Assessing the Availability of Community-Based Counselling Models for Sustainable Drug Use Reduction Among Substance Abusers in Nigeria

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Abstract
Substance abuse among Nigerian youths and adults has escalated into a public health crisis, severely overwhelming institutional psychiatric and law enforcement frameworks. This empirical study evaluated the availability, accessibility, and operational capacity of community-based counselling models—specifically Cognitive Behavioural Therapy (CBT), Motivational Interviewing (MI), Faith-Based/Spiritual Counselling (FBC), and Peer Mentorship/Support Groups (PMS), for sustainable drug use reduction in Nigeria. Utilizing a descriptive survey research design, the study targeted a population of 12,450 key community stakeholders across six geopolitical zones, from which a representative sample of 1,200 respondents was selected using multi-stage cluster sampling. Data were collected using a

validated 45-item structured questionnaire titled the Community-Based Counselling Models and Drug Reduction Questionnaire (CBCM-DRQ). Instrument reliability was established via Cronbach's alpha ($\alpha = 0.88$). Descriptive statistics (mean and standard deviation) answered four research questions, while Inferential Statistics (t-test and regression analysis at $\alpha = 0.05$) tested four null hypotheses. Findings revealed that while Faith-Based Counselling and Peer Mentorship models are moderately available, clinical models such as CBT and Motivational Interviewing remain severely scarce and under-resourced at the community level. Furthermore, the availability of integrated community counselling models significantly predicted long-term drug use reduction ($R^2 = 0.412, p < 0.001$). Key operational barriers identified include systemic stigma, acute shortages of licensed community counsellors, and poor funding integration with Primary Health Care (PHC) systems. The study provides a strategic blueprint for decentralizing addiction treatment through community-driven framework policy integration in Nigeria.

Keywords: *Community-Based Counselling, Drug Use Reduction, Substance Abuse, Nigeria, Cognitive Behavioural Therapy, Faith-Based Intervention, Public Health Policy.*

Introduction

Substance abuse in Nigeria has transitioned from a localized social deviance to a major national public health emergency. The national epidemiological survey by the United Nations Office on Drugs and Crime (UNODC) established that approximately 14.4% of Nigerians aged 15 to 64—representing roughly 14.3 million individuals—had used a psychoactive substance for non-medical purposes within a single year (UNODC, 2018). This prevalence rate is nearly three times the global average of 5.6%, underscoring an unprecedented crisis of addiction that spans prescription opioids (tramadol, codeine), cannabis, amphetamine-type stimulants (methamphetamine/"mkpuru mmiri"), and volatile solvents.

Historically, Nigeria's institutional response to drug abuse has relied heavily on supply-reduction mechanisms enforced by law enforcement bodies such as the National Drug Law Enforcement Agency (NDLEA), alongside tertiary psychiatric care delivered within specialized neuro-psychiatric hospitals. However, this supply-side and tertiary-care paradigm exhibits severe structural limitations. Federal neuro-psychiatric hospitals and formal rehabilitation centers are geographically centralized, exorbitantly expensive, and burdened by deep societal stigma, rendering them inaccessible to over 85% of substance abusers residing in peri-urban and rural communities (Eze et al., 2021). Consequently, institutional facilities handle less than 5% of the total national burden of substance use disorders, leaving a vast majority of affected individuals without therapeutic support.

In response to these systemic bottlenecks, public health paradigms internationally have shifted toward decentralized, community-based counselling models (CBCMs). Community-based counselling frameworks embed therapeutic interventions directly within the socio-cultural fabric of the individual's immediate environment. These models leverage indigenous structures, primary healthcare systems, faith organizations, and peer networks to deliver accessible, affordable, and culturally congruent psychological support.

Globally, four primary community counselling models have demonstrated efficacy in sustaining drug use reduction:

1. Community-Based Cognitive Behavioural Therapy (CBT): Focuses on cognitive restructuring, identifying relapse triggers, and developing adaptive coping mechanisms within local settings (Beck & Fleming, 2021).
2. Motivational Interviewing (MI): A person-centred, non-confrontational counselling style

designed to address ambivalence and foster intrinsic motivation for behavioural change (Miller & Rollnick, 2023).

3. Faith-Based and Spiritual Counselling (FBC): Integrates spiritual values, religious fellowship, and moral guidance to rebuild identity and community accountability (Oladipo et al., 2022).
4. Peer Mentorship and Support Groups (PMS): Utilizes trained, recovering peers to provide non-stigmatizing emotional guidance, modelling, and social reintegration (Adewole et al., 2024). Despite theoretical and global empirical consensus endorsing the efficacy of community-based counselling, its operational availability, institutionalization, and empirical effectiveness within the Nigerian socio-cultural landscape remain under-researched. The prevailing gap between policy rhetoric—such as the National Drug Control Master Plan (NDCMP)—and practical implementation at the grassroots level creates an urgent need for empirical investigation. Assessing the availability and functional capacity of these community counselling models is vital to formulating sustainable, low-cost, and scalable drug reduction strategies in Nigeria.

Statement of The Problem

The escalating trajectory of substance abuse in Nigeria continues to generate severe socio-economic, security, and developmental consequences. Beyond individual health deterioration such as psychosis, hepatic damage, and viral transmission through intravenous drug use, substance abuse directly correlates with rising rates of violent crime, armed robbery, insurgency, domestic violence, and academic failure among Nigerian youths (Onuoha et al., 2022). The core of the problem lies in the structural imbalance of Nigeria's drug demand reduction architecture as identified in the following problem statements:

Centralization and Inaccessibility problem: Existing rehabilitation mechanisms are overwhelmingly centralized in state capitals and urban centres. Rural and semi-urban communities where drug peddling and consumption thrive due to high youth unemployment and poverty, are virtually devoid of formal counselling infrastructure (Nwagu et al., 2020).

Systemic Stigma and Legal Deterrence problem: The criminalization of drug users under traditional enforcement frameworks drives substance abusers underground, preventing them from seeking help at formal institutions out of fear of arrest, discrimination, or social ostracization (Ibrahim et al., 2023).

Shortage of Specialized Professionals problem: Nigeria faces an acute deficit of licensed clinical psychologists, addiction psychiatrists, and certified guidance counsellors. The current doctor-to-patient and counsellor-to-population ratios cannot support individual-focused institutional care for millions of drug users (Ojo & Aluede, 2022).

Fragmentation of Local Models problem: Although informal community structures such as church support groups, traditional rulers' councils, and youth assemblies, attempt to manage drug-dependent individuals, these interventions are largely ad-hoc, unstandardized, and lack evidence-based psychological frameworks like CBT or MI.

Without empirical data mapping the availability, distribution, and operational effectiveness of community-based counselling models, public health authorities cannot systematically integrate these grassroots structures into the national primary health system. This study directly addresses this problem by empirically evaluating the availability, structural barriers, and efficacy of community-based counselling models for sustainable drug reduction in Nigeria.

Relevant Literature Review

Conceptualizing Community-Based Counselling and Sustainable Drug Use Reduction

Community-based counselling has increasingly been recognized as an important component of contemporary responses to substance use disorders (SUDs), particularly in settings where specialized treatment services are scarce, geographically concentrated, or financially inaccessible. Rather than locating counselling exclusively within psychiatric hospitals or specialized rehabilitation centers, community-based models bring prevention, early identification, brief intervention, psychosocial treatment, referral, relapse prevention, and recovery support closer to individuals, families, and communities. The World Health Organization (WHO) and United Nations Office on Drugs and Crime (UNODC) emphasize that effective treatment systems should provide a continuum of care ranging from community outreach and basic support to specialized treatment and social reintegration. Such systems should also involve families, communities, civil society, health professionals, and people affected by substance use in service planning and delivery (WHO & UNODC, 2020).

The concept of community-based counselling is particularly relevant to Nigeria because substance use is not merely an individual clinical problem. It is connected with family relationships, peer networks, unemployment, poverty, educational disruption, social exclusion, crime, mental health difficulties, and other community-level determinants. Consequently, an intervention that focuses only on the individual may have limited sustainability when the social and environmental conditions associated with substance use remain unchanged. The 2018 Nigerian National Survey on Drug Use reported considerable unmet treatment needs among high-risk drug users. Nearly 40% reported wanting help or treatment but being unable to obtain it, while only 12% had ever received treatment and approximately 4% had received treatment within the preceding 12 months. Counselling was the most frequently reported intervention during treatment, followed by detoxification, suggesting that counselling already occupies an important position within the Nigerian substance-use treatment landscape (National Bureau of Statistics [NBS] & UNODC, 2019).

Sustainable drug-use reduction therefore requires more than temporary abstinence. It involves helping individuals develop skills for coping with cravings, managing stress, repairing relationships, improving decision-making, resisting peer pressure, maintaining treatment engagement, preventing relapse, and reintegrating into productive social roles. Community-based counselling can potentially address these needs because it permits repeated contact between counsellors, service users, families, peer networks, and community institutions. The model can also reduce the distance between formal treatment and the everyday environments to which individuals return after treatment.

The International Standards for the Treatment of Drug Use Disorders identify community-based outreach, screening, brief intervention and referral, outpatient treatment, psychosocial interventions, and recovery management as components of a comprehensive treatment system (WHO & UNODC, 2020). Nigeria's National Drug Control Master Plan similarly identifies community-based outreach, screening, brief intervention and referral, outpatient care, residential treatment, and recovery management as elements of the national treatment strategy. It further proposes integrating substance-use management into primary healthcare and strengthening the capacity of community organizations involved in treatment and care (Federal Republic of Nigeria & UNODC, 2021).

The concept is also supported by evidence from low- and middle-income countries (LMICs). Suasnabar and Walters (2020) found that community-based psychosocial interventions can provide important responses to SUDs in LMICs, although implementation is constrained by shortages of resources, specialized personnel, supportive policies, and sociocultural barriers.

The authors emphasized the importance of adapting interventions to local contexts rather than simply transferring models developed in high-income countries.

From a counselling perspective, therefore, community-based models should be viewed as a continuum rather than a single intervention. They may include individual counselling, group counselling, family counselling, motivational interventions, psychoeducation, peer support, relapse-prevention counselling, referral, follow-up, and community sensitization. Their availability is consequently determined not simply by whether a counselling center exists, but by whether communities can access trained counsellors and receive continuous, culturally appropriate, affordable, and coordinated services.

For Nigeria, this conceptual position provides an important basis for assessing the availability of community-based counselling models. The central concern is whether existing services provide sufficiently broad and sustainable community coverage to reach substance users before their problems become severe, maintain engagement during treatment, and support recovery after formal treatment.

Availability and Accessibility of Community-Based Substance-Use Counselling Services in Nigeria

Availability is a fundamental prerequisite for effective counselling intervention. A service cannot contribute substantially to drug-use reduction if it is absent, inadequately staffed, geographically inaccessible, poorly funded, or unavailable at times when individuals require assistance. In Nigeria, the literature suggests a substantial gap between the need for substance-use services and the capacity of the treatment system to meet that need.

The Nigerian National Survey on Drug Use and Health provides important evidence concerning this treatment gap. Among high-risk drug users, approximately 40% reported that they wanted treatment but were unable to obtain it, whereas only 4% had received treatment during the previous year (NBS & UNODC, 2019). These findings are particularly significant for community-based counselling because the inability to obtain treatment may reflect several interconnected problems, including limited-service locations, inadequate information about services, financial constraints, stigma, insufficient trained personnel, and weak referral systems.

The national evidence also indicates that counselling is already a major treatment component. At the most recent treatment episode, counselling was reported by 73% of high-risk drug users, compared with 61% who reported detoxification, 35% relapse prevention, 33% social rehabilitation, and 24% self-help groups (NBS & UNODC, 2019). This distribution demonstrates that counselling has a potentially central role within Nigeria's treatment response. However, the relatively low proportion receiving relapse prevention and social rehabilitation suggests that treatment may not consistently extend into the longer-term recovery phase.

Availability also has a geographical dimension. Nigeria's large population, regional disparities, urban-rural differences, and uneven distribution of specialized health professionals create challenges for centralized treatment models. The National Drug Control Master Plan therefore proposes integration of substance-use management into primary healthcare facilities. The policy recognizes that primary healthcare facilities are often the first and most common points of contact but that the existing workforce has limited capacity to recognize, diagnose, and treat substance dependence (Federal Republic of Nigeria & UNODC, 2021).

This policy direction is consistent with the WHO's mhGAP approach, which seeks to expand evidence-based mental, neurological, and substance-use care through non-specialist health workers, especially in low- and middle-income countries (WHO, 2023). Community counsellors and other trained non-specialist providers can therefore contribute to early

identification and referral when adequately trained, supervised, and integrated into formal health and social-care systems.

International evidence reinforces the importance of addressing availability at structural as well as individual levels. Farhoudian et al. (2022), in an overview of systematic reviews, identified structural barriers as particularly prominent in SUD treatment. These included service availability, treatment capacity, financial barriers, and organisational limitations, alongside individual and social barriers. Similarly, Cernasev et al. (2021) identified stigma, treatment shortages, provider shortages, and treatment deserts as recurring barriers to accessing SUD treatment. The Nigerian situation therefore suggests that assessing the "availability" of community-based counselling requires a multidimensional approach. It should include the existence of services, geographical distribution, availability of professional counsellors, opening hours, affordability, referral mechanisms, continuity of care, availability of family counselling, relapse-prevention services, peer support, and follow-up mechanisms.

Importantly, availability does not automatically guarantee utilisation. A counselling service may exist within a community but remain underused because residents do not know about it, fear stigma, distrust service providers, cannot afford transportation, or perceive substance use as a moral rather than health problem. Consequently, availability must be considered together with accessibility, acceptability, appropriateness, and continuity.

For the present study, this literature establishes the rationale for investigating whether community-based counselling models are actually available to substance users in Nigerian communities. It also highlights the need to distinguish between nominal availability—where a service exists on paper—and functional availability, where individuals can realistically obtain appropriate counselling when they need it.

Counselling Approaches and Community-Based Models for Drug Use Reduction

Community-based counselling encompasses several psychosocial approaches that can be adapted to substance-use prevention, treatment, and recovery. These include individual counselling, group counselling, motivational interviewing, cognitive-behavioural approaches, family counselling, psychoeducation, relapse-prevention counselling, peer support, and brief interventions. The appropriateness of a particular model depends on the substance involved, severity of use, motivation for change, comorbid mental health problems, family circumstances, and available community resources.

Evidence supports the use of psychosocial interventions within community and outpatient settings. For example, a Cochrane review of psychosocial interventions for cannabis use disorder examined interventions delivered in outpatient and community settings and demonstrated the importance of structured psychosocial approaches in addressing problematic cannabis use (Gates et al., 2016). More broadly, Vogel et al. (2020) found that cognitive-behavioural and coordinated-care interventions showed evidence of improving treatment initiation, while 12-step promotion interventions demonstrated potential benefits for treatment attendance. Cognitive-behavioural counselling is particularly relevant because substance use is frequently associated with maladaptive thoughts, emotional difficulties, environmental triggers, and learned behavioural patterns. Within a community setting, counsellors can help individuals identify triggers, challenge dysfunctional cognitions, develop alternative coping strategies, manage high-risk situations, and establish behavioural goals. Such interventions can be delivered individually or in groups and can potentially be integrated into primary healthcare, educational institutions, youth programmes, faith-based organisations, and community centres.

Motivational approaches are similarly relevant because many substance users enter counselling with ambivalent attitudes towards change. A community counsellor can employ non-confrontational communication to strengthen motivation, explore discrepancies between

present behaviour and desired goals, and support incremental changes. This is especially important where compulsory or punitive approaches might drive substance users away from services. Family counselling is another potentially important component of community-based models. Substance use affects family members as well as the individual user, and family relationships can either increase vulnerability or provide support for recovery. Community-based services allow counsellors to work with family members on communication, boundary setting, supportive monitoring, relapse warning signs, and strategies for encouraging treatment adherence. Peer-based approaches can also complement professional counselling. Peer recovery support may facilitate treatment engagement by providing practical assistance, navigation, encouragement, and continuing contact after formal treatment. Evidence suggests that peer support can be useful in improving some treatment-engagement outcomes, although evidence concerning substance-use outcomes remains variable (Duopah et al., 2026).

Nigeria already possesses several community assets that could potentially support such models. The Nigerian drug-use evidence indicates that NGOs and faith-based treatment facilities are accessed by high-risk drug users, demonstrating that community and voluntary organisations already have a role within the treatment ecosystem (NBS & UNODC, 2019). Orjiakor et al. (2023), in a systematic review of community-based efforts addressing methamphetamine use, identified local councils, drug-control agencies, influential community members, people with lived experience, businesses, and existing health-promotion platforms as actors involved in community interventions. However, the review also found that many programmes were difficult to evaluate quantitatively and that enforcement agencies appeared less effective when acting alone. This finding has implications for counselling in Nigeria. A sustainable community model should not depend exclusively on professional counsellors working in isolation. Instead, counsellors may serve as coordinators within a broader network involving primary healthcare providers, social workers, community leaders, families, peer educators, religious organisations, schools, NGOs, and government agencies.

The 2026 systematic review by Gates et al. further reinforces this multidimensional understanding of community interventions. Across 87 reviews, the authors found that community initiatives generally involve multiple coordinated activities rather than a single intervention. The review highlighted meaningful community engagement as an important implementation principle.

Thus, community-based counselling should be understood as a coordinated system of psychosocial support rather than simply counselling delivered outside a hospital. Its potential contribution to sustainable drug-use reduction lies in continuity, local accessibility, family participation, culturally appropriate communication, early intervention, referral, and long-term recovery support.

Community Participation, Family Support, Peer Support, and Social Reintegration

Community participation is central to sustainable substance-use reduction because substance-use behaviour occurs within social environments. Family members, peers, religious institutions, community leaders, schools, workplaces, health facilities, and local organisations can either reinforce substance use or facilitate recovery. Consequently, community-based counselling models that actively engage these actors may provide broader support than individually focused interventions.

The International Standards for the Treatment of Drug Use Disorders recommend involvement of families and communities in planning and delivering services and emphasise the importance of maintaining social links and supporting social reintegration (WHO & UNODC, 2020). This principle is highly relevant to Nigeria, where extended-family networks, religious institutions,

traditional leadership structures, and community associations can exert considerable influence on social behaviour.

Family support is particularly important because recovery does not end when formal counselling sessions terminate. Individuals returning to their communities may encounter the same peer networks, stressors, economic pressures, and interpersonal conflicts that contributed to substance use. Counsellors can therefore work with families to create supportive environments, identify early signs of relapse, facilitate communication, and encourage appropriate treatment continuation.

Evidence from LMICs supports the relevance of social support. Suasnabar and Walters (2020) found that community-based psychosocial interventions operate within complex social, cultural, political, and resource contexts and emphasised the need for contextually adapted interventions. Similarly, a systematic review of barriers and facilitators to SUD treatment in LMICs found that family support and availability of effective treatment can facilitate treatment, whereas low motivation, limited recognition of the problem, and other individual and structural barriers can impede engagement (Aljohani et al., 2021).

Peer support represents another potentially valuable community resource. People with lived experience of substance use can provide practical assistance, encouragement, modelling of recovery, and navigation through treatment systems. Peer support can also reduce social distance between service providers and service users because individuals may perceive peers as more relatable. However, peer roles should be clearly defined, appropriately trained, supervised, and integrated with professional services.

Recent evidence suggests that peer support may improve engagement and treatment linkage, although findings on substance-use outcomes are not uniformly positive (Duopah et al., 2026). Therefore, peer support should be regarded as a complementary component rather than a replacement for qualified counselling and clinical treatment.

Community engagement is similarly important. Orjiakor et al. (2023) found that community-based responses to methamphetamine use involved diverse actors and that programmes could have broader effects across substances. However, the authors noted the need for stronger coordination and systematic evaluation. This observation is relevant to Nigeria, where multiple organisations may work independently, potentially resulting in fragmented services and weak referral pathways.

Whole-of-community evidence provides additional support for integrated approaches. A systematic review and meta-analysis of 24 trials involving more than 249,000 participants examined interventions implemented across multiple community settings, including schools, sporting organisations, police, community centres, media, and retail environments (Stead et al., 2018). Although methodological limitations were identified across the evidence base, the review demonstrated the importance of multi-setting approaches in addressing alcohol and other drug harms.

The most recent umbrella review of comprehensive community initiatives similarly found that community interventions are heterogeneous and that their effectiveness varies according to substance and intervention type. The review emphasised meaningful community engagement as a recurring implementation principle (Gates et al., 2026).

For Nigeria, these findings suggest that sustainable drug-use reduction should involve communities not simply as recipients of counselling but as active partners. Counsellors can facilitate community education, establish support groups, coordinate referrals, engage families, train peer supporters, work with religious and traditional leaders, and develop follow-up mechanisms.

Such an approach is consistent with a recovery-oriented model in which the goal extends beyond cessation of drug use to restoration of functioning, relationships, education,

employment, health, and community participation. Accordingly, assessing the availability of community-based counselling models should include the extent to which existing services involve families, peers, community organisations, and social-reintegration mechanisms.

Barriers to the Availability and Utilisation of Community-Based Counselling Models

Although community-based counselling offers substantial potential, its availability and utilisation may be constrained by individual, social, cultural, institutional, and structural barriers. Understanding these barriers is essential because establishing a counselling programme does not necessarily mean that substance users will access or benefit from it.

Farhoudian et al. (2022) classified barriers to SUD treatment into individual, social, and structural levels. Their overview identified substantially more structural barriers than individual or social barriers, suggesting that treatment gaps cannot be addressed solely by changing individual attitudes. Similarly, Cernasev et al. (2021) identified stigma, shortages of providers, and inadequate treatment availability as recurring obstacles to treatment access.

Stigma is especially important in community settings. Substance use may be interpreted as a moral failing, lack of discipline, criminality, or personal weakness rather than as a health and psychosocial problem. Such perceptions can discourage users from approaching counsellors and can cause families to conceal substance-use problems. Community-based counselling must therefore incorporate stigma reduction, confidentiality, respectful communication, and psychoeducation. Cultural and religious beliefs can also influence treatment-seeking behaviour. In communities where substance use is strongly condemned, individuals may fear public exposure and social exclusion. Research on access to substance-use services in Muslim communities demonstrates that stigma, clandestine drug use, and fear of exclusion can reduce treatment-seeking behaviour (Gilchrist et al., 2023). This issue has relevance to parts of northern Nigeria, although cultural contexts vary considerably across Nigerian communities and should not be treated as homogeneous.

Human-resource limitations represent another major barrier. Nigeria's National Drug Control Master Plan explicitly acknowledges limited capacity among primary healthcare workers to recognise and manage substance dependence and therefore proposes training and infrastructure development (Federal Republic of Nigeria & UNODC, 2021). A recent systematic review and meta-analysis of non-specialist health-worker training found that workforce development is an important strategy for expanding management of SUDs, particularly where specialist providers are limited (Ghosh et al., 2026).

Financial and infrastructural constraints also affect sustainability. Community counselling requires trained personnel, supervision, suitable spaces, transportation for outreach, referral networks, communication systems, educational materials, and mechanisms for follow-up. Without sustainable financing, programmes may depend heavily on short-term projects and donor funding, resulting in interruptions in service delivery.

Weak coordination between agencies can create another barrier. Substance-use services may involve health ministries, NDLEA, psychiatric facilities, hospitals, NGOs, faith-based organisations, counsellors, social workers, law-enforcement agencies, and community groups. If referral mechanisms are poorly coordinated, clients may move between services without continuity of care. The National Drug Control Master Plan calls for a comprehensive and coordinated treatment strategy precisely because treatment requires multiple levels of intervention (Federal Republic of Nigeria & UNODC, 2021).

Geographical accessibility is equally significant. Centralised rehabilitation facilities may be difficult to reach for rural populations and low-income families. Community-based services can reduce this problem by bringing early intervention and follow-up closer to users. However,

community programmes themselves require adequate geographical coverage and transportation resources.

Another barrier is insufficient continuity. Sustainable recovery requires ongoing support, but treatment systems may concentrate on acute intervention rather than long-term recovery management. Community counselling can bridge this gap through scheduled follow-up, relapse-prevention groups, family support, peer networks, and referral to vocational and social services.

The literature therefore suggests that the availability of community-based counselling should be assessed in terms of both supply and usability. A community may have a nominal counselling service, but if it lacks trained personnel, confidentiality, funding, referral systems, follow-up, or community acceptance, its practical availability may remain limited.

Community-Based Counselling as a Framework for Sustainable Drug-Use Reduction in Nigeria

The literature reviewed above indicates that sustainable drug-use reduction requires an integrated continuum rather than an isolated counselling intervention. The Nigerian context presents a substantial need for such an approach because national evidence demonstrates a considerable treatment gap, while counselling already constitutes an important component of existing treatment episodes (NBS & UNODC, 2019).

A sustainable community-based counselling framework for Nigeria could integrate six interconnected components: community outreach and awareness, early identification and screening, counselling and psychosocial intervention, family and peer support, referral and coordinated care, and long-term recovery monitoring. These components correspond closely with international treatment standards and Nigeria's national drug-control strategy (Federal Republic of Nigeria & UNODC, 2021; WHO & UNODC, 2020).

First, community outreach can improve awareness of substance-use risks and available services. Outreach may occur through community meetings, schools, religious organisations, youth associations, primary healthcare centres, social media, and local media. The purpose should not be fear-based messaging but accurate information, early identification, stigma reduction, and promotion of help-seeking. Recent evidence on comprehensive community initiatives emphasises meaningful community participation and coordinated interventions rather than isolated awareness campaigns (Gates et al., 2026).

Second, screening and brief intervention can enable earlier identification of problematic substance use. Primary healthcare workers, counsellors, social workers, and trained community personnel can identify individuals requiring counselling or specialist referral. Nigeria's National Drug Control Master Plan explicitly recommends screening, brief intervention, referral, treatment, aftercare, and follow-up as components of substance-use services (Federal Republic of Nigeria & UNODC, 2021).

Third, professional counselling should address the psychological and behavioural factors associated with substance use. Cognitive-behavioural techniques, motivational approaches, psychoeducation, problem-solving, emotional regulation, relapse-prevention planning, and individual and group counselling can be incorporated according to client needs. The evidence on treatment-utilisation interventions suggests that cognitive-behavioural and coordinated-care approaches may improve treatment initiation (Vogel et al., 2020).

Fourth, family and peer support should extend the counselling process beyond the professional-client relationship. Family members can participate in education, supportive monitoring, communication improvement, and relapse prevention. Peer supporters can facilitate engagement, navigation, and continuity. However, professional supervision remains important to maintain ethical and evidence-based practice.

Fifth, referral and coordinated care are essential because community counsellors cannot independently address every substance-related need. Individuals with severe dependence, withdrawal risks, psychosis, suicidal behaviour, significant medical complications, or complex comorbidities may require specialised clinical care. Community counselling should therefore function as an entry point and continuing support mechanism within a broader health and social-care network.

Sixth, long-term recovery monitoring is necessary for sustainable drug-use reduction. Recovery should include health, family functioning, education, employment, housing, social relationships, and community participation. WHO and UNODC recommend a comprehensive recovery-oriented approach that addresses these interconnected needs rather than focusing exclusively on substance consumption (WHO & UNODC, 2020)?

The literature also reveals an important research gap. Although Nigeria has national data demonstrating treatment gaps and evidence that counselling is already used within treatment settings, there is comparatively less evidence concerning the availability and comprehensiveness of community-based counselling models themselves, particularly across diverse Nigerian communities. Existing literature often focuses on prevalence, treatment barriers, institutional services, or specific substances rather than systematically examining what community-based counselling models are available, where they are available, who provides them, what components they contain, and whether they provide continuity from prevention through recovery.

This gap provides a strong rationale for the present study. Assessing the availability of community-based counselling models can generate evidence concerning the extent to which Nigeria's existing substance-use response has moved from predominantly institution-based treatment towards accessible, preventive, recovery-oriented and community-integrated care. It can also identify areas requiring investment in professional counsellors, community outreach, family interventions, peer support, referral systems, relapse prevention, and follow-up services. Overall, the literature supports the proposition that community-based counselling should form an important component of sustainable drug-use reduction, but the Nigerian context requires models that are locally accessible, culturally responsive, adequately staffed, properly supervised, affordable, coordinated with health services, and sustained over time. The present study therefore addresses an important empirical issue by examining the availability of these models among communities affected by substance use in Nigeria.

Research Objectives

1. To assess the level of availability of various community-based counselling models (CBT, Motivational Interviewing, Faith-Based, Peer Support) for substance abusers in Nigeria.
2. To determine the accessibility of existing community-based counselling services to substance abusers across urban and rural communities in Nigeria.
3. To examine the operational challenges inhibiting the effective deployment of community-based counselling models in Nigeria.
4. To evaluate the relationship between the availability of community-based counselling models and sustainable drug use reduction among substance abusers in Nigeria.

Research Questions

1. What is the level of availability of community-based counselling models (CBT, Motivational Interviewing, Faith-Based, Peer Support) for substance abusers in Nigeria?
2. How accessible are community-based counselling services to substance abusers across urban and rural settings in Nigeria?
3. What are the key operational challenges inhibiting the effective deployment of

community-based counselling models in Nigeria?
4. What is the nature of the relationship between the availability of community-based counselling models and sustainable drug use reduction among substance abusers in Nigeria?

Research Hypotheses

HO_1**:** There is no significant difference in the availability of clinical (CBT/MI) and non-clinical (Faith-Based/Peer Support) community counselling models in Nigeria.
HO_2**:** There is no significant difference in the accessibility of community-based counselling services between urban and rural substance abusers in Nigeria.
HO_3**:** Identified operational challenges (funding, stigma, trained personnel) do not significantly hinder the deployment of community-based counselling models in Nigeria.
HO_4**:** The availability of community-based counselling models does not significantly predict sustainable drug use reduction among substance abusers in Nigeria.

Research Design

This study adopted a descriptive survey research design integrated with correlational analysis. This design is appropriate for gathering quantitative data across geographically dispersed populations without manipulating variables.

Population of the Study

The target population comprised 12,450 key community stakeholders across Nigeria, including community health workers, licensed guidance counsellors, social workers, leaders of non-governmental organizations (NGOs), community leaders, and recovering substance abusers registered with local support networks across the six geopolitical zones.

Sample and Sampling Technique

A sample of 1,200 respondents was selected using a multi-stage cluster and stratified random sampling technique:
Stage 1: One representative state was randomly selected from each of the six geopolitical zones (Lagos [SW], Kano [NW], Rivers [SS], Enugu [SE], Plateau [NC], and Borno [NE]).
Stage 2: Two Local Government Areas (LGAs), one urban and one rural were selected from each state ($6 \times 2 = 12$ LGAs).
Stage 3: Stratified random sampling was used to select 100 respondents per LGA across stakeholder categories, yielding a total sample size of $N = 1{,}200$.

Research Instrument

Data were gathered using a self-constructed structured instrument titled the Community-Based Counselling Models and Drug Reduction Questionnaire (CBCM-DRQ). The questionnaire utilizes a 4-point Likert scale ranging from Strongly Agree (4), Agree (3), Disagree (2), to Strongly Disagree (1).

Validity of the Instrument

Face and content validity of the instrument were established by a panel of three experts: one Professor of Educational Psychology, one Senior Lecturer in Guidance and Counselling, and a Consultant Addiction Psychiatrist. Their feedback led to the refinement of item phrasing, elimination of double-barreled questions, and realignment of items with the four research objectives.

Reliability of the Instrument

To determine internal consistency, the instrument was pilot-tested on 50 non-sampled stakeholders in Ogun State. The data obtained were subjected to Cronbach's alpha reliability test, yielding an overall reliability coefficient of $\alpha = 0.88$, indicating high internal consistency and suitability for field administration.

Data Collection Method

The questionnaire was administered over a period of 12 weeks by the principal researchers assisted by twelve trained field research assistants (two per state). To enhance return rates and overcome literacy barriers among certain community participants, research assistants utilized direct administration and guided interpretation where necessary. Out of 1,200 questionnaires distributed, 1,142 were validly completed and retrieved, representing a 95.2% response rate.

Results

Answers to Research Questions

The results of data used to answer research questions one to four were presented in Tables 1 to 4 using mean and standard deviation.

Research Question 1: What is the level of availability of community-based counselling models (CBT, Motivational Interviewing, Faith-Based, Peer Support) for substance abusers in Nigeria?

Table 1: Mean and standard deviation analysis showing level of availability of community-based counselling models for substance abusers in Nigeria

S/N	Item	Level of Agreement				Mean	Std. Dev.	Decision
		SA	A	D	SD			
1	Cognitive Behavioural Therapy (CBT) services are readily available in my local community health center.	140	250	430	322	2.18	0.98	Disagreed
2	Motivational Interviewing (MI) is regularly offered to drug-dependent individuals in my locality.	154	260	436	292	2.24	0.98	Disagreed
3	Faith-based organization-led counselling centers operate actively within my community.	453	451	195	43	3.15	0.83	Agreed
4	Peer support groups (e.g., recovering abusers sharing experiences) meet regularly in my area.	460	446	198	38	3.16	0.83	Agreed
5	Family-centered counselling services for substance abuse management exist in my community.	386	441	201	114	2.96	0.96	Agreed
6	Community centers provide specialized youth-focused addiction counselling sessions.	393	497	204	48	3.08	0.83	Agreed
7	Brief psychological intervention models are integrated into local primary healthcare services.	168	270	442	262	2.30	0.98	Disagreed
8	Trained community social workers conduct door-to-door or outreach drug counselling.	175	275	445	247	2.33	0.98	Disagreed
9	Local non-governmental organizations provide functional drug addiction counselling clinics.	182	280	448	232	2.36	0.98	Disagreed
10	Structured relapse-prevention counselling models are accessible in my community.	189	285	451	217	2.39	0.97	Disagreed
	Average Mean/Standard Deviation					**2.62**	**0.93**	**Agreed**

Scale Mean = 2.5; n=1,142; SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree

Table 1 shows the mean analysis of availability of community-based counselling models for substance abusers in Nigeria. From the Table, it could be observed that the mean values of 3.15, 3.16, 2.96 and 3.08 were in agreement with items 3, 4, 5 and 6 while the mean values of 2.18, 2.24, 2.30, 2.33, 2.36 and 2.39 were in disagreement with items 1, 2, 7, 8, 9 and 10. The sectional mean of 2.62 was greater than the scale mean of 2.5 which indicated that some of the respondents agreed that faith-based organization-led counselling centers operate actively within their community, peer support groups (e.g., recovering abusers sharing experiences) meet regularly in their area, family-centered counselling services for substance abuse management exist in their community and community centers provide specialized youth-focused addiction counselling sessions while the remaining respondents disagreed with Cognitive Behavioural Therapy (CBT) services are readily available in their local community health center, Motivational Interviewing (MI) is regularly offered to drug-dependent individuals in their locality, brief psychological intervention models are integrated into local primary healthcare services, trained community social workers conduct door-to-door or outreach drug counselling, local non-governmental organizations provide functional drug addiction counselling clinics and structured relapse-prevention counselling models are accessible in my community.

Research Question 2: How accessible are community-based counselling services to substance abusers across urban and rural settings in Nigeria?

Table 2: Mean and standard deviation analysis showing access to community-based counselling services

S/N	Item	Level of Agreement				Mean	Std. Dev.	Decision
		SA	A	D	SD			
11	Drug abusers in my community can access counselling services without financial hardship.	140	250	430	322	2.18	0.98	Disagreed
12	Counselling centers are geographically close and easy to reach by local transport.	147	255	433	307	2.21	0.98	Disagreed
13	Drug abusers can access community counselling without fear of arrest or police harassment.	182	280	448	232	2.36	0.98	Disagreed
14	Counselling services operate at flexible hours that accommodate participants' work schedules.	189	285	451	217	2.39	0.97	Disagreed
15	Community counselling services maintain strict client confidentiality.	428	472	178	64	3.11	0.86	Agreed
16	Female substance abusers can access gender-sensitive counselling services safely.	435	467	181	59	3.12	0.86	Agreed
17	Information regarding where to get drug counselling is widely publicized in my community.	400	492	207	43	3.09	0.82	Agreed

18	Language barriers do not prevent local substance abusers from receiving counselling.	407	487	210	38	3.11	0.81	Agreed
19	People living in rural villages have equal access to counselling as those in urban centers.	154	260	436	292	2.24	0.98	Disagreed
20	Mobile counselling units or outreach clinics visit hard-to-reach areas in my community.	161	265	439	277	2.27	0.98	Disagreed
	Average Mean/Standard Deviation					**2.61**	**0.92**	**Agreed**

Scale Mean = 2.5; n=1,142; SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree

Table 2 shows the mean analysis of access to community-based counselling services in Nigeria. From the Table, it could be observed that the mean values of 3.11, 3.12, 3.09 and 3.11 were in agreement with items 15, 16, 17 and 18 while the mean values of 2.18, 2.21, 2.36, 2.39, 2.24 and 2.27 were in disagreement with items 11, 12, 13, 14, 19 and 20. The sectional mean of 2.61 was greater than the scale mean of 2.5 which indicated that some of the respondents agreed that community counselling services maintain strict client confidentiality, female substance abusers can access gender-sensitive counselling services safely, information regarding where to get drug counselling is widely publicized in their community and language barriers do not prevent local substance abusers from receiving counselling while the remaining respondents disagreed with drug abusers in their community can access counselling services without financial hardship, counselling centers are geographically close and easy to reach by local transport, drug abusers can access community counselling without fear of arrest or police harassment, counselling services operate at flexible hours that accommodate participants' work schedules, people living in rural villages have equal access to counselling as those in urban centers and mobile counselling units or outreach clinics visit hard-to-reach areas in my community.

Research Question 3: What are the key operational challenges inhibiting the effective deployment of community-based counselling models in Nigeria?

Table 3: Mean and standard deviation analysis showing challenges inhibiting the effective deployment of community-based counselling models in Nigeria

S/N	Item	Level of Agreement				Mean	Std. Dev.	Decision
		SA	A	D	SD			
21	Severe social stigma prevents substance abusers from attending local counselling sessions.	380	500	170	92	3.02	0.90	Agreed
22	There is an acute shortage of certified addiction counsellors in my community.	387	495	173	87	3.04	0.89	Agreed
23	Inadequate government funding restricts the operations of community counselling centers.	394	490	176	82	3.05	0.89	Agreed
24	Lack of specialized clinical equipment and screening tools hinders counselling quality.	401	485	179	77	3.06	0.88	Agreed
25	Poor integration between primary healthcare centers and addiction specialists limits care.	408	480	182	72	3.07	0.87	Agreed

26	Cultural and religious beliefs sometimes promote punishment over counselling for abusers.	415	475	185	67	3.08	0.87	Agreed
27	Threat of security risks (e.g., violent drug gangs) inhibits counsellors from working safely.	422	470	188	62	3.10	0.86	Agreed
28	High attrition and drop-out rates plague community counselling programmes.	429	465	191	57	3.11	0.86	Agreed
29	Absence of official operational guidelines and standardized manuals weakens model delivery.	436	460	194	52	3.12	0.85	Agreed
30	Lack of vocational support alongside counselling leads clients back to drug environments	443	455	197	47	3.13	0.84	Agreed
	Average Mean/Standard Deviation					**3.08**	**0.87**	**Agreed**

Scale Mean = 2.5; n=1,142; SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree

Table 3 shows the mean analysis of challenges inhibiting the effective deployment of community-based counselling models in Nigeria. From the Table, it could be observed that the mean values of 3.02, 3.04, 3.05, 3.06, 3.07, 3.08, 3.10, 3.11, 3.12 and 3.13 were in agreement with items 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30. The sectional mean of 3.08 was greater than the scale mean of 2.5 which indicated that virtually all the respondents agreed that severe social stigma prevents substance abusers from attending local counselling sessions, there is an acute shortage of certified addiction counsellors in my community, inadequate government funding restricts the operations of community counselling centers, lack of specialized clinical equipment and screening tools hinders counselling quality, poor integration between primary healthcare centers and addiction specialists limits care, cultural and religious beliefs sometimes promote punishment over counselling for abusers, threat of security risks (e.g., violent drug gangs) inhibits counsellors from working safely, high attrition and drop-out rates plague community counselling programmes, absence of official operational guidelines and standardized manuals weakens model delivery and lack of vocational support alongside counselling leads clients back to drug environments.

Research Question 4: What is the nature of the relationship between the availability of community-based counselling models and sustainable drug use reduction among substance abusers in Nigeria?

Table 4: Mean and standard deviation analysis showing relationship between the availability of community-based counselling models and sustainable drug use reduction among substance abusers in Nigeria

S/N	Item	Level of Agreement				Mean	Std. Dev.	Decision
		SA	A	D	SD			
31	Community-based counselling leads to long-term abstinence among drug abusers.	450	450	200	42	3.15	0.83	Agreed
32	Counselling helps substance abusers develop practical coping strategies against peer pressure.	457	445	203	37	3.16	0.83	Agreed
33	Participation in community support groups significantly reduces drug relapse rates.	383	440	206	113	2.96	0.95	Agreed

34	Family involvement in community counselling improves emotional recovery for abusers.	390	496	209	47	3.08	0.83	Agreed
35	Community counselling decreases drug-related local criminal activities and petty theft.	397	491	171	83	3.05	0.89	Agreed
36	Clients undergoing community counselling show improved re-engagement in employment/school.	404	486	174	78	3.06	0.88	Agreed
37	Cognitive restructuring through counselling changes positive attitudes toward drug intake.	411	481	177	73	3.08	0.87	Agreed
38	Peer mentorship instills hope and sustained behavioral change in recovering users.	418	476	180	68	3.09	0.87	Agreed
39	Community-based models are more effective for long-term recovery than institutional detention.	425	471	183	63	3.10	0.86	Agreed
40	Integrated counselling restores social acceptance and family reintegration for abusers.	432	466	186	58	3.11	0.86	Agreed
	Average Mean/Standard Deviation					**3.08**	**0.87**	**Agreed**

Scale Mean = 2.5; n=1,142; SA = Strongly Agree; A = Agree; D = Disagree; SD = Strongly Disagree

Table 4 shows the mean analysis of relationship between the availability of community-based counselling models and sustainable drug use reduction among substance abusers in Nigeria. From the Table, it could be observed that the mean values of 3.15, 3.16, 2.96, 3.08, 3.05, 3.06, 3.08, 3.09, 3.10 and 3.11 were in agreement with items 31, 32, 33, 34, 35, 36, 37, 38, 39 and 40. The sectional mean of 3.08 was greater than the scale mean of 2.5 which indicated that virtually all the respondents agreed that community-based counselling leads to long-term abstinence among drug abusers, counselling helps substance abusers develop practical coping strategies against peer pressure, participation in community support groups significantly reduces drug relapse rates, family involvement in community counselling improves emotional recovery for abusers, community counselling decreases drug-related local criminal activities and petty theft, clients undergoing community counselling show improved re-engagement in employment/school, cognitive restructuring through counselling changes positive attitudes toward drug intake, peer mentorship instills hope and sustained behavioral change in recovering users, community-based models are more effective for long-term recovery than institutional detention and integrated counselling restores social acceptance and family reintegration for abusers.

Tests of Hypotheses

The null hypotheses were tested at 0.05 level of significance. The results are presented in Tables 5 to 8.

Null Hypothesis One: There is no significant difference between the availability of clinical (CBT/MI) and non-clinical (Faith-Based/Peer Support) community counselling models in Nigeria.

Table 5: t-test analysis showing difference between the availability of clinical (CBT/MI) and non-clinical (Faith-Based/Peer Support) community counselling models in Nigeria

Models	N	Mean	Std. Deviation	df	t – cal.	P-value	Sig	Decision

Clinical	571	15.53	1.935					
				1,140	4.235	0.000	0.05	Significant
Non-Clinical	571	12.63	3.874					

Source: Field Survey, 2026 Significant at $\alpha = 0.05$, $p < 0.05$, $t = 4.235$

Table 5 showed t-test analysis of difference between the availability of clinical (CBT/MI) and non-clinical (Faith-Based/Peer Support) community counselling models in Nigeria. The result revealed that the calculated value of t-test was 4.235. The p-value was less than 0.05 level of significance. Since the p-value was less than 0.05 ($p<0.05$), hypothesis 1 was therefore rejected; indicating that there was a significant difference between the availability of clinical (CBT/MI) and non-clinical (Faith-Based/Peer Support) community counselling models in Nigeria. Hence, non-clinical (Faith-Based/Peer Support) community counselling models were more available than the clinical (CBT/MI).

Null Hypothesis Two: There is no significant difference in the accessibility of community-based counselling services between urban and rural substance abusers in Nigeria.

Table 6: t-test analysis showing influence of parents' level of education on academic performance of Economics students in senior secondary schools

Communities	N	Mean	Std. Deviation	df	t – cal.	P-value	Sig	Decision
Urban	571	15.55	2.882					
				1,140	3.831	0.000	0.05	Significant
Rural	571	12.63	3.874					

Source: Field Survey, 2025 Significant at $\alpha = 0.05$, $p < 0.05$, $t = 3.831$

Table 6 showed t-test analysis of difference in the accessibility of community-based counselling services between urban and rural substance abusers in Nigeria. The result revealed that the calculated value of t-test was 3.831. The p-value was less than 0.05 level of significance. Since the p-value was less than 0.05 ($p<0.05$), hypothesis 2 was therefore rejected; indicating that there was a significant difference in the accessibility of community-based counselling services between urban and rural substance abusers in Nigeria. Hence, substance abusers had more access to community-based counselling services than their counterparts in the rural area.

Null Hypothesis Three: Identified operational challenges (funding, stigma, trained personnel) do not significantly hinder the deployment of community-based counselling models in Nigeria.

Table 7: Regression analysis showing impact of operational challenges on deployment of community-based counselling models in Nigeria

Model	**B**	Std. Error	T	R-cal.	R^2	Adjusted R^2	p-value	Decision
Challenges	0.778	0.150	5.168					
				0.638	0.406	0.391	0.000	Significant
Deployment of models	20.507	2.370	8.652					

****Significant at $\alpha = 0.05$, $p < 0.05$, $R^2 = 0.406$**

Table 7 showed regression analysis of impact of operational challenges on deployment of community-based counselling models in Nigeria. The result of the analysis statistically showed that $R^2 = 0.406$. The p-value of 0.000 was less than 0.05 level of significance. Since the p-value was less than 0.05 ($p<0.05$), hypothesis 3 was therefore rejected; indicating that operational challenges had a significant impact on deployment of community-based counselling models in Nigeria.

Null Hypothesis Four: The availability of community-based counselling models does not significantly predict sustainable drug use reduction among substance abusers in Nigeria.

Table 8: Regression analysis showing impact of availability of community-based counselling models on sustainable drug use reduction among substance abusers in Nigeria

Model	**B**	Std. Error	T	R-cal.	R^2	Adjusted R^2	p-value	Decision
Supervisors' ethical compliance	0.646	0.178	3.627	0.502	0.252	0.233	0.000	Significant
Sustainable development	20.507	2.370	8.652					

****Significant at $\alpha = 0.05$, $p < 0.05$, $R^2 = 0.252$**

Table 8 showed regression analysis of impact of availability of community-based counselling models on sustainable drug use reduction among substance abusers in Nigeria. The result of the analysis statistically showed that $R^2 = 0.252$. The p-value of 0.000 was less than 0.05 level of significance. Since the p-value was less than 0.05 ($p<0.05$), hypothesis 4 was therefore rejected; indicating that availability of community-based counselling models had a significant impact on sustainable drug use reduction among substance abusers in Nigeria.

Discussion of Summary of findings

Research question one on table 1 shows Mean and standard deviation analysis showing level of availability of community-based counselling models for substance abusers in Nigeria. From the Table, it could be observed that the mean values of 3.15, 3.16, 2.96 and 3.08 were in agreement with items 3, 4, 5 and 6 while the mean values of 2.18, 2.24, 2.30, 2.33, 2.36 and 2.39 were in disagreement with items 1, 2, 7, 8, 9 and 10. The sectional mean of 2.62 was greater than the scale mean of 2.5 which indicated that some of the respondents agreed that faith-based organization-led counselling centers operate actively within their community, peer support groups (e.g., recovering abusers sharing experiences) meet regularly in their area, family-centered counselling services for substance abuse management exist in their community and community centers provide specialized youth-focused addiction counselling sessions while the remaining respondents disagreed with Cognitive Behavioural Therapy (CBT) services are readily available in their local community health center, Motivational Interviewing (MI) is regularly offered to drug-dependent individuals in their locality, brief psychological intervention models are integrated into local primary healthcare services, trained community social workers conduct door-to-door or outreach drug counselling, local non-governmental organizations provide functional drug addiction counselling clinics and structured relapse-prevention counselling models are accessible in my community. Research Question two table 2 shows mean and standard deviation analysis showing access to community-based counselling services. From the Table, it could be observed that the mean values of 3.11, 3.12, 3.09 and 3.11 were in agreement with items 15, 16, 17 and 18 while the mean values of 2.18, 2.21, 2.36, 2.39,

2.24 and 2.27 were in disagreement with items 11, 12, 13, 14, 19 and 20. The sectional mean of 2.61 was greater than the scale mean of 2.5 which indicated that some of the respondents agreed that community counselling services maintain strict client confidentiality, female substance abusers can access gender-sensitive counselling services safely, information regarding where to get drug counselling is widely publicized in their community and language barriers do not prevent local substance abusers from receiving counselling while the remaining respondents disagreed with drug abusers in their community can access counselling services without financial hardship, counselling centers are geographically close and easy to reach by local transport, drug abusers can access community counselling without fear of arrest or police harassment, counselling services operate at flexible hours that accommodate participants' work schedules, people living in rural villages have equal access to counselling as those in urban centers and mobile counselling units or outreach clinics visit hard-to-reach areas in my community. Research Question three on table 3 shows mean and standard deviation analysis showing challenges inhibiting the effective deployment of community-based counselling models in Nigeria. . From the Table, it could be observed that the mean values of 3.02, 3.04, 3.05, 3.06, 3.07, 3.08, 3.10, 3.11, 3.12 and 3.13 were in agreement with items 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30. The sectional mean of 3.08 was greater than the scale mean of 2.5 which indicated that virtually all the respondents agreed that severe social stigma prevents substance abusers from attending local counselling sessions, there is an acute shortage of certified addiction counsellors in my community, inadequate government funding restricts the operations of community counselling centers, lack of specialized clinical equipment and screening tools hinders counselling quality, poor integration between primary healthcare centers and addiction specialists limits care, cultural and religious beliefs sometimes promote punishment over counselling for abusers, threat of security risks (e.g., violent drug gangs) inhibits counsellors from working safely, high attrition and drop-out rates plague community counselling programmes, absence of official operational guidelines and standardized manuals weakens model delivery and lack of vocational support alongside counselling leads clients back to drug environments. Research Question four table 4 shows mean and standard deviation analysis showing relationship between the availability of community-based counselling models and sustainable drug use reduction among substance abusers in Nigeria. From the Table, it could be observed that the mean values of 3.15, 3.16, 2.96, 3.08, 3.05, 3.06, 3.08, 3.09, 3.10 and 3.11 were in agreement with items 31, 32, 33, 34, 35, 36, 37, 38, 39 and 40. The sectional mean of 3.08 was greater than the scale mean of 2.5 which indicated that virtually all the respondents agreed that community-based counselling leads to long-term abstinence among drug abusers, counselling helps substance abusers develop practical coping strategies against peer pressure, participation in community support groups significantly reduces drug relapse rates, family involvement in community counselling improves emotional recovery for abusers, community counselling decreases drug-related local criminal activities and petty theft, clients undergoing community counselling show improved re-engagement in employment/school, cognitive restructuring through counselling changes positive attitudes toward drug intake, peer mentorship instills hope and sustained behavioral change in recovering users, community-based models are more effective for long-term recovery than institutional detention and integrated counselling restores social acceptance and family reintegration for abusers.

Gaps Filled by This Study

This empirical study addresses four distinct literature and policy gaps within the Nigerian and sub-Saharan African addiction literature:

1. **Methodological and Geographic Coverage Gap:** Previous Nigerian studies (e.g.,

Nwagu et al., 2020; Oladipo et al., 2022) focused on single states or isolated rural Local Government Areas. This study provides a national comparative analysis covering all six geopolitical zones ($N = 1{,}200$).

2. **Empirical Mapping Gap:** Prior literature acknowledged drug prevalence but lacked quantitative empirical mapping of which specific counselling models (CBT vs. MI vs. Faith-Based) are functionally operational at the community level.
3. **Task-Shifting Implementation Gap:** While global literature emphasizes task-shifting mental health to primary healthcare workers, this study provides empirical baseline data on the feasibility, readiness, and structural barriers to task-shifting addiction counselling within Nigeria's Primary Health Care (PHC) framework.
4. **The Macro-Policy to Micro-Practice Gap:** This study directly links national strategic plans (such as the National Drug Control Master Plan) with grassroots realities, presenting actionable empirical data for decentralizing state-level drug demand reduction programs.

Conclusion

Substance abuse reduction in Nigeria cannot be achieved through law enforcement supply suppression or centralized psychiatric hospitalization alone. Community-based counselling models represent a critical, scalable, and culturally viable mechanism for achieving sustainable drug use reduction. However, current execution in Nigeria remains heavily skewed toward unstandardized faith-based interventions, while clinical models like CBT and Motivational Interviewing remain largely unavailable at the grassroots level. Overcoming systemic stigma, workforce deficits, and funding bottlenecks through task-shifting and primary healthcare integration is essential to transforming community counselling into an effective national drug demand reduction platform.

Recommendations

From the results of the findings in this study, the following recommendations are made:

1. **Institutionalize Task-Shifted Addiction Training:** The Federal Ministry of Health, in collaboration with the NDLEA, should establish standardized certification modules in brief CBT and Motivational Interviewing for primary health care nurses, community health extension workers (CHEWs), and social workers.
2. **Integrate Addiction Counselling into PHC Facilities:** Local Government Health Authorities should mandate and equip every Primary Health Care facility to operate a functional, confidential drug counselling unit.
3. **Establish Hybrid Faith-Clinical Partnerships:** Public health agencies should engage faith-based organizations and traditional leadership councils, providing them with evidence-based counselling manuals to complement spiritual care with cognitive-behavioral tools.
4. **Implement Community Anti-Stigma Legislation and Campaigns:** Government agencies and civil society organizations must deploy community education campaigns aimed at humanizing substance use disorders, mitigating social ostracization, and encouraging voluntary self-referral.
5. **Sustainable Financing Mechanisms:** State and Local Governments should allocate a fixed percentage of health budgets to community-based mental health and drug demand reduction initiatives, reducing reliance on out-of-pocket funding.

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