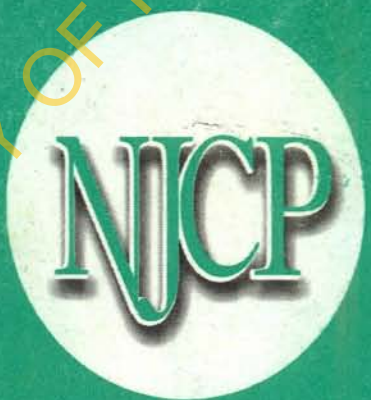


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Social skills training for secondary drug prevention in high risk adolescents in Ibadan, Nigeria

Benjamin O. Olley

ABSTRACT

Substance abuse is a common health problem among adolescents in Nigeria, particularly owing to its relationship with a chain of behaviours that encourages the spread of HIV/AIDS. The effectiveness of social skills training in secondary prevention of substance use was examined among high risk adolescent school attendees in Ibadan. One hundred and forty eight adolescents (63% response rate) of 235, aged 15 to 17 years, who reported having smoked tobacco, cannabis or having drunk alcohol in an initial survey on sexual behaviours of adolescents in Ibadan and who were invited to participate in a one day educational programme on drug abuse named "My life in my hand" (mlmh) participated in the study. They were consecutively assigned to one of two conditions: (a) Mlmh skills training or (b) a control intervention involving no skills training. mlmh skills training is a combination of cognitive and behavioural techniques to improve adolescents' social skills and restructure their social network. Results showed that incidence of tobacco, alcohol and cannabis use decreased significantly over the two month assessment period in the mlmh skills group but not in the no-skills group. Social skills training as a secondary preventive measure was found to be effective in substance use reduction among adolescents in Ibadan. Future preventive strategies may consider a social-cognitive approach in HIV risk reduction.

Keywords: social skills training; secondary drug prevention.

INTRODUCTION

Drug use and abuse among adolescents is still a common phenomenon in Nigeria, despite media campaigns and other educational strategies aimed at curtailing it (Odejide, 2000; Degenhardt et al 2008). Among the findings is that alcohol had been used by the vast majority of survey participants in the Americas, Europe, Japan, and New Zealand, compared to smaller proportions in the Middle East, Africa and China, and that alcohol use by age 15 was far more common in European countries than in the Middle East or Africa (Degenhardt et al 2008). Public concerns about health effects of substance use have prompted the Nigerian government to ban smoking in public places and to prohibit the sale of tobacco products to underage youth through legislation. There are also national agencies set up to control the use and abuse of drugs such as the National Drug Law Enforcement Agency (NDLEA). Some of the activities of the

NDLEA have centred on affective education, aimed to impact positively on intra-individual variables such as self esteem and assertive behaviours.

In spite of these preventive strategies, the use of substance such as alcohol, tobacco, cannabis is still common in big cities of the country (Morakinyo and Odejide, 2003). Known as "gateway" drugs, use of alcohol, tobacco and cannabis during adolescence frequently leads to the abuse of other drugs including cocaine and heroin (Kandel, 1975), which top the list of substances commonly abused by young people in Nigeria (Odejide, 2000). Indeed, Oshodin (1981) observed that alcohol use was quite common among secondary school students in Bendel State. A recent survey among 2290 school-going adolescents in Ibadan showed that 184 (8%) abused alcohol in the month preceding the study (Olley & Adejuwon, 2006).

Tobacco smoking is the leading cause of preventable death in the world today, (WHO, 2003). More than three quarters of smokers have their first cigarette before 18 years of age (Wiehe, Garrison, Christakis, Ebel & Rivera, 2005). Studies on the prevalence and pattern of tobacco use in Nigeria, though few, have predominantly concentrated on institutionalized youth. (Ogunremi & Okonofua, 1977; Ogunremi & Rotimi, 1979; Oshodin, 1980; Adelekan, 1989; Abiodun, Adelekan, Ogunremi, Oni & Obayan, 1994).

Pioneering the trend of tobacco smoking in Nigeria, Elegbeleye and Femi-Pearse (1976) in a survey of smoking habits among secondary school children and medical students in Lagos, found that 40% of boys and 8.4% of girls in secondary school smoked cigarettes. Gender analysis showed that the smoking habits of boys were influenced by those of their friends. Similarly, Alakija (1984), in examining the smoking behaviours of 238 medical students (204 males and 34 females) at a University in Nigeria, found a prevalence of 11.7% among males, while no female students indicated smoking. The main reason cited among males for smoking was to "relieve tension". The majority of students were introduced to cigarettes by friends when they were in secondary school.

The few studies on cannabis use among Nigerians indicate that it is a drug of abuse. Anumonye, (1980) observed that children in Lagos started using cannabis as early as age 11. Ogunremi and Okonofua (1977) found among students at a Nigerian university, a drug abuse rate of 26% with cannabis being the commonly abused drug. Subsequent studies (ICAA, 1989, Adelekan et al 1992; Odejide, 1993) have all confirmed the increasing trend of cannabis use among young people in Nigeria.

The aforementioned trends in substance abuse underpin many interventional programmes designed by government and non-governmental organizations as well as contemporary researchers to prevent drug abuse among adolescents. Many of these interventions, which have been school based, have adopted a normative educational approach in prevention and have predominantly used peer leaders (students delivering an educational programme who are of similar or slightly older age than the students receiving the programme). Evidence has shown that while peer-educators appear to be effective in establishing conservative norms and attitudes related to drug use, they have been found to be less effective in imparting factual information and in promoting engagement in behaviours that are required for change (Fisher et al 2004).

Social skills training (SST) is one intervention that has received wide application in risk reduction of drugs in a variety of youth settings, (Botvin, Eng & Williams, 1980; Ellickson, Bell & McGuigan, 1993; Donaldson, Graham & Hansen, 1994; Hovell, et al, 1998). SST utilizes a social influence approach in helping young people resist peer pressure and to appropriately manage social situations that put them at risk for continuous drug use (Palinkas, Atkins, Miller & Ferreira, 1996).

Opinions are divided, however, about the effectiveness of social skills training in reducing tobacco, marijuana and alcohol use. While some studies have found an effect (Ellickson, Bell & McGuigan, 1993; Howell, et al 1998), other studies have found no effects (Hansen & Graham, 1991; Flay, Miller, Hedecker, Siddiqui & Sussman, 1995; Werch & Owen, 2002) and some have actually produced harmful outcomes (Palinkas, Atkins, Miller & Ferreira 1996). The objective of this study, therefore, was to test the efficacy of a social skills based risk reduction programme for secondary prevention of substance use among high risk school-going adolescents in Ibadan.

HYPOTHESIS

Our hypothesis was that a social programme designed to teach adolescent to be more assertive in their use of resistance skills, to maximize their exposure to positive social influences, and to restructure their social networks so as to minimize exposure to negative social influences, combined with a normative education programme that included information on the hazards of drug use, would be more effective in reducing the incidence of substance use (alcohol,

tobacco & cannabis) among users than a control non-skills exposure group at 2 & 4 weeks post intervention, respectively.

METHODS

Research Design

A pretest-posttest design (Christensen, 1988) was employed for the study. It is a quasi experimental design, which enables the establishment of relationships between baseline and post-intervention measures. In this regard, a baseline assessment of the adolescents' cannabis, tobacco and alcohol abuse was done with a post training evaluation of the incident use of these drugs.

Participants

One hundred and forty eight adolescents (63% response rate) out of 235, who reported having smoked tobacco, cannabis or having drunk alcohol and who also reported several sexual health behaviours participated in this study (Olley; 2008). They responded to an advertisement, facilitated by their respective school counsellors, inviting them to a resource-based drug cessation training program. Demographic information collected included chronological age, family composition (e.g. whether parents stays together, educational level of parents [father/mother] ethnicity, whether he/she hawks after school hours, perception of violence at home and type of parenting style.

Recruitment and training procedures

Participants were contacted through their school guidance counsellor after permission from the school administrators had been obtained. The study team had a pre-selection group meeting with all school guidance counsellors involved. They were also briefed about the outcome of the survey and how they could help in motivating participants for the intervention programme. Adolescents were recruited based on their participation in the initial survey. Adolescents who had indicated that they had taken any of the three substances that were investigated, in addition to having engaged in at least one sexually risky act (non-use of condom at last sex; multiple sexual partners, use of alcohol heavily before sex etc) and willingness to be assisted, were included. Each adolescent was contacted through an advertisement placed with their respective school counsellors. The skills-training programme was basically a didactic instructional session with each training module consisting of 3 hour sessions.

First, in an effort to minimize the possibility of the Hawthorne effect (the feelings of being observed in experimental condition), the 148 adolescents who reported to the follow-up invitation attended a 120-min enlightenment educational programme. Known as "My Life in my hand", this normative educational intervention covered the extent to which drug use was prevalent and acceptable among adolescents as well as consequences of drug use for adolescents and young people, helping them to understand their own physical, emotional, and cognitive development; sexual responsibility, ranging from values clarification to decision-making about drug use. Thereafter, adolescents were consecutively assigned to one of two conditions: (a) skills training plus life in my hands (mlmh) and (b) no skills training. The mlmh-skills training programme is a combination of cognitive and behavioural training to improve social skills and to restructure the adolescent's social network through provision of scientific facts, modelling by skilled adults and peers, practising these skills through role play, giving and receiving positive and negative feedback, and practising these skills at home (homework assignments). The programme has five major objectives for the outcome of treatment: (a) to assertively refuse requests to use alcohol, tobacco, and cannabis again; (b) to assertively handle fair and aggressive criticism from parents, adult authority figures, and peers; (c) to increase positive social support by describing who is in the social network, increasing the number of positive influences in the network, spending more time with positive influences in the network, spending more time with positive influences in positive activities, and improving social conversation skills; (d) to decrease negative social support by describing who is in their social network, decreasing the number of negative influences in their network, and spending less time with those who engage in high-risk behaviours by using avoidance and coping skills; and (e) to develop assertive problem solving skills. These have been organized into modules and presented in Table 1. The author, with help from a doctorate level student, moderated and facilitated each session and administered the skills training programme. The training programme, assessment and follow-up evaluation took place during the long vacation period between July and September 2006 at the premises of one of the schools used for the survey. Participants were reimbursed for transportation and were seen post-study by author for further management.

All adolescent participants were assessed at three major points during the project: (a) pre-intervention, (b) 2 weeks post-intervention and (c) 4 weeks post-intervention. The adolescents were interviewed regarding demographic information, drug use, and sexual behaviour.

Statistical Analysis

Analysis of reported drug use was limited to the pre-intervention, post-intervention, and 4 weeks post-intervention assessment data. The within-group comparisons of percentage of adolescents reporting alcohol, cannabis, and tobacco across the three periods were compared using Mantel-Hansel χ^2 tests for trend. Two sets of analyses of these trends were conducted: (a) analyses of all data available at each assessment and (b) analyses restricted to adolescents who provided complete data at all three assessments. Between-group comparisons of percentages of adolescents reporting use of any of the three categories of drugs at 4 weeks post-intervention were conducted to determine the odds of using each of these three categories of drugs at 4 weeks post-intervention in the mlmh skills group relative to the no skills group after controlling for several factors (via pre-intervention drug use, age, family type, parents staying together, hawking after school hour, educational level of father and mother).

RESULTS

Table 1: Demographic characteristics of project "My life in my hand" (mlmh) participants by intervention.

Characteristics	Intervention	
	No skills (n=74)	Skills (n=74)
Age \bar{x} (sd)	16.1 (1.4)	16.0 (1.4)
Fathers' education below tertiary (%)	64	67
Mother's education below tertiary (%)	72	79
Polygamous home environment (%)	42.3	40.4
Stays with both parents (%)	56	57
Yoruba (%)	79.5	75.5
Igbo (%)	16.1	15.4
Hausa (%)	7.6	10.6
Others (%)	6.6	8.5
Hawking after school (%)	27.3	36.3
Christians	67.5	63.9
Islam	32.5	36.1
Sexually active (%)	89.2	85.9
Use of condom last sex (%)	19.6 (4.12)	17.2(3.7)
Lost to follow-up (%)	5.1	6.4

Table 2: Percentage of project mlmh participants who report drug use at various periods post assessment

Drug use category and skills group	Assessment period					
	Pre-assessment		2 weeks post assessment		4 weeks post assessment	
	n	%	n	%	n	%
Alcohol						
No skills	74	100.0	67	90.5	58	78.3*
Skills	74	100.0	74	100.0	64	86.4*
Cannabis						
No skills	74	100.0	22	29.7	18	24.3*
Skills	74	100.0	24	32.4	19	25.6*
Tobacco						
No skills	74	100.0	56	75.6	52	23.0*
Skills	74	100.0	67	90.5	60	81.0*

Ages of the 148 participants ranged from 15 to 19 years, with a mean of 16.7 ± 1.8 years. They were predominantly Yoruba-speaking youth. The mean number of years of school attended at the time of recruitment was 11.6 ± 1.7 years. Compared with adolescents not exposed to skills training, the skills training group were significantly more likely to hawk after school hours. Most of the adolescents (89%, skills training vs. 86%, non-skills training) were sexually active. The majority of adolescents (56%, skills training vs. 57%, no-skills training) stayed with both of their parents. About half (50.2%) attended 4 or more weeks of the 5-week programme of classroom instruction (mlmh) viz (Table 1).

The prevalence of alcohol, tobacco and cannabis use at each assessment period is presented in Table II. One hundred percent of this cohort reported use of one or more drugs within the 3 months preceding the intervention. There were no significant differences between the skills group and the no skills group in the prevalence of any category of drug use pre-intervention. Relative to adolescents in the control group, adolescents in the mlmh skills group who reported alcohol use at pre-intervention were approximately 4 times as likely to reduce the use of cannabis as well as tobacco 4 weeks post intervention. Generally there was a statistically significant decrease in the use of alcohol, cannabis and tobacco over the two assessment periods in the mlmh skill group compared with the no skills group.

DISCUSSION

The adolescents in this cohort, representing 8% of participants in a large community survey, reported some form of substance use during the 3 months

prior to study entry. These estimates are less than those reported in studies of drug use among adolescents in general (Botvin et al 1996; Ellickson et al. 1933; Donaldson et al 1994; Wiehe et al 2005). A substantial number reported a decrease in the use of these substances 4 weeks post-intervention. Relative to adolescents in the control group, adolescents in the mlmh skills group who reported alcohol use at pre-intervention were approximately 4 times less likely to report using alcohol at 4 weeks post-intervention. Similarly, adolescents exposed to the mlmh skills intervention were twice less likely to use cannabis and tobacco at 4 weeks post intervention.

Research on school-based drug prevention programmes has shown that although normative education and social skills training have quite different effects on drugs use, the combination of the two to prevent drug use in this cohort was more effective than the use of normative education alone. Our results show that when combined with skills training, normative education significantly reduced the incidence of substance use among the adolescents. These data support previous documentation of treatment effects of social skills intervention in preventing drug use among young persons in the short term (Flay, 1985; Glynn, 1989; Hansen & Graham; 1991; Ellickson et al 1993). They contribute to the sparse literature on secondary drug prevention in the context of high risk sexual behaviours among adolescents in Nigeria. An important area of future research, however, will be to examine the effects of (mlmh) social skills training package over a longer assessment period, particularly among institutionalized drug dependents.

These findings should be interpreted in the context of some significant methodological limitations. Firstly, adolescents who were included in the study were all self-referred. It may, therefore, be that the most distressed and/or least resilient adolescents may have responded. Secondly, researchers who facilitated the skills training and post intervention assessment were not 'blind' to the adolescents' drug status at baseline and this may have biased the findings.

Thirdly, additional limitations were the small sample, the low rate of follow-up, and the lack of a tool to assess a change in behaviour over time. Fourthly, the adolescents recruited to participate were identified as drug users on the basis of self-report and not on the basis of urine drug screen results. Future research should involve urine testing as a way of identifying severity of drug dependence and high risk status among these adolescents. Finally, the results

may be an artifact of the multiple comparisons conducted rather than an indication of a genuine difference between the two intervention groups.

These limitations notwithstanding, the present data underscore the need for risk reduction interventions for drug use among high risk adolescents in Nigeria, and suggest the importance of increasing the number of positive social network influences.

CONCLUSION

In conclusion, these findings provide a useful and empirical basis for the efficacy of a social skills training programme on substance risk reduction among adolescent abusers in the short term, and have implications for providing a model of intervention for drug abuse prevention at the community level. It is, however, recommended that the long-term outcomes of such an intervention be assessed in future studies.

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Correspondence:

B.O. Olley, Department of Psychology, University of Ibadan, P.O. Box 29530
Secretariat HO, Ibadan, Oyo-State, Email:Olley28@yahoo.com