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An Investigation Into Prevalence And Factors Contributing To Relapse Among Alcoholics In Selected Rehabilitation Centres In Nairobi County, Kenya

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Abstract:
From the year 1999, there has been increasing alcohol abuse in Kenya with associate adverse consequences. As a result of this, there has been an increase in the establishment of treatment and rehabilitation services and demand for the same to assist abusers in recovery and avoid relapse. However, despite the availability and demand of these services, there has been also a simultaneous increase in the relapse cases. This casts doubt on the effectiveness of the existing treatment and rehabilitation services in meeting the ever-increasing number of cases admitted. This study sought to assess the effectiveness of treatment and rehabilitation services in addressing alcohol relapse in selected centres in Nairobi, Kenya. The study adopted an ex post facto causal comparative research design. The target population was all the relapse cases in the 14 rehabilitation centres registered by NACADA in Nairobi. A random sample of 109 alcoholics and 8 counselors drawn from 4 purposively selected rehabilitation centers were involved in the study. Data was collected through the administration of two sets of self-structured questionnaires to the selected respondents. The questionnaires were piloted to validate and test its reliability before the actual data collection. The data were then processed and analysed using descriptive statistics including frequencies and percentages with the aid of Statistical Package for Social Sciences (SPSS) version 15.0 for Windows. The results of study have shown that relapse was influenced by the interaction of past-risks within the individual and environmental situations and level of preparedness to cope with these past-risks to resist drinking. These findings may benefit NACADA, Ministry of public health, mental health agencies, psychologists, counselors, Non-Governmental Organizations, policy makers, researchers, drug abusers and families of alcoholics. The study recommends there is need to restructure treatment and rehabilitation services and programs in order to effectively address the increasing alcohol abuse menace and associated relapse.

Key words*: Prevalence, Relapse, Alcoholics, Rehabilitation Centers, Nairobi County*

1.Introduction

The issue of drug and substance abuse has traditionally been met by a dismissive attitude based more on moral precepts than a concern for the health issues involved. Yet, it is not a problem which can be isolated from the society, which is quite to the contrary. It is now much more widely understood that drug and substance abuse is harmful (UNODC, 2006). According to a report by the United Nations Office of Drug Abuse and Crime (UNODC, 2006), drug abuse is on the increase and causes adverse social, health and economic implications. The economic cost is estimated at between 0.5 to 1.3% of gross domestic product in many countries. The World Health Organization (WHO) indicates that the most widely used drugs are alcohol, tobacco, marijuana, opium and its derivatives, cocaine and hallucinogens. Others are khat (miraa), inhalants and volatile solvents like petrol and glue. Also available are synthetic drugs mainly barbiturates. Studies also indicated that prescribed and over-the counter drugs are being abused more widely than reported (Kamonjo, 1997). UNODC (2005) add that an estimated 30% of the general adult population worldwide uses alcohol, out of which 20% are men and 10% are women.

According to WHO (2002), alcohol abuse is a great risk factor for morbidity and mortality globally. It is estimated that 4% of the health burden measured as Disability Adjusted Life Years (DALYs) and 3.2% (or 1.8 million) of all deaths in 2000 were attributable

to alcohol. Various studies indicate that though most of the health burden is found in developed countries (9.2% of DALYs), alcohol is the leading risk factor in developing countries where it accounts for 6.2% of the health burden. Alcohol abuse has multiple significant social, economic, psychological and health effects. It contributes to chronic and acute health problems because of its direct toxic effects on organs, its intoxicating properties (accidents and injuries), and it is a dependency-producing substance Crime (UNODC, 2005). In Africa, the problem of alcohol has been a constant presence for years. Except where it is banned for religious reasons, large quantities of alcohol are still being brewed (Obot, 2000). However, regardless of improvement in technology, large amounts of unprocessed and unhygienic alcohol are still being consumed, especially by the poor (WHO, 2004).

In Kenya, drug abuse is escalating and has permeated the whole society strata. However, high at risk are the youths and those in the early adulthood, who forms more than a half of the population (National Agency for the Campaign Against Drug and Substance Abuse – NACADA, 2007; Gacicio, 2003; Otieno, 1999). The youth seem to be dangerously exposed to this menace (Ngeno, 2002). It is estimated that there are more than 2 million drug addicts, with about 90% addicted to alcohol, and 70% of the families affected by alcohol abuse (WHO, 2002). The UNDOC World Drug Report of 2000 ranked Kenya among the four most notorious African nations with drug problems; and the port of Mombasa as a major transit point for drug trafficking (UNODC World Drug Report, 2005; Bayer & Waverly, 2005). Alcohol has the highest national abuse rate of 36.3%, followed by nicotine (17.5%), Bhangi (9.9%), heroin (8.0%), Miraa (2.7%) and cocaine (2.2%). Alcohol use has been attributed to social dysfunctions and laxity in legal provisions and application (Ndetei, Mutiso, Khasakhala, Odhiambo, Kokonya & Sood, 2004). Figures 1 and 2 illustrate the prevalence in percentages of drug abuse in Kenya by students and non-students, across the eight provinces and the five commonly abused substances.

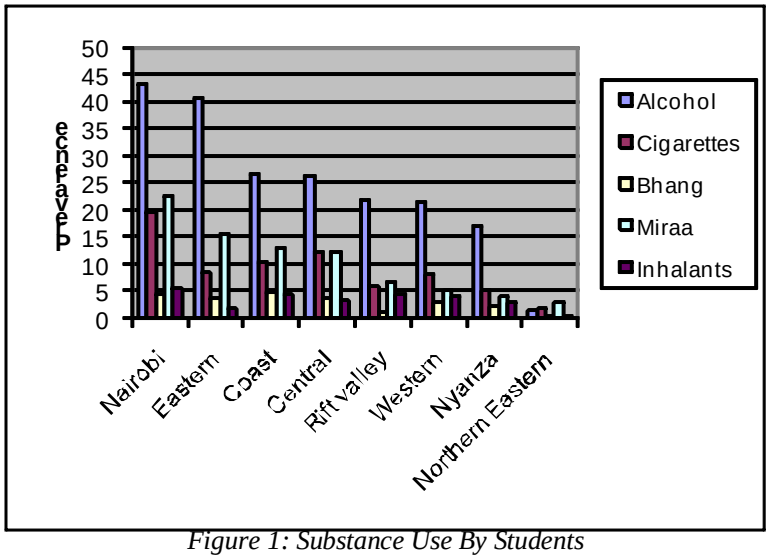

Figure 1: Substance Use By Students
Source: NACADA, 2007

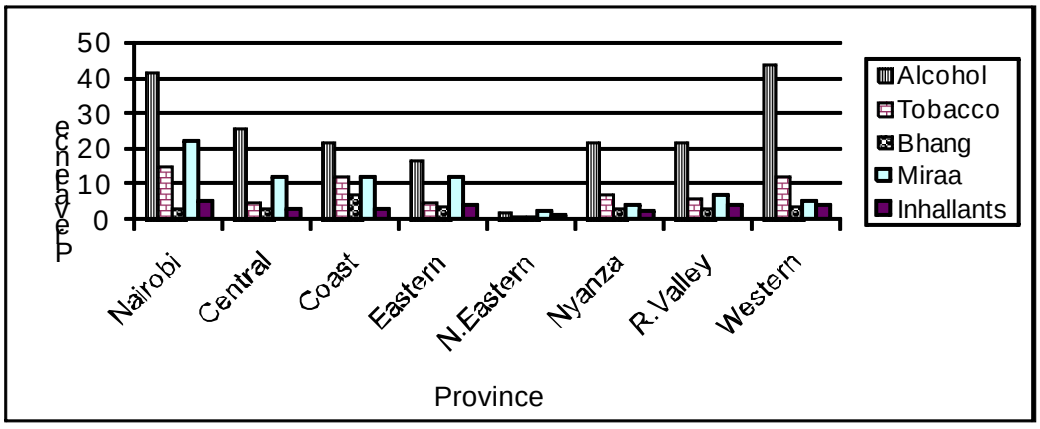

Figure 2: Substance Use By Non-Students
Source: NACADA, 2007

Figures 1 and 2 indicate that although the prevalence of drug abuse varies across the regions, alcohol was the most abused. In 1998, after realizing the potential adverse effects of drug abuse, the United Nations Special Session of the General Assembly indicated that tackling drug abuse required demand reduction programs. In Kenya, the Government has instituted various legislations and policies to

curb drug abuse. It created the National Campaign against Drug Abuse (NACADA) in 2001 to coordinate the prevention, reduction and control of drug and substance abuse through public education, empowerment, and enforcement liaison for a healthy and productive country (NACADA, 2007).

NACADA (2007) in its survey of alcohol and drug addiction treatment and rehabilitation centers owing to the increasing population of drug addicts in the country. The report shows that there has been an exponential growth in the number of rehabilitation centers in Kenya in the recent past. Whereas there were only 13 centers which were operational by 1999 in the country, the figure rose to more than 48 centers registered by NACADA in 2007. Majority of the centers began operating in the last seven years. However, it was also observed that despite the increase in demand in treatment and rehabilitation services in the country as indicated by the increasing number of centers, there was also a simultaneous increase in the number of relapse cases (at least 60%). This is attributed to the fact that drug addiction and alcoholism being a chronic disorder of the brain, the possibility of relapse exists.

Studies from other countries indicate that globally, approximately 70 to 90% of alcoholics are likely to experience at least one relapse over the 4-year period following treatment (Polich, Armor & Braiker, 1981). The higher percentage of the addicts who go into treatment will relapse within the first year after completing a traditional program. Thus, relapse as a central issue of alcoholism treatment warrants further study (Polich, Armor & Braiker, 1981). This leaves information gap on why majority of the clients are relapsing after receiving treatment and rehabilitation services. It also casts doubts on the effectiveness of the existing rehabilitation and treatment services in meeting the ever-increasing demand.

2.Statement Of The Problem

Alcohol abuse in Kenya poses adverse consequences to the users, their families and the larger society. This has led to the establishment of treatment and rehabilitation services to tackle this problem. Information from NACADA (2007) indicates that there has been an exponential growth in the number of rehabilitation centers in the country from 13 centers being operational by 1999 to more than 48 centers in 2007. However, despite the increase in the number of centers and demand for the services offered in the country, there is also a simultaneous increase in the number of relapse cases. On average, NACADA (2007) estimates that there is an annual relapse rate of 60% of all admitted cases in the country. This is ironical as the demand for treatment and rehabilitation services are expected to be accompanied by a decline in the relapse rate. The situation casts doubts on the effectiveness of the treatment services in handling drug abuse and preventing relapse cases. Therefore, there is a need for a study to investigate why majority of the clients admitted in rehabilitation centres are relapsing even after receiving treatment and rehabilitation services. There is also need to establish factors contributing to alcohol relapse among alcoholics in Kenya.

3.Purpose Of The Study

The purpose of the study is to establish the effectiveness of treatment and rehabilitation services in addressing alcohol relapse in selected rehabilitation centres in Kenya.

4.Objectives Of The Study

The specific objectives of the study were:

- To determine the prevalence of alcohol relapse in selected rehabilitation centres in Kenya
- To establish factors contributing to alcohol relapse among alcoholics in selected rehabilitation centres in Kenya.

5.Research Questions

The study sought to answer the following research questions:

- What is the prevalence of alcohol relapse in selected rehabilitation centers in Kenya?
- What are the factors contributing to alcohol relapse among alcoholics in selected rehabilitation centres in Kenya?

6.Research Methodology

This study adopted an ex post facto causal-comparative research design. The design was adopted in this study because treatment and rehabilitation services which have been implemented in rehabilitation centers were studied after they had exerted effect on the dependent variable (relapse).The researcher then proceeded to study the effects of treatment and rehabilitation services in retrospect for its possible relationship to relapse cases (Kerlinger, 1973; Mugenda & Mugenda, 1999).

7.Population Of The Study

The target population for this study comprised the alcoholics and their service providers in all the 14 drugs and alcohol rehabilitation centers registered by NACADA in Nairobi. The 14 centres in Nairobi from 29% of all centres in the country (NACADA, 2007). These centers offered residential and non-residential services, with some having both in-patient and out-patient programs, while others had only in-patient program. Table 1 summarizes the 14 centers and their nature.

Name	Services	Program
Asumbi Karen	Residential Rehabilitation	In-patient
Brightside	Residential Rehabilitation	In-patient
Chiromo Lane Medical Centre	Residential Rehabilitation	In-patient
Dapar Counseling Centre	Residential Rehabilitation	In-patient
Maisha House	Non-residential Rehabilitation	In-patient
Mathari Hospital	Residential Rehabilitation	In-patient
Medicare Wellness Limited	Residential Rehabilitation	In-patient
Nziwa Springs Counseling Centre	Residential Rehabilitation	In-patient
Nairobi Place	Residential Rehabilitation	In-patient
Nairobi probation Hostel	Residential Rehabilitation	In-patient
Psychological Health Services	Non-Residential Rehabilitation	Out-patient
Salvation Army	Non-Residential Rehabilitation	Out-patient
Youth Counseling Centre	Non-Residential Rehabilitation	Out-patient
Youth Education Support	Non-Residential Rehabilitation	Out-patient

Table 1: Distribution Of The Rehabilitation Centers In Nairobi
Source: NACADA, 2007

8.Sampling Procedure And Sample Size

Four centers were purposively sampled. The 4 centers included Mathari, Asumbi Karen, Maisha and Nairobi Place. Mathari Hospital was chosen as the only public centre in the area. It offered residential services and out-patient program. Asumbi Karen was included for offering residential services without any out-patient program. Maisha and Nairobi place, unlike Asumbi, offered residential services but also have out-patient services. Table 2 summarizes the distribution of clients and service providers from the 4 selected centers in Nairobi.

Name	Number of counselors	Number of alcoholics
Maisha house	2	8
Mathari hospital	10	28
Nairobi place	7	99
Asumbi Karen	6	16
Total	25	151

Table 2: Distribution of the Clients and Service Providers
Source: NACADA, 2007

In order to determine a representative sample size of alcoholics to be drawn from an estimated 151, this study adopted a formula by Kathuri and Pals (1993) for estimating a sample size, n, from a known population size, N.

$$n = \frac{\chi^2 NP(1-P)}{\sigma^2 (N-1) + \chi^2 P(1-P)}$$

Where:

n = required sample size
N = the given population size of potential alcoholics, 151 in this case
P = Population proportion, assumed to be 0.50
σ^2 = the degree of accuracy whose value is 0.05
χ^2 = Table value of chi-square for one degree of freedom, which is 3.841

Substituting these values in the equation, estimated sample size (n) was:

$$n = \frac{3.841 \times 151 \times 0.50 (1 - 0.5)}{(0.05)^2 (151 - 1) + 3.841 \times 0.5 \times (1 - 0.5)}$$

$$n = 109$$

Proportionate stratified sampling was used to ensure that the sample was proportionately and adequately distributed among the 4 centers according to the population of each centre. In doing this, each centre was allocated a proportion of the sample by dividing the estimated number of alcoholics in the centre by the total number of estimated alcoholics in the 4 centers and then multiplied by the sample size (109). However, after data collection and analysis, only 100 alcoholics were included as others were lost through inconsistent responses and non-response. Out of 100 alcoholics, 43 were relapses who were isolated at data analysis. Purposive

sampling was used to select two counselors from each of the four rehabilitation centers. The two counselors were included the head of the counselling program and any other councillor in the centre.

9.Data Collection Instruments

The study used two sets of questionnaires. One questionnaire was administered to the alcoholics while the other was administered to the counsellors). The questionnaires consisted of mainly closed-ended items and a few open-ended items. The two questionnaires had various items seeking different information from each targeted respondent. The alcoholics' questionnaire elicited information on their personal background, alcohol use history, causes of relapse, and services offered in their centre. The counsellor questionnaire sought information on the various aspects of effective alcohol treatment and rehabilitation services in their centres. Each set of questionnaires had items seeking similar information from the respondents so as to allow the researcher to gauge their opinions and perceptions on various aspects of effective treatment and rehabilitation services.

10.Data Collection Procedure

The researcher proceeded to collect data after receiving permission from the Department of Psychology, Counseling and Educational Foundations, National Council for Science and Technology and NACADA. Permission was sought from the management of the 4 purposively selected centers and the one targeted for piloting. The researcher then visited the selected centres before actual data collection for familiarisation and acquaintance with the management. During this visit, the researcher informed the management about the purpose of the intended study and booked appointments for data collection. After familiarisation, the researcher then personally collected data from the respondents using the mentioned instruments. The instruments were administered by the researcher and collected immediately.

11.Data Analysis

The collected data was accurately and consistently edited, coded and scored. Frequencies and percentages were used to analyze data and it was presented using tables. Statistical Package for Social Sciences (SPSS) version 15.0 for windows aided in data analysis.

12.Results And Discussions

12.1.What Is The Prevalence Of Alcohol Relapse In Selected Rehabilitation Centres In Kenya?

The question sought to establish the prevalence of relapse in the selected rehabilitation centers in Kenya. Of the alcoholics who participated in the study, 43% had relapsed as compared to 57% who were in rehabilitation centers for the first time as shown in Table 3. Four percent of the respondent did not respond to the question. Of the alcoholic relapsees, 45.5% had slipped to drinking again after a period of sobriety more than five times as compared 27.3% who had relapsed once as indicated in Table 3.

How many times	Frequency	Percent
No response	2	6.0
2-4 times	9	21.2
Once	12	27.3
Five times or more	20	45.5
Total	43	100.0

Table 3: Distribution Of Relapse By How Many Times Alcoholics Slipped To Drinking

From table 4, most relapsees indicated that the longest period of abstinence from alcohol since deciding to quit were 30.3% for 3-6 months. The same percentage indicated that they stayed in state of sobriety for less than 30 days as shown in Table 4.

Period of Abstinence	Frequency	Percent
1-2 years	4	9.0
No response	6	15.2
30-90 days	7	16.2
Less than 30 days	13	30.3
3-6 months	13	30.3
Total	43	100.0

Table 4: Distribution of Alcoholic Relapsees by Period of Abstinence after Quitting Drinking

The findings indicate that almost half of the respondents in rehabilitation centres were relapsees.This findings agree with prevalence statistics of past studies that indicated majority of alcoholics were likely to relapse over a four year period following treatment (Polish et al. 1981; Rollins et al. 2005).

12.2.What Are The Factors Contributing To Alcohol Relapse Among Alcoholics In Selected Rehabilitation Centers In Nairobi, Kenya?
The question aimed to determine factors within the institution and community that affect the effectiveness of alcohol treatment and relapse prevention**.** The factors included the family, peers, easy availability of alcohol, mass media exposure, level of training of the personnel and adequate provision of services in rehabilitation centers.
Most respondents indicated that peer-group influence (46.5%) and family (25.6%) contributed to their relapse as indicated in Table 5.

Factors	Frequency	Percent
Curiosity	1	2.3
Stressful events	3	7.0
Others	8	18.7
Family influence	11	25.6
Peer group influence	20	46.5
Total	43	100.0

Table 5: Perception Of Alcoholics On Factors That Contributed To Their Relapse

Most of respondents indicated that alcohol was very easy to get if they wanted to (53.5%). This was compared to 7% and 14% who indicated that alcohol was difficult and impossible to get respectively as shown in Table 6.

Easy availability	Frequency	Percent
Difficult	3	7.0
Impossible	6	14.0
Easy	11	25.5
Very easy	23	53.5
Total	43	100.0

Table 6: Availability Of Alcohol

The findings that alcohol was easily available to respondents supported findings of past studies that asserted that social acceptability, legal status of alcohol and economic factors like price and taxation affect the availability and desirability of drug and thus extent of their use (Papalia, Olds & Feldman, 1999; Escandor & Galvez, 2005; NACADA, 2004a).
In terms of religious membership, most of the relapsees were Catholics (51.2%) as compared to Protestants (23.3 %) and Muslims (9.3%). Those who attended at least one month in religious service were 48.8% as shown in Table 7.

Attendance	Frequency	Percent
No response	4	9.4
At least once a year	4	9.3
At least once a week	7	16.3
Rarely	7	16.3
At least once a month	21	48.8
Total	43	100.0

Table 7: Distribution Of Relapsees By Attendance Of Religious Service

The findings that less relapsees were Muslims concurred with past study that stated that most members of the Muslims community did not take alcohol on religious grounds (NACADA, 2004). Majority of relapsees were those who had irregular attendance (74.4%) in religious service which supported the past studies that spirituality inversely correlated with alcohol abuse (Willis and Sandy, 2003; Koenig, McCullough & Larson, 2001).
The respondents who indicated that they were often exposed to pro-alcohol advertisements were 60.5% as compared 25.6% who were often exposed to same advertisement in the internet as indicated in Table 12. Those who were exposed to pro-alcohol advertisements through the street billboards were 51.2%.

Mode	No response		Never		Rarely		Often	
	Freq.	Percent	Freq	Percent	Freq	Percent	Freq	Percent
TV	6	14.0	2	4.6	9	20.9	26	60.5
Movie	6	14.0	3	7.0	18	41.9	16	37.2
Radio	5	11.6	1	2.3	16	32.2	20	46.5
Billboard	6	14.0	2	4.7	13	30.2	22	51.2
Magazine	6	14.0	3	7.0	19	44.2	14	32.6
News papers	4	9.3	5	11.6	17	39.5	17	39.5
Internet	4	9.3	13	30.2	15	34.9	11	25.6

Table 8:Distribution Of The Relapsees By Mass Media Exposure

The results in table 8 indicate that the mass media provided important clues that motivate the respondents to slip to drinking. These findings concurred with Escandor and Galvez (2005) who asserted that advertisement of alcohol show immediate pleasure that these products generate in the individual and this raise the urges within recovering alcoholic to slip to drinking.

All the counselors were professionally trained with 71.4% with diploma and 14.3 % with a certificate. Those who did not indicate were 14.3%. The counsellors who indicated that they had attended the seminar were 71.4%.

Almost half of the relapses (48.9%) indicated that their family involvement in treatment and relapse prevention and follow up services were inadequate as shown in Table 9. Those who indicated that they were inadequate service in warning signs identification and management were 39.6%.

Service	Adequate		Not Adequate		Not Available	
	Freq.	Percent	Freq.	Percent	Freq	Percent
Stabilization through detoxification	19	44.2	15	39.5	7	16.3
Assessment on alcohol recovery and relapse history	27	62.8	12	27.9	4	9.3
G & C relapse history	28	65.1	14	32.6	1	2.3
Warning signs identification and management	25	58.1	17	39.6	1	2.3
Network of support and attendance	22	51.1	16	37.2	5	11.6
Inventory making	21	48.8	19	44.2	3	7.0
Family involvement	18	41.9	21	48.9	4	9.3
Follow up	16	37.2	21	48.9	6	14.0

Table 9: Adequacy Of Rehabilitation Services

The findings in table 9 indicate that non-involvement of family and support groups, account for respondents' slip to alcohol. This concurs with past studies by UNODC (2006) who assert that there is a higher probability of obtaining and maintaining sobriety for those who seek therapy and also join support groups than those who seek therapy alone (UNODC 2006).

13.Conclusion

Based on the findings of this study, the following conclusions can be drawn:

- Almost half (43%) of the alcoholics in rehabilitation centres were relapses and they had slipped to drinking more than once. The primary goal of alcoholism treatment, as in other areas of medicine, is to help the patient to achieve and maintain long-term remission of disease. For alcohol dependent persons, remission means the continuous maintenance of sobriety. However, this is not always true as evident in the results of this study.
- Poor preparation in acquisition of skills to prevent relapse accounted for slip to drinking after a period of sobriety among respondents. When individuals complete their recovery programs most times they are not equipped with the tools necessary to re-enter society. The lack of skills many times is the root of the relapse problem. Without the skills, the recovering addicts who find themselves in difficult situations are unable to cope with their urges and turn to using alcohol once again.

14.Recommendations

In view of the conclusions, the following recommendations have been made:

a) The alcoholics should be assisted by rehabilitation centres to assume an active role in changing drinking behaviour. This could be done by assisting the alcoholics to modify their lifestyles to enhance their abilities to cope with past-risk situations; identify and

respond appropriately to internal and external cues that serve as relapse warning signals; and implement self-control strategies to reduce the risk of relapse in any situation. The earlier the alcoholics are aware of the risks, the sooner they can intervene by using coping skills and by using these cues as both warning signs and as a reminder to engage in alternative or remedial actions.

b) Family members should be involved in the therapeutic process to help them recognize behaviours and problems related to addiction. Research has shown that understanding and encouragement to alcoholics is the best approach family members can take in dealing with the situation.

15.References

1) Bayer, J. & Waverly, K. (2005). Tobacco Control Policies. Strategies and Setbacks. Brigden Co-publication of the World Bank and Research for International Tobacco Control.
2) Escandor, R. & & Galvez, C. (2005). Free from drugs and addictions: In the face of AIDS and enemies of society. Madrid: Talleres Graficos Penelara.
3) Gacicio, E. (2003). The Role of Stake Holder in Combating Drug and Substance Abuse. Paper
4) Presented at HIV-AIDS Teacher Training Tool Development Retreat Matuu, Kenya From 4th to 10th May 2003.
5) Kamonjo, B. N. (1997). The Correlates, Prevalence and Attitude Towards Drug Abuse Among
6) 1st, 2nd and 3rd Year University Students in Kenya.Unpublished M.Ed. Thesis, Kenyatta University, Kenya.
7) Kathuri,N.J and Pals,D.A.(1993). Introduction to Educational Research.Egerton
8) University:Education Media Centre.
9) Kerlinger, F. N. (1973). Foundations of Behavioural Research. (2nd Edition). New York: Holt Rinehart and Wilson, Inc.
10) Koenig, H. G., McCullough, M. E. & Larson, D. B. (2001).Handbook of religion and
11) health. New York: Oxford University Press.
12) Mugenda, O. M, & Mugenda G. D. (1999). Research Methods: Quantitative and Qualitative Approach. Nairobi: Acts Press.
13) NACADA (2004) Youth in peril: Alcohol and drug abuse in Kenya. Nairobi: MOH
14) National Agency for the Campaign against Drug and Substance Abuse (2007). A Handbook on Prevention of Drug and Substance Abuse in Kenya. Nairobi: Ministry of Health
15) Ndetei, M., Mutiso, V., Khasakhala, L., Odhiambo,G., Kokonya, D., Sood,M.,et al., (2004). The Assignment of the Linkage between Drug abuse And HIV/AIDS in Kenya. A Rapid Situation Assessment.
16) Ngeno, D.K. (2002). Drug Abuse and Its Influence on Student Learning Behaviour in a Study
17) of Secondary School in Kericho District. Unpublished M.Ed. Thesis, Nairobi University, Kenya.
18) Obot, I. S. (2000). The Measurement of Drinking Patterns and Alcohol Problem in Nigeria. Journal of Substance Abuse, 12: 169-181.
19) Otieno, L.O. (1999). Students in Kenya Secondary Schools (Key note address). Delivered at Ukweli Catholic Pastoral and Development Centre 12th August. Nairobi Christian Churches.
20) Papalia, D. E., Olds, W. S. & Feldman, D .R. (1999). A child's world: Infancy through
21) adolescence. Boston: McGraw Hill.
22) Polich, J.M.; Armor, D.J.; & Braiker, H.B. (1981). Stability and Change in Drinking Patterns. In: The Course of Alcoholism: Four Years after Treatment. New York: John Wiley & Sons, 1981. pp. 159-200.
23) United Nations Office of Drug Abuse and Crime (UNODC) (2005). World Drugs Report. (Pg-10). Published by United Nations.
24) United Nations Office of Drug Abuse and Crime (UNODC) (2006).Demand Reduction
25) Training Manual: Practical Guidelines for Effective Interventions in Drug Abuse Prevention, Treatment and Rehabilitation in Africa. May, 2006. Published by United Nations.
26) World Health Organization (2004). Global Status Report on Alcohol. Geneva: WHO.
27) World Health Organization – WHO (2002). World Health Report. Geneva: WHO.
28) Willis , A. T. & Sandy, M. C. (2003).Adolescent perceived importance of religion lessens drug
29) use. Psychology of Addiction Behavior, 12, 1 23-31. Retrieved September 2009, from http: //www.apa.org/journal/adb/pressrelease/march2003/adb1792.html