as requested. The basic structure of the community action component of a national drug and alcohol prevention project is illustrated in the organigram in Annex I.

The function of the Community Action Committee is partly to give advice to the local population on drug-related matters, partly to serve as an information channel between the local community and the national centre, and partly to mobilise funds and other resources for prevention activities. Committee members themselves are often actively involved in lecturing to school-children and youth groups on the dangers of drugs and alcohol, or in fund-raising for campaign work. The Committee acts independently because activities undertaken at local level are not usually funded by the national resource centre. This arrangement gives committee members both responsibility and authority, as they are not merely carrying out proposals made at national level. The element of independence is motivating for committee members, who give their time voluntarily.

The basis of community action is networking through informal social contacts. Committee members can intervene on behalf of recovering addicts by helping them find employment and assistance when needed. They can also give professional advice on practical matters, such as handling money and finding a home, or personal matters such as health problems and mental stress. These activities are more concerned with secondary prevention than primary prevention, which is aimed at the whole population rather than particular individuals. This point indicates the importance of the work of the committee members, who are aware of local needs of all kinds and who are in a position to respond to them.

Community action work must have a target. The target may be quantifiable and relatively easy to measure (e.g. a reduction in the number of drug- or alcohol-related accidents during the year), or it may be qualitative, relying largely on people's impressions and informed opinions for assessment (e.g. an improvement in the quality of life in the locality). The ultimate target of community action is to involve the local population at all levels in raising awareness of the dangers of drugs and alcohol and thus to strengthen the general level of resistance to the attraction and temptation of dependency-creating substances.
Understanding the high-risk groups

During the past twenty years an enormous amount of literature has been published on the question of substance abuse and the reasons why people fall into dependency and addiction. However, researchers have not yet reached a comprehensive understanding of the phenomenon in spite of advances in biophysiology and pharmacology.

In a country where drug abuse is common any young person or adult may be considered at risk, but some are at greater risk than others because drug problems are not distributed uniformly over social groups. Adolescents are at high risk, even if they live in so-called “safe” areas, because of the stresses caused by the personal development which takes place during adolescence. During this period the healthy young person will learn to:

develop self-confidence;
take the initiative;
explore, experiment and take risks;
discover personal aptitudes and come to terms with weaknesses;
develop an independent identity;
work towards emotional and social maturity;
assume some economic independence;
become physically mature.

During this difficult phase young people lose the protection afforded by childhood before they gain the experience and maturity of adulthood. In addition to this it must not be forgotten that adolescents have to respond to the stresses of their environment at the same time as they are working towards their own personal development. The environmental stresses include:

increasingly complex relations with other people;
problems related to sexuality;
the disappearance of the extended family;
finding a job or starting a training course;
negative peer pressure;
new technology;
the population explosion.
In addition to the above, those adolescents and young adults who live in high-risk areas often have to cope with a particularly difficult situation in the family and community. They probably experience economic hardship and may have psychological problems. They also lack facilities for leisure-time occupations.

There are only two possible responses to the many types of stress listed above; fight or flight. It is a tragedy that so many adolescents and young adults have chosen the latter course, through drug taking and heavy drinking. However, not ALL young people in high-risk areas use drugs, and not ALL young people in low-risk areas refuse drugs. We must therefore be very cautious when using expressions such as “high risk” and “low risk”.

Programmes and activities designed to combat substance abuse in all areas must develop different approaches aimed at non-users, experimenters, occasional users, regular users and addicts.

Non-users must be encouraged to continue to refuse drugs and helped to resist peer pressure to experiment. Experimenters must be informed that although drug users may appear to function normally they run the risk of becoming addicted, taking an overdose or being arrested. Occasional users are the most difficult group to convince because they derive pleasure from drugs but do not suffer from withdrawal symptoms and are not yet dependent. For the same reason regular users are difficult to reach, although they may realise that they are already developing tolerance and increasing their intake of the drug. Alcoholics, drug addicts and poly-drug abusers need to be motivated to seek treatment, even if they have made previous unsuccessful attempts to stop drinking or taking drugs. Treatment must be followed by after-care and rehabilitation services, preferably at community level.

The expression “high-risk” group does not refer only to adolescents living in an environment where drug-taking and drinking are common. Other high-risk groups are retired people who drink to help themselves to cope with loneliness and boredom, and business and professional people in stressful jobs. The adult children of alcoholics are also considered to be at risk because they grew up in an environment where alcohol was always present. Also at high risk are people who live in urban slums because very often the production and sale of home-made alcohol is their main source of income. This group should be the target of special programmes designed to tackle the multiple problems of slum dwellers; such programmes should include field workers and peer leaders with whom the slum dwellers can identify. Youth clubs and other youth movements should be involved
in the planning and implementation of these programmes, which need to help young people develop the necessary coping skills to grow up and lead a drug-free life in a high-risk environment.

Working in high-risk areas or with high-risk groups is a tough job requiring sustained effort and almost unlimited patience. Field workers and programme initiators must bear in mind that modifying the immediate environment of adolescents and young adults will take years, and that readjusting social trends and lifestyles will take decades. Such long-term goals are realisable if field workers and members of community action groups are genuinely motivated and are determined to start NOW.

The present manual is designed to help all those interested in community action to plan and implement their activities. It is intended for government officials, policy makers, programme planners, primary health care personnel, educators, voluntary social workers, religious groups and youth club leaders; in fact it can be useful to any individual or group wishing to contribute to the fight against drug and alcohol abuse.

The manual consists of two parts.

Part I describes a step-by-step methodology to be followed in planning and implementing a community-based demand reduction programme. It deals systematically with the different steps involved in mobilising the community and in designing, implementing and evaluating the programme.

Part II gives a brief introduction to the role of government agencies and nongovernmental organisations (NGOs) in the fight against drug abuse. It then lists a number of activities that can be undertaken by the main community organisations and institutions, including primary health care services, parents' groups and womens' organisations, schools, religious groups, the police and customs services, the media, the business community and service clubs. The organisations mentioned and activities listed are not exhaustive. Programme planners are expected to add to the suggestions and to try out new ideas. Besides adapting the proposed activities to the local situation, programme planners and policy makers must have the courage to initiate and innovate.

The manual also includes some basic information about important aspects of the problem.
of substance abuse. People involved in community action need to be well informed about the realities of the situation in order to tackle their work with confidence and competence. In-depth knowledge about intervention skills can only be provided through intensive training courses and workshops, which should be organised with the help of local and foreign experts. It may be possible to organise some technical cooperation activities in this field with the assistance of international agencies interested in combating substance abuse. The international community is continuously calling for global, international, regional and national cooperation to reduce both the supply and demand for dependency-forming substances. In this context it goes without saying that cooperation must first become a reality at the local community level.
PART I

PLANNING AND IMPLEMENTING A COMMUNITY-BASED PROGRAMME
Taking the initiative

During the last few years governments in developing countries have begun to show real concern about the problems and dimensions of substance abuse. There is now a clear understanding of the need to revise legislation, to strengthen and update agencies and to improve services. New measures and appropriate strategies also have to be developed. Until very recently most resources have been directed towards supply reduction through suppressing the production, distribution and sale of illicit drugs. However, worldwide experience and research shows that demand reduction strategies are equally important in the fight against substance abuse and that there is a need for the further development of demand reduction strategies through a wider variety of prevention, treatment and rehabilitation approaches.

Factors to consider

Before designing programmes and setting objectives it is important to consider the factors which influence the policy and organisation of demand reduction programmes:

- the political structures in place and the political processes involved;
- the dynamics of decision making by government agencies;
- the traditional methods of problem solving and decision making;
- the interactions between leadership and power groups within the community;
- the availability of financial and human resources at community level;
- the feasibility of international assistance in terms of finance and training.

In spite of the urgent need for action and the pressure to respond quickly, it is necessary to take the time to plan a step-by-step approach and to avoid hasty decisions and mistakes. Decision makers and service providers have a duty to plan carefully and to pay attention to all the elements involved in a community-based programme. There are eight essential steps in the planning process:

- needs assessment;
- community mobilisation;
- training and manpower development;
- development of material resources;
- setting goals and objectives;
- defining activities to meet the objectives;
- implementing and monitoring activities;
- evaluating the process and results.

Needs assessment

In order to tackle even a simple problem effectively it is necessary to have a clear understanding of its causes and consequences. When the issue is as complex as the problem of substance abuse it is clear that a thorough assessment of the situation is essential. There are three main reasons why needs assessment must be carried out adequately:

- to enable policy makers and programme planners to make a rational and effective use of assets, particularly in developing countries where financial resources are very limited;
- to provide clear facts in order to convince government officials, policy makers, community leaders and funding agents of the urgent need for community action;
- to establish priorities for the action plan.

A scientific survey is the most reliable way of collecting data, but it is also the most expensive method. However, there are a number of alternative approaches, and a lack of resources and expertise should not prevent programme planners in developing nations from making an assessment of the nature and extent of substance abuse in their country. Information available from three main sources can be helpful until the necessary funds and expertise are available for large-scale surveys; the information sources are substance abuse indicators, social anthropology and the informed opinions of community leaders.

Substance abuse indicators

These are quantitative and verifiable data which can be obtained from police records and the health services. They provide information on the following important aspects of the problem:
- the drugs which are used in the community;
- the demographic characteristics of the drug users;
- the number of known drug smugglers, dealers and users;
- the number of seizures including illicit alcohol and prescription drugs;
- the purity of the illegal drugs seized, which indicates the closeness of the offender to the producer or smuggler of the drugs;
- variations in the market price of drugs, which indicates the availability of drugs on the streets;
- the number of drug-related deaths by overdose, suicide, homicide, work accidents and traffic accidents;
- the number of alcohol- and drug-related crimes of violence and theft, compared with the number of cases not related to substance abuse;
- the percentage of admissions to hospitals, treatment centres and prisons which are related to substance abuse;
- the number of known traffickers.

These data, collected over a number of years, indicate trends in drug trafficking and some of its consequences. However, it must be noted that experience in the industrialised countries seems to indicate that the “known” addicts probably represent only about ten percent of the real number of addicts in a given community at a given time. In developing countries the known cases may represent a still lower proportion of the total number of addicts in view of the stronger social stigma attached to drug addiction in many parts of the world.

In order to ensure that police and health service records are as accurate as possible it is advisable to update and standardise the files on a regular basis. This work could be undertaken by social scientists or social workers with experience in the field of substance abuse who should collaborate closely with the data collection and record keeping sections of the police and prison departments and health services. Data recorders may need to follow a basic in-service course on principles of case work and counselling to develop their awareness of the delicate and sensitive psychosocial factors involved in the data collection process, particularly in regard to substance abuse.
Social anthropology

Substance abuse is not only a question of figures and statistics. One of the most important aspects for programme planners is the need for information on the beliefs, traditions, values and practices of socio-cultural and ethnic groups within the community.

Social anthropology provides policy makers with a good insight into the sub-culture of drug abuse. Through detailed case histories a wealth of information can be gathered about the knowledge, beliefs and values, attitudes and behaviour patterns that characterise drug abusers in their specific socio-cultural context. Social anthropology is a simple method of collecting information by involving the human resources which already exist in the community to be studied. According to Walters (1980) the types of information that can be obtained by "street anthropologists" are the following:

- types of drugs used;
- age and circumstance of first drug taking;
- routes of administration;
- economics of drug use;
- drug effects;
- relationship of setting to perceived effects;
- physical and social benefits and risks;
- adverse reactions and treatment histories;
- criminal justice cases.

Informed opinions

In every community there are individuals whose professional or social role puts them in a position to provide an informed opinion on the nature and extent of substance abuse. These natural information-providers include:

- local doctors;
- mental health specialists;
- primary health care workers;
- school teachers;
- youth leaders;
- police officers;
- lawyers;
- family counsellors;
- probation officers;
- bankers;
- shop keepers;
- taxi drivers;
- café and bar owners;
- community elders.

Data may be collected by interview. Generally, a questionnaire is used to cover the basic information required but this should be complemented by an unstructured interview in which the respondent talks spontaneously about the problem. Aspects of the drug scene which were previously unsuspected by prevention workers may come to light in this way.

Epidemiological survey

An epidemiological survey is the best method for measuring the nature and extent of substance abuse in a given locality, but it is also the most expensive of the methods discussed here. Programme promoters will need the collaboration of the local university survey team and/or experts from the private sector and outside consultants. Considerable expertise is required to choose a good sampling method and to design a questionnaire which will be appropriate for the educational level of the population and the socio-cultural context. If the necessary funds are available the epidemiological survey should be repeated at regular intervals to show trends in the prevalence and incidence of substance abuse in the locality.

Alternative data collection methods include self-administered mail questionnaires, group-administered questionnaires and telephone interviews, although the latter are not appropriate for the rural areas of developing countries.

Assessing existing programmes and services

After collecting all the available data on the nature and extent of substance abuse in the community, programme planners need to assess the existing programmes and services and the human and material resources available for community action.
The following factors should be taken into consideration:

- the number of government agencies and nongovernmental organisations offering prevention and treatment services;
- the types of activity arranged and the approaches adopted towards prevention, treatment and rehabilitation;
- the socio-demographic characteristics of the various target groups being reached;
- the communication network and collaboration between the agencies and organisations working in the field;
- the facilities and equipment available, including teaching materials and transport.

Interpreting assessment data

The findings of the data-collecting effort must be interpreted with caution. It is important to complement the indicators of drug abuse obtained from addiction registers, health service records and seizure statistics with reliable data from other sources. Assessment studies sometimes produce conflicting results, which again emphasises the need for alternative interpretations. The methodology and findings of the assessment should be formally reported in a document to be circulated for comment and specialists in social measurement techniques should be asked to assist in interpreting the data collected.

In summary, needs assessment is a complex undertaking. In order to achieve the best possible result the national substance abuse resource centre will need the help and support of experts to design, initiate and evaluate programmes and to undertake research studies on issues specific to local conditions.

Community mobilisation - the need for linkages

Substance abuse is a community concern that requires a community response. The problem must be faced in the home, in night clubs and tourist resorts, in public parks and playgrounds, in schools and youth clubs, at social gatherings and at work.

Substance abusers and the families of substance abusers need the support of government services. At the same time nongovernmental organisations must be encouraged to work in
the field of prevention, treatment and rehabilitation. The various organisations engaged in combating drugs and alcohol should, however, avoid a duplication of services. Nongovernmental organisations should aim to supplement government assistance by filling gaps in the services offered. They can often respond to local needs more effectively than public services owing to certain special characteristics:

- they can act quickly because of their informal structure and independent status;
- their voluntary nature means that they are less restricted by financial constraints than either the public or the private sector;
- they are close to the community and can reach specific target groups:
- their members are genuine field workers and the local population can identify with them;
- their leaders usually have influence and prestige, and can successfully press for action or solicit support.

There are three major preparatory steps for involving the community in action to combat substance abuse. The first step is to reach a consensus on the need for action by approaching the various community groups individually and contacting leaders in order to discuss the situation and to share ideas for action programmes. The second step is to enlist potential volunteers to serve on the Community Action Committee. It should be stressed that expert knowledge is NOT a requirement for this work; a genuine commitment to winning the fight against substance abuse is the most important quality that an individual needs to make a difference to the drug scene in the local community. The third essential step is to make sure that the aims and objectives of the resource centre are clearly understood by all the individuals and groups participating in the work.

Constraints in community mobilisation

Several factors might make it difficult at first to interest the general public in drug- and alcohol-prevention activities, the first problem being that drug-taking is not always seen as an issue of concern. Certain drugs and alcohol have traditionally been a part of the local way of life in the majority of communities and although addiction is clearly unhealthy it is frequently seen as a personal problem rather than a social problem. The resource centre may have to counter this view by making the general public aware of the dimensions of the problem and the real costs of addiction, both in terms of economic loss and in terms of damage to the quality of life.
A second difficulty which is frequently encountered is that access to women, adolescents and social drop-outs may be difficult for religious or political reasons. The personality of those who voice community needs and organise programme activities may be decisive in reaching certain target groups. Community action workers need to have credibility and to be accepted by social groups who are marginalised from the mainstream of community life.

Political and financial interests in the profits to be made from dependency-creating substances are extremely powerful. Activities related to combating drug and alcohol abuse may have to face lobbies or other pressures from those who sanction the abuse of these substances.

Other difficulties faced in mobilising community resources have to do with the personality of the individuals involved in the work. Programme promoters, educators and trainers who themselves use substances which create dependency will not have the necessary credibility in the eyes of the community.

Involvement in community action requires a lot of time and energy, and above all it requires sustained commitment and enthusiasm. Promoters must therefore guard against the danger of "burn-out" by delegating responsibility. A second-line community action group will need to be developed as activities progress.

There is often a tendency to fight against other people instead of fighting against the problem and conflicts will inevitably arise between individuals serving in community action programmes, and possibly also between nongovernmental organisations and service-providers. In all circumstances the interests of alcoholics and drug addicts and their families must be given priority over self-interest and petty jealousies. Individuals and groups must have the humility to accept the fact that they will not go far alone and that they need a strong coalition of well-intentioned partners. Above all they must be ready to share experience, expertise and resources and be willing to learn from their own mistakes and those of others.

Training and manpower development

Community educators and field workers are the agents of change whose work is indispensable in a community-based prevention programme. We have already stressed in
this manual that it is not necessary to be a specialist or expert to start such a programme and that people who are genuinely motivated can make a real difference to the situation in their community if they have some basic knowledge about substance abuse. Information on the following subjects is necessary for field workers and other potential resource persons working in primary prevention programmes: prevention approaches; basic definitions of the terminology of substance abuse; signs and symptoms of drug use and abuse; the nature of denial; the nature of negative peer pressure; and decision-making skills to resist negative peer pressure. In addition, field workers should have some knowledge of the types of drugs used in the community, the modes of use, their effects and withdrawal symptoms. Some basic facts on drugs are provided in Annex II to this manual. The following sections present general information on the other six topics listed above.

Prevention approaches

There is now increasing awareness among drug control agencies that too little emphasis has been placed on strategies to reduce the demand for drugs. Until very recently the effort to control substance abuse focused largely on reducing supply by suppressing the production and distribution of illicit substances, but it is now accepted that supply reduction must be balanced by demand reduction, which means preventing people from starting to use dependency-creating substances, or preventing them from continuing to use these substances indefinitely.

Preventive measures can be applied at three levels. The first is primary prevention, which aims at controlling or reducing the incidence of substance abuse by preventing experimentation or delaying the age at which young people begin to drink alcohol. Secondary prevention attempts to reduce the prevalence of substance abuse by early diagnosis and by providing counselling and treatment for drug users to encourage them to return to a drug-free lifestyle. Tertiary prevention aims to prevent recovering addicts from relapsing through the provision of rehabilitation and social réintégration programmes.

The four main approaches to primary prevention are through drug education and information, alternative activities, values clarification, and social skills.

Drug education and information campaigns are widely used in many countries. The main strategies are the provision of objective information and the use of scare tactics. Factual information is provided about the different types of drugs of abuse, the modes of
administration, the effects on health, and the economic and social consequences of abuse. This type of campaign has often been criticised because it may arouse the curiosity of non-users if too much stress is laid upon the euphoric effects of the drugs. On the other hand the objective and scientific information provided can demolish myths and misconceptions about alcohol and drug abuse. For example, there is new scientific evidence that cannabis, which is usually believed to be harmless, can damage the brain, the respiratory organs and the reproductive system. Scientific information can also help to raise awareness of the real dangers of needle-sharing and casual sex in the spread of AIDS. Information campaigns should not be limited to giving facts about drugs but should also lay stress on the benefits of a drug-free lifestyle.

The scare approach is very commonly used by parents. It may discourage youngsters who have never experimented with drugs but it does not work with adolescents who have experienced euphoria induced by a drug. Young people who are at particularly high risk very often do not care about the long-term consequences of drug abuse and are only concerned with immediate gratification. They may be using drugs themselves or have friends who are regular users but who suffer no apparent consequences. It is pointless to tell such adolescents that their first experiment with drugs or alcohol will make them ill, as their experience has already shown them that this is not the case. The young people will then not be interested in hearing what these teachers have to say about drug-taking because they will believe that they know nothing about the subject.

Young people need to explore their environment, experiment with life and test their limits. Therefore they should have creative and meaningful experiences which fulfil these needs and provide an outlet for their energy. Recreational centres must provide activities that serve some of the functions of drinking or drug-taking: excitement, challenge, relaxation, and relief from frustration, alienation, discrimination, pain, sickness and boredom. Such activities are more important when children are left to themselves outside school hours because both parents are working; it is particularly important to provide occupation for children during the school holidays. The activities which satisfy the needs of adolescents include; physical exercise such as swimming, running and climbing; organised sport which fosters the discipline of obeying rules; games which develop the team spirit and sportsmanship in accepting defeat and frustration without resort to alcohol or drugs; hiking in aesthetically satisfying surroundings; camping and sharing tasks and responsibilities; undertaking voluntary social work; learning to appreciate art; learning to relax in a healthy way; acquiring the discipline of good eating habits and diet; and learning about counselling
techniques.

The values clarification approach is based on the assumption that choices are influenced by values and that people who abuse drugs have not developed a clear set of moral or spiritual values. This approach relies heavily on inculcating good behavioural norms and moral values in young children. It is assumed that children who have been taught not to lie to their parents and teachers will be able to express their feelings freely irrespective of peer pressure. They are also expected to be able to resist the pressures of advertising for alcohol. The values clarification approach is an effective prevention tool for young children and adolescents who have not yet experimented with drugs. It is less effective for occasional or regular users, who are enjoying the “pleasure phase” of drug taking. In addition, the approach is not effective with people who are already dependent on drugs because the whole world of the addict revolves around the drug, which has priority over everything else in life.

The social skills approach is based on the assumption that most new drug users are encouraged to experiment by an actual user. Experience has also shown that hard-core addicts who have experienced severe withdrawal symptoms rarely induce non-users to try. The main culprits in spreading drug use are casual and occasional users who seem to be enjoying life. Therefore the social skills (or interpersonal) approach aims to provide non-users with coping skills to resist external pressure to use drugs. The following skills form the basis of this approach:

- interpersonal communication;
- increasing feelings of self-worth and self-esteem;
- resisting peer pressure;
- problem solving and decision making;
- analysing and resisting advertising for alcohol;
- assertiveness and stress management;
- controlling anger and frustration;
- distinguishing between positive and negative persuasion.

Substance abuse is a complex problem and no single approach used in isolation will be successful in preventing it. Community educators should determine which combination of approaches would best suit the needs of the individual or group in question.
Basic definitions

The following terms are very frequently used in discussions on substance abuse.

Drug: any natural or synthetic substance which, when taken into a living organism, may modify its functions.

Use: use of a substance implies that the individual is in control, not compromising physical health or damaging family life, social activities or work abilities.

Misuse: misuse refers to a non-medical or inappropriate use of psychoactive drugs.

Abuse: abuse of a substance refers to a pathological pattern of use causing impairment in social or occupational functioning. The duration of abuse is at least one month.

Tolerance: tolerance is a state in which markedly increased amounts of the substance are required to achieve the desired effect.

Dependence: abuse leads to dependence, which is characterised by a compulsion to take the drug on a continuous or regular basis in order to experience its mental effects or to avoid the discomfort resulting from its absence. There are two types of dependence: 
physical dependence, which is a state triggered by the abrupt cessation of a drug which has produced an adaptive physiological state, and psychological dependence, which is characterised by an emotional drive to continue taking a drug whose effects are felt to be necessary to maintain a sense of well-being.

Withdrawal syndrome: withdrawal or abstinence syndrome is characterised by the stressful symptoms resulting from sudden deprivation of a drug that is habitually used. Symptoms may be mild and not always clinically evident (cocaine, cannabis), or very marked (opiates), or even life threatening (barbiturates).
Signs and symptoms of drug use and abuse

Field workers and educators engaged in a public awareness campaign are constantly asked to describe the signs and symptoms of drug use. Great caution is required in answering this question and people must be constantly warned about the danger of jumping to hasty conclusions at the first possible signs demonstrated by their children, students, friends and relatives. It must be stressed that the symptoms which are listed below are NOT proof of drug taking; they are no more than indications that a person MAY be using drugs. Even if several of the symptoms appear at the same time it may mean no more than that the individual in question is passing through a period of emotional or psychological stress.

With all the reservations mentioned above, the following are some of the signs and symptoms that may be associated with drug use and abuse:

- sudden mood changes;
- unexplained irritability or aggression;
- loss of interest in hobbies, sports or studies;
- frequent lies and subterfuges;
- bouts of drowsiness or sleepiness;
- loss of interest in physical appearance;
- unpunctuality and absenteeism;
- borrowing money;
- "losing" money or valuables;
- lack of respect for authority;
- unusual smells on the body or clothes;
- stains or marks on the skin or clothes;
- approval of the drug culture.

The nature of denial

Programme initiators and field workers must be prepared to face a barrier which is very often a stronger deterrent than any threat that traffickers can make. This is DENIAL. Denial must be faced at the level of users, families, the community and the state.
USERS deny having a drug problem even after they realise that they have started to develop tolerance or have already become dependent. FAMILIES deny that one of their members has a drug problem because the honour and good reputation of the family is at stake. Unfortunately, many families give higher priority to protecting their reputation than to protecting the lives of their members. The COMMUNITY denies that there are abusers and traffickers in its midst, or will only admit that there is a problem in the big cities and the slums. The STATE denies that the problem is serious in spite of an increasing number of arrests and cases of overdose. If the problem is acknowledged the authorities fear that they will be held responsible for causing it or for allowing the situation to deteriorate.

Users, families, the community and the state, by denying the reality of the problem, tend to put the blame on the product, the media, neighbouring countries, etc., thus reinforcing the belief that the only possible strategy in the fight against drug abuse is supply reduction. In the meantime all the victims of substance abuse continue to suffer physically, morally and economically.

When substance abuse reaches epidemic proportions the responses are inadequate and inappropriate because they have not been prepared realistically. Hasty solutions are sought and very often only a single aspect of this complex problem is addressed. It frequently happens that foreign models and approaches are "imported" and adopted without proper consideration of the economic and socio-cultural context in which they are to be applied.

The nature of negative peer pressure

The negative influence of peers is very often associated with drug abuse, particularly among adolescents. Parents of young delinquents or drug abusers are well aware of a terrible force against which they feel helpless but which they are unable to understand.

When the issue of substance abuse occurs, the attitude of uninformed parents is first to deny the existence of the problem, then to moralise, plead, threaten, scold and evoke the family honour and reputation. They then try to arrange for treatment, but frequently end by
cutting themselves off from their child when nothing works. In response to the same situation the peer group provides approval, a sense of intimacy, and prestige when the inexperienced drug taker moves from legal to illegal hard drugs. In cases where parents might tend to over-protect their children and take all their decisions for them, the peer group encourages young drug users to decide for themselves about their lifestyle. The peer group also provides a strong sense of belonging. All members of the group have similar values and behaviour patterns; they have their own symbols, ways of dress, music and dance, which together amount to a sub-culture within the larger community.

For all the reasons above peer pressure, which may appear irrational to parents, exerts a strong influence on young drug users or abusers. The same applies to adults who fall into drug use, because it must not be forgotten that peer pressure is relevant to all age groups. It fulfils, although negatively, some of the basic psychological and social needs of the individual.

Under such real pressure from their peers it is not hard to understand why drug users disobey or desert their families to move into the drug culture. While they are still in the euphoric stage they do this in order to gain more pleasure, and when they have started to experience withdrawal symptoms they do not hear the pleas of their family or see their distress because they have reached the point where the next dose has priority over everything else.

Decision-making skills to resist negative peer pressure

Decision making is quite a difficult process. Certain skills are required for a person to be able to make the right decision in a difficult situation. Some decisions require a long period of reflection and deliberation. They might include choosing a career or starting a family. Other situations demand a quick decision. For example, a person driving a car has to decide in a flash of a second what action to take in an emergency, and at the same time be as sure as possible that the decision is correct.

Resolving to resist negative peer pressure to use drugs is very difficult, because, apart from
the physical and psychological attraction of drugs, the peer group uses rejection strategies against someone who tries to refuse drugs. For example, they might be called a coward or a baby. In a slightly different situation the peer group might exert pressure on reluctant members by providing assurance against the dangers and consequences of risk-taking behaviour.

Without denying that it is quite difficult to resist negative peer pressure, it is still possible to avoid problems by adopting the procedure below:

1. Identify and define the activity that is being proposed by thinking about the following questions:
   - is this proposed activity legal?
   - if it is legal, is it moral? (e.g. truancy)
   - is it dangerous to the self or others?
   - will adults be present where this activity is to take place?
   - would parents approve if they knew of this activity?
   - does it correspond to the family's cultural values?

2. Devise a plan of action based on the answers to the questions above.

3. Evaluate the possible outcomes of the plan. Try to anticipate the likely consequences of the chosen course of action and assess their advantages and disadvantages. Re-examine values and emotions which might have become distorted by the impact of advertising and other media images. Emotional reactions interfere with the decision-making process and can prevent a person from making an objective and rational choice. Balance the short-term pleasure against the real risk factors associated with drug use.

4. When the evaluation exercise is finished the next step is to act upon the strategy which has been consciously and deliberately chosen. This means finding strong arguments to resist negative peer pressure or to counteract any other type of difficulty.

5. Whether the final outcome of the decision was positive or negative, it is possible to learn a lesson for the future. When a similar situation arises again it will be much
To help memorise the different steps of the decision-making process described above, they can be described as the IDEAL method.

I dentify the nature of the activity, situation or problem.
D evise a plan.
E valuate the possible outcomes of the plan.
A ct upon the chosen strategy.
L earn from past mistakes to avoid future problems.

The previous sections presented some very basic and general information for people working in community-based prevention of substance abuse. For further knowledge and training in specific intervention skills intensive training courses need to be organised with the help of local and international experts. Priority should be given to developing skills in the principles of social work, case work (individual counselling), family counselling, group counselling, rehabilitation and aftercare (relapse prevention), assessment of drug dependents, short-term and long-term management of drug-dependent persons, and treatment approaches.

Development of material resources

Members of the Community Action Committee will need to make an assessment of the material resources available for a public awareness campaign. They have to know what teaching aids and audio-visual equipment can be reserved for their use, and then they have to develop or buy any other material which is found to be necessary. Materials developed in other countries, such as documentaries, posters or TV spots, will need to be adapted for the local community. Even after they have been adapted they will have to be pre-tested on the target audience before they are put into general use. Pre-testing consists of assessing the reactions of a target audience to a particular approach, message or material, which will then be modified accordingly.

A pre-test can also be used to determine the background knowledge, attitudes and perceptions of participants at the beginning of a training course or seminar. A post-test questionnaire is then administered after the course to measure the impact it has made.
Setting goals and objectives

Having gathered all the necessary information on the nature and extent of substance abuse and the existing programmes and services, the next step for the members of the Community Action Committee is to develop complementary programmes. These new programmes should have specific objectives designed to attain the major goal of community action against substance abuse. The major goal is to reduce the demand for alcohol and other drugs and to provide help to those already affected by alcoholism and drug abuse. The smaller and more specific objectives are usually determined by the gaps that have been discovered between the existing programmes and services, the material resources available in the community and the real needs which have been identified.

Specific objectives must respect the following criteria. They must be:

- limited in time (they must state when various aspects of the programme are to be accomplished);
- qualifiable (they must be clear and precise, not vague and ambiguous);
- measurable (they must help determine the success or failure of the programme);
- realistic (they must not be utopian or unreasonable).

An example of a specific objective might be as follows:

To reduce by March 1993 (time) the number of arrests of young people between 15 - 24 (quality) for possession of illicit drugs in the community of . . . . . . . . by 25 per cent (measurable and realistic).

Defining activities to meet the objectives

This is usually done by reversing the observations made during assessment. For example;

<table>
<thead>
<tr>
<th>Observation</th>
<th>Activity proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>No parent groups</td>
<td>Set up ten parent groups by organising talks and film shows to sensitise parents.</td>
</tr>
</tbody>
</table>
Lack of resource persons

Increase number of resource persons by organising short training courses and seminars for primary health care staff, social workers, teachers, police officers.

Deficient mass media coverage

Improve contacts with the media through meetings, submitting articles to the press and by using a multi-media approach (magazines, posters, TV, radio, theatre).

Having defined the activities which will meet the specific objectives the Committee will have to calculate the human and material resources required to organise these activities. It may be necessary to raise funds by holding a campaign on an appropriate occasion such as the local carnival.

Implementing and monitoring activities

The resource centre may start to implement its prevention, treatment and rehabilitation programmes as soon as it has a full-time staff including a national project coordinator, a centre manager, a job placement officer, one or two trained counsellors and a secretary.

The full-time staff will, of course, need the support of a pool of professionals and voluntary social workers at two important levels of the structure of the centre, i.e. the Advisory Board and the Community Action Committee. Another vital aspect is the link with the network of government ministries and agencies and nongovernmental organisations. The responsibilities of each agency and organisation must be clearly defined and rationally delegated in order to facilitate the monitoring of the activities.

Monitoring is a day-to-day evaluation of activities during the implementation of a programme or project. It depends on the establishment of a communications network which functions horizontally between government agencies and nongovernmental organisations and vertically between the local population and the policy makers and programme planners.

In order to monitor tasks each member of the Committee should be responsible for
monitoring the implementation of the activities specific to each group or organisation involved. Regular meetings of the Community Action Committee should be held every month or every three months so that each organisation may report on its past activities, the problems it has encountered and the progress achieved in present activities, and its plans for future activities. At these meetings the responsibilities to be assigned to each nongovernmental agency or service can be discussed and agreed.

Members of the Committee, who are usually very busy people, should make a point of being present at every meeting and of studying the agenda carefully in advance.

If possible, a full-time coordinator should be appointed for the proper monitoring of activities which are intra- or inter-nongovernmental organisation.

Detailed record keeping is not only important for good management and service delivery, but can also help projects and programmes to learn from their mistakes. It is even more important if it has been decided to replicate a particular model which was developed by a different programme, perhaps in a different country, or conversely, if another programme displays interest in replicating this model. Such detailed day-to-day record keeping can probably best be organised in the form of a diary.

In order to benefit from the close monitoring of activities members of the team and managers of specific programmes must remain open to feedback and feel able to contemplate different approaches.

Efforts must be constantly sustained to foster, develop and strengthen the community network. A multidisciplinary and integrated approach can be encouraged by including a cross-section of the community in the implementation of every programme.

Evaluating the process and results

A major difficulty in organising the fight against drug abuse is that no objective evaluation has ever been carried out on hundreds of programmes all over the world. The result is that many nongovernmental organisations or government services continue to offer activities which are popular and successful but have neglected to improve their less successful approaches. A large number of organisations have ceased their activities in the prevention of alcohol and drug dependence, simply because they have not evaluated the programmes
they started in order to detect and correct their weaknesses. Evaluation does not mean only deriving satisfaction from the successful parts of a programme; it also means discovering shortcomings in planning and implementation. Substance abuse programmes need to be evaluated and revised constantly because of the changing pattern of drug use and the occasional appearance of new drugs on the market.

A proper evaluation exercise provides the following benefits for programme planners:

- factual data which permit the formulation of more realistic objectives and strategies:
- better identification of the needs of target audiences and high risk groups;
- better understanding of conditions in the field and the needs of field workers on the part of policy makers and funding agents.

Precise information adds to the credibility of a programme and justifies further funding and expansion of activities. It also ensures that maximum use is made of existing services and resources. Further, the testing of strategies, approaches and audio-visual materials results in a more rational use of human and financial resources.

The two most important aspects of evaluation are process evaluation (efficiency) and outcome evaluation (effectiveness).

Process evaluation is usually an assessment of the efficiency of the methodology and procedures used during a campaign. It helps to identify barriers and obstacles that block service delivery and also brings to light factors that may have been overlooked or unknown to the initiators of the project at the planning stage.

The factors to be assessed in a process evaluation are as follows:

- punctuality and assiduity of programme operators and field workers;
- number of operators actually participating in the activity compared with the number planned;
- experience and training required of personnel;
- time actually spent on specific activities compared with the time estimated;
- money spent compared with budget provision;
- reasons why funds voted were not utilised;
approaches which proved to be appropriate for the target audience;
- number of posters, stickers, pamphlets and handouts distributed;
- number of talks, film shows and exhibitions organised;
- dynamics of successful collaboration between nongovernmental organisations and other agencies.

Outcome evaluation aims to measure the effectiveness of the programme and the impact it has made on the target audience. It indicates whether the programme has reached its objectives and the extent to which the different community groups have changed their beliefs, attitudes and behaviour.

An outcome evaluation should not be made immediately after a programme has finished because the desired results may not be observable for some time. However, too long a delay may mean that the impact the programme has made is beginning to be forgotten. It is for programme planners to decide on the best moment to carry out the evaluation in their own particular context.

The factors to be assessed in an outcome evaluation are as follows:

- the extent to which target groups developed an understanding of their role in prevention;
- the way in which the activity or programme was received by the community;
- the number of persons it reached;
- the number of people who have requested the services offered by the programme;
- the number of enquiries made about the programme;
- the extent to which young people can demonstrate the skills they have learned in problem solving, decision making and drug resistance;
- the extent to which high risk groups have developed self-esteem and assertiveness;
- the advantages derived by members of the community in terms of school, family, social rehabilitation, health recovery and economic progress.

Factors to be assessed after a certain lapse of time include:

- the number of arrests connected with alcohol and drugs;
- the number of hospital admissions and accidents connected with substance abuse;
- increases in personal income as a result of improved attendance at work;
- money saved by firms operating an Employee Assistance Programme by a reduction in the number of working hours lost through absenteeism and poor time keeping.

Individual programmes should be evaluated in the light of their specific objectives. It is useful for planners to know which were the most popular and least popular activities in the programme so that the least popular functions can be re-examined. A successful activity should also be re-evaluated periodically because the situation in the field changes constantly. Findings from programme evaluation coupled with any new epidemiological findings should help planners decide whether to re-invest in a programme, adjust it or discontinue it in favour of some other prevention initiative.
PART II

THE ROLE OF GOVERNMENT AGENCIES

NONGOVERNMENTAL ORGANISATIONS

AND OTHER COMMUNITY GROUPS
Primary health care services

Primary health care staff are responsible for bringing health services to the community, particularly in rural areas. Medical personnel and social workers, together with traditional healers, represent a very important network through which prevention, treatment and rehabilitation programmes can be channelled. Their presence is fully accepted by the community, which gives them a major advantage in drug- and alcohol prevention activities. In the routine of their daily work they deal with patients suffering illness or accidents as a result of substance abuse; they treat the victims of traffic accidents, those injured at work, people involved in fights and other forms of violence, attempted suicides and overdose cases. Health personnel are thus very familiar with the consequences of substance abuse and are usually willing to take part in prevention work.

As a matter of routine, then, primary health care personnel intervene in crisis situations and provide short-term treatment for alcohol- and drug-abusers. On the basis of their knowledge and experience they can become first-choice educators for primary prevention programmes. They simply need some additional training in intervention techniques and the possibility of improving and updating their knowledge of new drugs coming onto the market and new modes of use and abuse. It should be noted in this connection that methaqualone (mandrax) smuggling is fast becoming a real threat in many African countries, and doctors need to be very aware of the risks of over-prescribing for their patients. Pharmacists and health educators should work to raise public consciousness of the real dangers of using prescription drugs for non-medical purposes.

Primary health care workers are also ideally placed to start or pursue the collection of epidemiological data for research purposes and to help policy makers and programme planners design accurate and relevant campaigns based upon local realities. Finally, primary health care professionals need to participate in the development of a pool of trainers and resource persons to support the programmes. Once prevention activities have gained the necessary momentum specific courses for the training of trainers will have to be developed with expert help.

Parents’ groups

Members of all kinds of organisation, both formal and informal, have one thing in common - parenthood. Parents have the most significant role to play in any programme for the
prevention of substance abuse and the treatment and rehabilitation of addicts.

It is not easy for parents of adolescents today to help their children cope with even the normal stresses of growing up, not to mention possible drug problems. Adolescents are living in a world of high technology and sophisticated mass communication, where rapid change undermines the security of familiar things. Parents who have not kept pace may complain about the behaviour and lifestyle of their children and point out that they were adolescents too, and that they did not react as their children are reacting. It is certainly a fact that today's parents were adolescents before their children, but not like them. They did not grow up in the same psycho-social environment. The adolescents of the 1950s and 60s were not exposed to the millions of images that are penetrating our homes today, often glamourising the drug-subculture of western countries. Pop music, videos, pornographic magazines and other cheap publications have saturated the market and invaded our public places. It is hardly possible to ignore their presence.

Today's parents have a duty to assume the new roles they are called upon to play. They must not rely entirely on the schools for their children's psycho-social development, and they must make sure that they have the information they need to protect their children from the use and abuse of drugs.

When people rely too heavily on the educational system to guide their children they forget that the mother and father are the child's first two teachers in any society. In many developing countries, where the extended family is still common, children can benefit from the presence of more than just two "teachers" in their infancy. However, this important cultural advantage is fast disappearing and even the nuclear family is threatened as fathers move to big cities to find work and children are left alone with their mother for long periods. Sometimes whole families move to slums on the outskirts of big cities, where the children are exposed to a high-risk environment.

Parents today can no longer be contented with feeding and clothing their children and leaving them to grow up without supervision or guidance. It is their duty to give protection from the negative influences that surround their children on all sides, notably peer pressure and advertising. Parents must understand that prevention of substance abuse is not a question of supply reduction alone. While police and customs officers are doing their best to suppress production, smuggling, distribution and consumption of illicit drugs, parents need to set up or join existing community groups to form a strong coalition to reduce the
demand for drugs and alcohol. Instead of always relying entirely on the government and waiting for things to happen, parents must come out of the shadows and make things happen by acting NOW.

Sometimes people who desire to serve their community take no action to set up a parents' group because they have no meeting place. This is not really a problem at all, as many national nongovernmental organisations all over the world started with regular meetings of a small group of 15 - 20 people in the homes of interested neighbours, on a rotation basis. Such groups can also make good use of under-utilised classrooms after school hours if they can make appropriate arrangements with the local education authority.

Parents' groups can work to protect young people from substance abuse by:

- seeing that a responsible adult is always present during youth activities;
- offering only soft drinks to their children and their children's friends;
- setting clear standards of behaviour for their children and insisting that they be home at a reasonable time in the evening;
- avoiding the use of tranquillisers and pain killers when their children are sick;
- teaching healthy eating habits from the very beginning. Children who understand that abuse of food, notably sugar, salt and fat can be harmful to health are likely to refuse illicit drugs when they are told of the harm they cause, even in small amounts;
- helping children to develop self-discipline, self-esteem and decision-making skills;
- encouraging children to learn to defend themselves and solve their own problems, by not being over-protective;
- developing an attitude which is not threatening or blaming when talking to children;
- getting to know the families of their children's friends.

In order to promote the growth of parents' organisations the members of the original group might undertake to bring along one more parent to the next meeting. Parents' groups should contact any women's organisations in their area because women as wives, mothers and sisters are transmitters of positive lifestyles and cultural values. Sometimes they are also the victims of an alcoholic father, husband, brother or son. Parents' groups and women's organisations can make a formidable team when they work together and all the possibilities for collaboration should be explored.

Parents who are anxious to protect their children from substance abuse need to know the
signs and symptoms to watch for so that they can take immediate action to prevent further drug taking if their child begins to experiment with illicit substances. The commonest signs and symptoms of drug taking have already been presented in Part I of this manual.

Parents' groups and women's organisations can help adolescents become aware of the dangers that surround them so that they are better able to protect themselves. For example, they might organise a lecture or discussion on guarding against the persuasive effect of alcohol advertisements. The main advertising technique is to associate the product with the kind of users that adolescents would like to be. They show alcohol being consumed by rich people, successful people, attractive and healthy people. Advertisements show people having fun and enjoying themselves while drinking; they do not show the misery and despair caused by alcohol.

Other activities which might be organised by parents' groups and women's organisations could concentrate on the dangers of substance abuse and teenage pregnancy. Films, lectures and discussions should stress that the body of a young teenage girl is often not fully grown and not reproductively mature, and that a high proportion of teenage pregnancies end in miscarriage or still birth. They should emphasise the dangers of abortion and the risks of trying to conceal a pregnancy. The effects of alcohol and drugs on the unborn child can be devastating and no dependency-creating substances at all should be used during pregnancy. There is a particularly serious risk of damage to the foetus during the early weeks of pregnancy among girls and women who continue to drink or take drugs, not knowing yet that they are pregnant.

Parents' groups and women's organisations can organise talks, film shows and exhibitions on the role of all the members of the family of a substance abuser during treatment, and even more particularly during rehabilitation and social réintégration. They should lay stress on the dangers of relapse after treatment and work to promote relapse prevention strategies. Finally, in order to gain the best publicity for their cause these groups might seek the active support of the First Lady, either at local level or at national level.

School programmes

Debate on whether schools should provide drug education for their pupils has continued
for decades. School administrators, teachers and parents have shown considerable reluctance to introduce discussion of substance abuse into the school timetable, arguing that there are no drug users among school students. This is an example of the denial response which was discussed in Part I of the manual. In many countries the educational community still refuses to accept that at least a few of their students may have started to experiment with drugs.

Educators and parents must realise that alcohol is available everywhere and that children are bound to come into contact with heavy drinkers. If other drugs, such as cannabis, amphetamines, opiates and cocaine are fairly easily available in the community, then sooner or later young people will come into contact with them as well, and possibly with drug abusers who will induce them to experiment. It is therefore essential that young people learn about drugs from people who really care for them, not from addicts. Parents can give guidance in the home, teachers can give drug education at school and religious leaders can discuss the topic at their meeting place. This is infinitely better than for such education to take place in the streets and bars where the "teachers" are drug-abusing peers, dealers and pushers.

A drug education programme given in a school in no way compromises the reputation of that school. Quite the reverse is true, because it adds to the credibility of the school and demonstrates that the administrators and teaching staff have a real sense of civic responsibility as well as having the best interests of their pupils at heart.

Even if there are known cases of students using or abusing drugs, this does not necessarily mean that they have experimented with drugs on school premises. They interact with many youths who are not at school, and they may well be using drugs outside class hours and away from the school setting.

School children and students are a captive audience for anti-drug and alcohol campaigns; programme planners can take advantage of the fact that they do not have to attract young people to attend meetings and discussions because they are already on the spot. Schools may choose to offer drug education as an extra-curricula activity or to integrate it into the regular timetable. In countries which have arranged drug education on an extra-curricula basis the results have not been very encouraging. This seems to be because the initiative was not supported by teachers who argued that their duties did not include such subjects or by parents and students because there were no examination credits attached to the
classes. Other countries have therefore chosen to integrate drug education in the existing school curricula. Below we give an example of an integrated approach to prevention education through the school curriculum.

<table>
<thead>
<tr>
<th>General science</th>
<th>Nutrition (abuse of sugar, salt and fats)</th>
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<tbody>
<tr>
<td></td>
<td>Medicines - need to read instructions carefully and avoid improper use</td>
</tr>
<tr>
<td></td>
<td>Stress and stress management - physical exercise, aerobics and relaxation</td>
</tr>
<tr>
<td></td>
<td>Effects of drugs on the development of adolescents</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language and communication skills</th>
<th>Role playing of peer pressure situations, focusing both on negative pressure and the decision-making skills needed to resist it</th>
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Teacher training courses should begin to include modules on drug education in order to help the teachers of the future with this aspect of their work in schools. In the meantime the education authorities should organise in-service courses, seminars and workshops with the support of health care personnel, police officers and social workers. These professionals
may also be invited to the schools as guest speakers to complement the work of the teachers on specific topics related to substance abuse and to make the curriculum more effective.

Tasks to be undertaken by schools

- Draw up and circulate a clear policy prohibiting illicit drugs, alcohol and the improper use of prescription drugs on school premises, at school-sponsored functions and while students are representing the school. All students, parents and staff should receive a copy of the policy document, which must specify the penalties following any violation of the rules.
- Establish a solid school - family partnership.
- Introduce drug education classes into the existing curriculum.
- Invite professionals working in the field of drug abuse as guest speakers.
- Invite voluntary workers and interested parents as guest speakers and discussion leaders.
- Emphasise the role of physical education and sport in developing a healthy lifestyle.
- Make a file of newspaper cuttings on the national and local drug problem; discuss the content of these articles with students in class.
- Hold discussions, film shows and seminars for students and parents.
- Organise fund-raising activities to support anti-drug programmes (a fun run, sales of stickers or T-shirts).
- Refer high risk students to counselling services.
- Organise health-promotion activities such as athletics meetings and hikes.
- Set up anti-drug clubs using student leaders as positive role models.
- Establish a correspondence network with other anti-drug clubs, nationally or locally.
- Organise recreational activities and healthy occupations during school holidays.
- Strengthen the parent - teacher association and motivate the members to act as a bridge between the family and the school.
- Set up a school advisory board with representatives from the school administration, the parent - teacher association, the student council, the police, the media, local nongovernmental organisations, the medical profession, youth organisations and religious bodies.
Religious groups

It is well known that the three fundamental elements governing drug abuse are the agent (the drug), the host (the user or abuser) and the context (the socio-cultural environment). The religious beliefs and traditions of a society, its cultural and moral values determine the ways in which that society reacts to drugs, the importance it attaches to substance abuse and the attitudes it displays towards users and abusers. The heads of religious bodies and the leaders of socio-cultural organisations play a very significant role in demand reduction by reinforcing the teachings and principles of religion.

Like the school community, the religious community can benefit from the presence of a captive audience. Religious leaders can address their regular congregation without the need to invest a great deal of time and energy in persuading the public to attend the meeting. It may be said that members of a church congregation are unlikely to be abusing drugs or alcohol, but they could well be unaware that their own children are experimenting with drugs if they do not know the signs and symptoms of drug abuse.

Another very important mission of religious leaders is to stress the distinction between the sinner and the sin. Non-users of alcohol and drugs sometimes tend to condemn the individuals who fall into addiction rather than attack the cause of their distress. Medicine aims to destroy the disease and save the patient, and prevention strategies aim to destroy the drug culture and save the victims.

Tasks to be undertaken by religious bodies and socio-cultural organisations

- Promote and strengthen traditional customs and beliefs.
- Publicise and support anti-drug and alcohol activities.
- Make drug education publications available on the bookshelves.
- Include subjects related to drug and alcohol abuse in the training of religious leaders. They should have some knowledge of tolerance and dependence, signs and symptoms of abuse, withdrawal syndrome, the causes and consequences of abuse, prevention, treatment and rehabilitation approaches, causes of relapse and prevention of relapse, individual, group and family counselling.
- Refer substance abusers to treatment and counselling services.
- Remind members of the congregation of the importance of spiritual values.
Invite members of the congregation to take part in an outreach programme attached to the place of worship. There is an urgent need to contact the ever-increasing numbers of young people who are leaving their families and drifting into the big cities where they no longer have the support of their parents and the extended family. With some training volunteers can develop a caring attitude towards abusers and relapsed addicts who no longer attend religious meetings and refer them for professional care.

The police and customs services

Law enforcement officers have a vital role in preventing substance abuse. The four main objectives of penal laws have been identified as the defence of public security, the punishment of the offender, the deterrent effect of making an example to discourage others, and the subsequent rehabilitation of the offender. The fourth objective is quite frequently forgotten even though failure to rehabilitate an offender is the main cause of recidivism and the perpetuation of the wrong. Further, many offenders cannot logically be rehabilitated or reintegrated into society because they were never integrated into the mainstream of community life.

There are three main groups of offenders in the world of drug abuse. They are:

- drug dealers who are selling drugs for profit and who do not use drugs themselves;
- drug dealers who are themselves addicted and who are dealing mainly in order to ensure their own supplies; they are arrested frequently;
- drug addicts who have resorted to crime in order to pay for their drugs; they are usually arrested while committing a crime or while purchasing drugs.

There is a consensus on the need to imprison the non-addicted, profit-seeking dealers or smugglers and to seize their assets. However, it can be very difficult to make a moral distinction between addicted dealers, who are often exploited by the big dealer, and addicted consumers who get involved in theft, violence and prostitution in order to buy drugs. It is not easy to decide how far they are responsible for their actions in the light of the various contributing factors that lead to experimentation, tolerance and dependence.

The legislation of Washington DC defines an addict as "a person who habitually uses any habit-forming narcotic drugs so as to endanger the public morals, health, safety or welfare,
or who is so far addicted to the use of such habit-forming narcotic drugs as to have lost the power of self-control with reference to his addiction”.

Canadian legislation describes an addict as “a person suffering from a disorder or disability of mind as evidenced by his being so given over to the use of alcohol or drugs that he is unable to control himself or is incapable of managing his affairs or endangers himself or others”.

These definitions imply a recognition that counselling and rehabilitation services need to be introduced in prisons. Outside prison, for high-risk groups and the community at large police officers, customs officials and prison wardens can act as educators, social workers, allies and friends who care for the welfare of the community.

Tasks to be undertaken by law enforcement officers

- Give talks on the importance of rules, discipline, law and authority.
- Disseminate information on the law regarding the production, processing, trafficking, possession and consumption of illicit drugs.
- Seek information from the community about the following questions:
  - the extent to which existing legal provisions are applied in practice;
  - the reasons why the law is not applied;
  - the need for new legal provisions to counteract new techniques and strategies adopted by drug dealers.
- Develop more positive attitudes towards prisoners and ex-prisoners.
- Set up a pre-release scheme to prepare prisoners for social insertion or reinsertion;
  - the staff of the resource centre should collaborate in this scheme, which would have the major objectives of preparing prisoners to face life without resorting to drugs and alcohol, and of preparing prisoners’ families to adopt a caring and supportive attitude towards the released prisoner in order to prevent relapse.
- Introduce drug education into the training curriculum for law enforcement officers.
- Update and extend data collection to include etiological and epidemiological factors of substance abuse.
- Make prisoners aware of the dangers and modes of HIV transmission and the risks of promiscuity in prisons.
- Encourage police officers to specialise in drug prevention activities.
The media

Radio, television and the press are basic tools for spreading a message quickly, although the mass media are generally conditioned by whether an event is "newsworthy". Heroin, cocaine, and crack are considered newsworthy and so are overdose cases involving young people, but alcohol, tobacco and psychotropic pills have no news value, nor do recovering addicts and their problems during rehabilitation.

However, it must not be forgotten that the media have helped to raise public awareness of a drug problem in many countries where its existence was denied or was not accorded any importance. Once the population is conscious of the problem and the need for action the role of the media is to support and supplement the efforts of government agencies and nongovernmental organisations to reduce the demand for drugs through prevention, treatment and rehabilitation programmes.

Although media messages are considered to be impersonal and receive little feedback from the target audience, they can still be used to support and reinforce community activities by announcing functions and events in advance and by reporting them as they happen. Good media coverage is important for several reasons. It can:

- build public support for the goals of the resource centre or a prevention programme;
- inject enthusiasm into field workers;
- create a snowball effect if the event is newsworthy;
- strengthen the legitimacy of the resource centre or the work of the Community Action Committee in the public view;
- put the spotlight on the resource centre so that the opinions of the staff will be known in the area.

A press release is a cheap means of providing reporters with basic information on any event organised by the resource centre or a nongovernmental organisation. A press release usually answers questions beginning with WH:

WHO is organising the event or function? WHAT is being organised? WHERE is it taking place? WHEN is it scheduled? WHY is it being organised?
General strategies in the development of media contacts

- Establish personal contacts with editors of newspapers and directors of TV and radio stations.
- Make sure that each member of the Community Action Committee is in touch with at least one journalist and keeps this journalist informed of prevention activities.
- Be impartial and do not neglect "minor" media.
- Involve journalists in workshops and training courses on substance abuse. This will improve their understanding of the complexity of the problem and may encourage them to adopt a less sensational and more positive approach in their reporting.
- Choose knowledgeable people to give interviews in order to build up the programme's credibility.
- Involve well-known and respected public figures in the publicity in order to attract attention.
- Avoid glamourising the drug culture.
- Avoid mentioning the euphoric effects of drugs in short press articles or TV spots which do not allow for a clear explanation of the dangers of repeated use.
- Include people with first-hand knowledge of the drug culture in coverage of prevention work.
- Prepare and distribute media kits with background information on the strategies being implemented and the responsible agencies.
- Prepare material for the publishing or broadcasting in the form which the media request.
- See that the messages to be publicised are accurate and well presented.
- Avoid copying the style of communication used in other countries and make sure that the message is intelligible to the local population.
- Respect deadlines.
- Send unsolicited material to local newspapers, radio and TV stations.
- Include the name and phone number of a contact person working in prevention who will give further information to the media.
- Send a word of thanks to producers, editors and reporters.

In working with the press it is useful to negotiate with editors who run regular editorials on specific issues, or a letters-to-the-editor feature, or a special weekly column to raise public awareness of important questions. The articles that are submitted to the press should be very carefully written by experienced people so that they are accurate and credible. This is
a means of avoiding mis-reporting. Newspapers and journals are, of course, primarily a source of information and should be used as such by prevention programmes. A collection should be systematically built up of articles and data on alcohol- or drug-related crimes and accidents, cases of suicide and overdose, and violent incidents connected with substance abuse.

In working with radio and TV stations it is important that messages should be positive and that they should emphasise the solution rather than the problem. It is wise to take advantage of the live quality of these media by organising talk shows and encouraging direct phone calls from listeners and viewers. Invite addicts and recovered addicts to appear on the show with their families and friends to give first-hand accounts of the experience of addiction. Social workers, health staff and law enforcement officers should also be invited to talk about their work in the prevention of substance abuse. After a talk or documentary film it is interesting to arrange a discussion session and a panel of experts might be invited from time to time to take part in this. When the prevention project itself prepares short radio or TV spots for submission they must be in conformity with the standard time slots allotted by the media.

Multi-media activities can also make an impact on public awareness and sympathy. Exhibitions, puppet shows and the theatre can attract a lot of attention. Involve popular singers in anti-drug concerts and invite well known athletes and sports personalities to drug- and alcohol-free discos, carnivals, sports meetings and fund-raising activities.

Finally, as an annual event a prevention project could organise a Drug Awareness Week using a multi-media approach and culminating in a major event on June 26, which is the International Day against Drug Abuse and Illicit Trafficking.

The business community

In countries where human expertise is limited and financial resources are scarce, the business community has a major role to play in supporting prevention, treatment and rehabilitation programmes. Both in the industrialised parts of the world and in the developing countries private sector firms and agencies working against substance abuse are moving towards mutual support and assistance. All over the world business firms and
companies sponsor drug prevention campaigns and promote healthy activities.

Substance abuse does not affect the abusers and their families alone; it also affects their employers, the community and the whole nation. This is why Employee Assistance Programmes and other workplace initiatives are an important component of prevention strategies. The Community Task Force needs to draw the attention of employers to the consequences of substance abuse among the workforce, and to make them aware that it can occur at all levels of the hierarchy from top managers to handymen. The following consequences are a direct result of substance abuse at the workplace:

- sickness causes increased medical costs;
- absenteeism and bad timekeeping reduce output;
- accidents result in injury, disability or death;
- accidents also damage machines and equipment;
- there are supervision problems because discipline is not maintained;
- bad labour relations cause disputes;
- crimes such as pilfering and embezzlement increase because addicts need money to buy their drugs;
- addicts start pushing drugs at the workplace in order to maintain their own supplies;
- deadlines are missed and business is lost because of impaired judgment;
- trainees fail to benefit from courses because they cannot learn;
- time is wasted during working hours because dependents cannot concentrate.

As a result of all the above factors, the quality of service declines, production is sub-standard, resources are wasted and public confidence is lost.

Apart from the negative effects of substance abuse which are obvious in the workplace there can also be consequences for the physical and social environment. Public health may be endangered and criminality is likely to rise when there is a problem of substance abuse among workers. For example, poor quality products may cause illness or injury to consumers. Drug abusing workers in the transport sector could cause fatal accidents to innocent members of the public, and workers responsible for essential services could cause a serious decline in the quality of life of the community if these services broke down.
Tasks to be undertaken by private firms

- Support public awareness campaigns by providing transport, refreshments, etc. during seminars and training courses.
- Provide training and employment opportunities to youths who are at risk of substance abuse and to recovering addicts.
- Sponsor pamphlets, stickers, posters, T-shirts, etc. which can be marked with a logo to identify the donating firm.
- Sponsor large-scale coverage of drug-free concerts, sports and recreational activities.
- Invite prevention workers to talk to employees about problems of substance abuse.
- Send managers and supervisors on training courses for the prevention of substance abuse at the workplace.
- Refer employees who are abusing drugs or alcohol for treatment and grant them paid leave until they are able to resume work.
- Pay for time on radio and TV for anti-drug spots and programmes.

Note: See the companion manual on workplace programmes for more information on the role of the business community in the prevention of drug and alcohol problems.

Service clubs

Clubs such as the Rotary Club, the Lions Club and Round Table can undertake or sponsor the same type of activities as the business community. Members of these clubs are usually people who are well known locally and have many contacts in the community. Such clubs can put the expertise of their members at the disposal of the Community Task Force to stimulate the multi-disciplinary approach which is necessary for combating the drug problem. They can also sponsor study tours to help field workers improve their knowledge and skills, and last but not least, they can undertake fund-raising on a large scale to finance programmes for prevention, treatment and rehabilitation.

The Community Action Committee and the high-risk groups

The introduction to this manual includes a section on understanding the high-risk groups, notably young people. Members of the Community Action Committee need to be aware of
the various risk factors which might predispose certain individuals or groups towards substance abuse. The three types of factors involved are individual risk factors, psychological risk factors and environmental risk factors. It may be difficult to make a clear distinction between them and in any case they tend to operate together so that a person might be influenced by all three types at the same time. Nevertheless, it is useful to think about them in isolation and the lists below may be helpful in this.

Individual risk factors

Genetics: Increasing evidence is emerging that certain individuals may be genetically predisposed to develop addiction.
Age: Certain drugs are abused more by young people than older people and vice versa.
Sex: Generally, men use alcohol and drugs more than women do.
Personality: The "non-conformist" type might be at higher risk than the conventional type. Poor communication and problem-solving skills are common among addicts. Lack of religious belief is also associated with substance abuse.

Psychological risk factors

- Lack of interest in achievement
- Rebellion, alienation and early anti-social behaviour
- Lack of empathy with others
- Sensation-seeking behaviour
- Need for immediate gratification
- Risk-taking behaviour
- Lack of self-confidence and self-esteem
- Psychological stress
- Affectional deprivation
- Feelings of unworthiness

Environmental risk factors

- Easy availability of drugs
- Alcoholism or drug addiction among family members
- Social expectation of drug use
- Perceptions of the drug culture
- Unemployment
- Discrimination
- Lack of parental control
- Broken home
- Low educational level
- Occupations which involve contact with alcohol (e.g. catering industry)
- Negative peer pressure
- Extreme poverty in the midst of affluence
- Influence of the media and advertising
- Lack of enforcement of drinking laws.

Primary prevention is aimed at the whole population but the Community Action Committee can still organise activities with the high-risk groups particularly in mind. Below are some examples of such activities.

- Work closely with leaders of youth clubs and train volunteers as peer counsellors.
- Organise recreational activities and social events which will interest young people.
- Launch awareness campaigns to inform the at-risk groups about the services which are available in the community.
- Organise drug free / alcohol free parties.
- Organise recreational activities for the lonely, the sick and the old.
- Run sustained information campaigns aimed at reducing casual sex, to combat the increasing threat of AIDS.
- Help young people to improve their coping skills (communication, problem solving, stress management).
- Provide accurate information about the so-called "soft" drugs.
- See that the social and psychological needs of young people are met in the local community.
Bibliography


Basic structure of Community Action

CENTRE ADVISORY BOARD

NGO

HELP RECRUIT MEMBERS PROVIDE RESOURCES, AND FACILITATE ACCESS TO OTHER GROUPS

NATIONAL PROJECT COORDINATOR

Coordination with other Centre activities

CENTRE MANAGER

SOCIAL WORKER (Professional Guidance)

COMMUNITY ACTION COMMITTEE

CORE MEMBERSHIP OF 6-10 MEETS WEEKLY

VARIOUS SORTS OF COMMUNITY PROJECTS/CAMPAIGNS
### Some basic facts about drugs

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<th>MODE OF USE</th>
<th>EFFECTS</th>
<th>WITHDRAWAL SYMPTOMS</th>
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<td><strong>I. OPIATES</strong></td>
<td>Analgesic</td>
<td>Smoking - Oral/IM/IV</td>
<td>Depressant Analgesic Antitussive Euphoria Sedation Nausea Vomiting Constipation Respiratory depression</td>
<td>Common Cold-like symptoms: - Rhinorrhea - Goose flesh - Feeling hot and cold - Abdominal cramps - Diarrhoea - Restlessness Pains yawning - Bone Muscle Joint</td>
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<tr>
<td>• Opium</td>
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<td>• Morphine</td>
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<td>• Heroin</td>
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<td>• Pethidine</td>
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<td>• Codeine</td>
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<tr>
<td>• Methadone</td>
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<td><strong>II. ALCOHOL</strong> (Ethanol)</td>
<td>Solvent/disinfectant</td>
<td>Oral</td>
<td>Depressant Sedative/anxiety relief in small dose Depression ataxia in larger dose</td>
<td>Tremors of hands, tongue and body. Anxiety, Insomnia Most severe, Delirium Tremens</td>
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<td><strong>III. SEDATIVE/HYPNOTICS</strong></td>
<td>&quot;Sleeping pills&quot;</td>
<td>Oral</td>
<td>Sedatives: calm, anxiety and restlessness. Hypnotics: Induce drowsiness and sleep</td>
<td>Insomnia Anxiety Statu epilepticus Tremors Anorexia Abdominal cramp Irritability</td>
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<tr>
<td>• Benzodiazepine</td>
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<tr>
<td>• Barbiturate</td>
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<td><strong>IV. CANNABIS</strong></td>
<td>Treatment of glaucoma in a few countries (e.g. Jamaica)</td>
<td>Smoking</td>
<td>Depressant in low dose. Hallucinogen in high dose. Apathy, Psychosis</td>
<td>Amotivational Syndrome</td>
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<tr>
<td>• Marijuana</td>
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<td>• Hashish</td>
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<td>• Gandia (active agent: 9 - tetrahydrocannabinoid - THC)</td>
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<td><strong>V. HALLUCINOGENS</strong></td>
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<td>Oral/IM/IV</td>
<td>States of altered perceptions as illusions, hallucinations and delusions</td>
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<td>• LSD (Lysergic Acid Zethyamide)</td>
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<td>• Mescaline</td>
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<td>• PCP (Phencyclidine)</td>
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<td>DRUG</td>
<td>MEDICAL USE</td>
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<td>I. Amphetamines</td>
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<tr>
<td>Dexedrine</td>
<td>Appetite suppressant</td>
<td>Oral</td>
<td>Euphoria, increased alertness, wakefulness, appetite suppression, decreased fatigue. Schizophrenia-like psychosis</td>
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<td>Benzedrine</td>
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<tr>
<td>Methylamphetamine (Ice)</td>
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<tr>
<td>Ephedrine</td>
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<td>II. Cocaine (an alkaloid extracted from the leaves of the coca plant) Crack</td>
<td>–</td>
<td>Smoking, Snorting, I/V</td>
<td>Euphoria, increased alertness</td>
<td>Insomnia, lethargy fatigue; Aches and pains; Nausea and vomiting, loss of weight Paranoid psychosis</td>
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<tr>
<td>III. Khat</td>
<td></td>
<td>Chewing</td>
<td>Euphoria, increased alertness, decreased fatigue, appetite suppressant</td>
<td>Fatigue, lethargy, decreased alertness</td>
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<td>The khat leaves from the shrub catha edulis. Active principle: cathirome</td>
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<td>IV. Cola Nuts</td>
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<td>Chewing</td>
<td>Euphoria, decreased fatigue</td>
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<td>V. Nicotine</td>
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<td>Smoking</td>
<td>Decreased fatigue</td>
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<td>VI. Caffeine</td>
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<td>Inhaling</td>
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